

Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017- 2021

Division of HIV/AIDS Prevention

**National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention**

HIV/AIDS Bureau

Health Resources and Services Administration

June 2015



Centers for Disease Control and Prevention and Health Resources and Services Administration

2017 - 2021 Integrated HIV Prevention and Care Plan, Including the Statewide Coordinated Statement of Need

Executive Summary

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) developed this guidance to support the submission of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), a legislative requirementⁱ for Ryan White HIV/AIDS Program (RWHAP) Part A and B Grantees. This guidance will help to accelerate progress toward reaching the goals of the National HIV/AIDS Strategyⁱⁱ which include preventing new HIV infections, increasing access to care and improving health outcomes, and reducing HIV-related health disparities. This guidance is set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan. CDC's and HRSA's Integrated HIV Prevention and Care Plan Guidance is based on collaborative planning which addresses local needs and which is flexible in addressing challenges that vary from one community to another. This new format will allow jurisdictions to submit one Integrated HIV Prevention and Care Plan, to both CDC and HRSA.

This guidance builds upon CDC and HRSA's efforts to further reduce reporting burden and duplicated efforts experienced by grantees; streamline the work of health department staff and HIV planning groups; and promote collaboration and coordination in the use of data; all of which inform HIV prevention and care program planning, resource allocation, evaluation, and continuous quality improvement efforts to meet the HIV prevention and care needs in jurisdictions. The Integrated HIV Prevention and Care Plan should also reflect the community's vision and values regarding how best to deliver HIV prevention and care services.

This guidance is written in four sections that provide a framework for HIV prevention and care to grantees: (1) prevention and care needs assessment process and results; (2) integrated HIV prevention and care plan; (3) monitoring and improvement and (4) submission and review process. The Integrated HIV Prevention and Care Plan must cover calendar years 2017 – 2021, and serve as a jurisdictional HIV/AIDS Strategy. HIV planning bodies should use this living document as a roadmap to guide its HIV prevention and care planning throughout the year. Updates to the Integrated HIV Prevention and Care Plan can be developed at the jurisdictional level and submitted annually, if necessary, to reflect local needs and changes in the health care delivery system.

Introduction

The context of HIV prevention and care in the United States has evolved due to changes in the health care delivery system, chiefly the implementation of the Affordable Care Act (ACA)ⁱⁱⁱ, and recent advances in biomedical, behavioral, and structural strategies to prevent and control HIV in the US. The National HIV/AIDS Strategyⁱ and the White House HIV/AIDS Care Continuum Initiative^{iv} have bolstered further integration of HIV prevention and care efforts and fostered new approaches to addressing barriers to HIV testing and care and treatment. Federal agencies, state and local health departments, community-based organizations, health care providers, and people living with HIV (PLWH) continue to use the goals of the National HIV/AIDS Strategy and the HIV Care Continuum to measure progress toward the goals of preventing HIV, diagnosing people who do not know their HIV status, linking PLWH to care and treatment, retaining PLWH in care and treatment, prescribing HIV medication treatment to PLWH, and achieving viral suppression.

To better support the integration of HIV prevention and care service delivery, CDC and HRSA developed this guidance with a new format to support the submission of an Integrated HIV Prevention and Care Plan, including HIV prevention and care planning activities for jurisdictions, as well as the Statewide Coordinated Statement of Need (SCSN), a legislative requirement^v for Ryan White HIV/AIDS Program (RWHAP) Part A and B grantees. In order to reduce the burden of planning and reporting, CDC and HRSA created this guidance that will contribute to the following goals: aligning of submission dates, reducing reporting burden, leveraging resources for HIV prevention and care, utilizing integrated epidemiologic profiles, and submitting a multiyear plan that will cover a period of 5 years.

Background: CDC Jurisdictional HIV Prevention Plan, HRSA SCSN, and HRSA Comprehensive Plans

Since 1993, health departments funded by CDC, through the Comprehensive Human Immunodeficiency Virus (HIV) Prevention Programs for Health Departments Funding Opportunity Announcement, are required to have an HIV prevention planning process that includes the establishment of an HIV prevention planning group (HPG) and the development of a jurisdictional HIV prevention plan. The Division of State HIV/AIDS Programs (DSHAP) within HRSA's HIV/AIDS Bureau (HAB) requires Ryan White HIV/AIDS Program Part B Grantees to convene a planning advisory group and to submit a Statewide Coordinated Statement of Need (SCSN) which includes the participation of a variety of stakeholders and requires the participation of all of the RWHAP Part Programs funded in the jurisdiction. HAB's Division of Metropolitan HIV/AIDS Ryan White Programs Part A Grantees are legislatively required to participate in the development of the SCSN. The purpose of the SCSN is to provide a collaborative mechanism to identify and address the most significant HIV needs of PLWH and to maximize coordination, integration, and effective linkages across all Ryan White HIV/AIDS Program Parts. Both RWHAP Part A and B Grantees are also required to submit a comprehensive plan.

Moving Forward: CDC and HRSA Expectations for an Integrated HIV Prevention and Care Plan

All CDC/DHAP and HRSA/HAB funded jurisdictions (the 50 states, RWHAP Part A-funded Eligible Metropolitan Areas and Transitional Grant Areas, directly-funded CDC HIV prevention cities, Puerto Rico, the United States Virgin Islands, and the United States Affiliated Pacific Island jurisdictions) are required to have a planning process that includes the development of a Comprehensive Plan and the establishment of either an HIV Planning Group, Planning Council, or Advisory Group, hereafter, referred to as “planning body.” HIV planning contributes to HIV prevention and care and treatment service delivery through developing strategic collaboration among stakeholders. HIV planning entails broadening the group of partners and stakeholders which include other Federal, state, and local HIV/AIDS programs and organizations, engaged in prevention planning, improving the scientific basis of program decisions, targeting resources to those communities at highest risk for HIV transmission and acquisition, and addressing disparities in health outcomes along the HIV Care Continuum. Please refer to the most recent HIV Planning Guidance (HPG)^{vi} and the Ryan White HIV/AIDS Program Part A^{vii} and Part B^{viii} Manuals for more details about HIV planning processes.

The Integrated HIV Prevention and Care Plan is a vehicle to identify HIV prevention and care needs, existing resources, barriers, and gaps within jurisdictions and outlines the strategies to address them. It is the intent of this Guidance to help stimulate the development of integrated plans that will reduce the burden of historically independent plan submissions and increase efficiencies in the use of planning resources, as well as contribute to resultant improvements in program effectiveness and health outcomes for the HIV at-risk and infected populations. The Integrated HIV Prevention and Care Plan, including the SCSN, also articulates the existing and needed collaboration among PLWH, service providers, funded program implementers, and other stakeholders. While there is not a standard template for the Integrated HIV Prevention and Care Plan, the plan submitted must include all of the components outlined in the guidance. Jurisdictions may utilize or reference existing content from program implementation plans, state or city plans, or other planning documents, if that content addresses the guidance requirements.

- One Integrated HIV Prevention and Care Plan may be submitted on behalf of several jurisdictions (e.g., the State, the Part A jurisdictions in that State, CDC directly funded cities in that State), but each HRSA and CDC-funded jurisdiction needs to participate in the completion and submission of an Integrated HIV Prevention and Care Plan.
- The Integrated HIV Prevention and Care Plan should include information on who is responsible for developing the Integrated HIV Prevention and Care Plan within the jurisdictions (i.e., RWHAP Part A planning councils, RWHAP Part B advisory groups, and CDC HIV planning bodies).
- The Integrated HIV Prevention and Care Plan should define and provide the goal(s) (i.e., coordination in planning of HIV prevention and care services) which allows jurisdictions to articulate their roadmap on how they will address the prevention, care, and treatment needs in their service areas and accomplish the goals of the National HIV/AIDS Strategy and the principles and the intent of the HIV Care Continuum.

The Integrated HIV Prevention and Care Plan is required to align with the goals of the National HIV/AIDS Strategy (NHAS) and to use the principles and the intent of the HIV Care Continuum to inform the needs assessment process and the service delivery implementation. Jurisdictions funded by both CDC DHAP and HRSA HAB should submit a single Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need; however, jurisdictions may submit separate plans to both the CDC and HRSA if local structural factors are such that a single submission is not feasible. For jurisdictions with directly-funded state and city health departments, the city Integrated HIV Prevention and Care Plan should complement the state Integrated HIV Prevention and Care Plan, including the SCSN and effectively depict and address the HIV epidemic within the jurisdiction.

All funded entities must submit an Integrated HIV Prevention and Care plan responsive to the guidance. It is ideal and preferable that an Integrated HIV Prevention and Care Plan be submitted to CDC and HRSA, however, CDC and HRSA acknowledge there is no one-size-fits-all model for integrated HIV planning, and therefore, the initial result in the process may be the submission of separate plans which are responsive to the guidance.^{ix} CDC and HRSA strongly encourage collaboration between HIV prevention and care to respond to all components of the guidance.

State and/or local jurisdictions (municipalities) have the option to submit a(n):

- Integrated state/city prevention and care plan to CDC and HRSA;
- Integrated state-only prevention and care plan to CDC and HRSA;
- Integrated city-only prevention and care plan to CDC and HRSA;
- City-only prevention plan to CDC; or a
- City-only care plan to HRSA.

The Integrated HIV Prevention and Care Plan is a vehicle to develop a coordinated approach to addressing the HIV epidemic at the state and local levels. The progress on achieving the objectives presented in the Integrated HIV Prevention and Care Plan will be reported on a periodic basis through CDC and HRSA's existing reporting requirements (i.e., annual application, annual progress reports, and implementation plans).

Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

Needs assessment is a process of collecting information about the needs of persons at risk for HIV infection and people living with HIV (those receiving care and those not receiving care); identifying current resources available to meet those needs, and determining what gaps in HIV prevention and care services exist.

Conducting a needs assessment is a legislative requirement for Ryan White HIV/AIDS Programs (RWHAP) Part A Grantees and a programmatic requirement for the Centers for Disease Control and Prevention (CDC) Division of HIV Prevention (DHAP) Grantees. Conducting and submitting the SCSN is a legislative requirement for RWHAP B grantees, with other RWHAP Part Program participation required. The specific CDC and HRSA requirements are:

- RWHAP Part A Grantees must “participate in the development of a statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under Part B.” [Section 2602(b)(4)(F)]
- RWHAP Part B Grantees must facilitate the development of a Statewide Coordinated Statement of Need, a process to collaboratively identify significant issues related to the needs of PLWH in the State and to maximize coordination across all Parts and programs, resulting in a document reflecting the input and approval of all RWHAP Parts. The RWHAP Part B participates in SCSN meetings; recruits participants; and drafts and submits the SCSN document. The SCSN involves a meeting that is convened by the State and includes RWHAP grantees from all Parts as well as PLWH, members of a Federally recognized Indian tribe as represented in the State, providers, and public agency representatives. [Section 2617(b)(6)]
- CDC funded grantees are required to conduct a needs assessment (e.g., resources, infrastructure, and service delivery). If a needs assessment does not exist or is outdated, the applicant will have to conduct or update the capacity-building needs assessment of the health department, HIV prevention service providers, and other prevention agencies/partners, including CBOs’ capacity to provide HIV prevention services (e.g., testing, navigation, and linkage to care).

RWHAP Part B Grantees are required to include representatives from HIV prevention, HIV surveillance, substance abuse, mental health, Medicaid, Medicare, Community Health Centers, Veterans Health Administration, Housing and Urban Development (HUD), and other entities that may be appropriate for developing a Statewide Coordinated Statement of Need for HIV services. Likewise, CDC Grantees are also strongly encouraged to utilize a wide variety of representatives to identify resources and gaps in HIV prevention and care services. Conducting comprehensive needs assessments is a partnership activity of the planning council/TGA planning body and RWHAP Part A Grantee, with the planning council/TGA planning body taking the lead role. Utilizing these representatives to develop the SCSN/needs assessment component of the Integrated HIV Prevention and Care Plan document will strengthen the development of the needs assessment and help establish partnerships essential to the implementation of the Integrated HIV Prevention and Care Plan.

A. Epidemiologic Overview

An Epidemiologic Overview provides a description of the burden of HIV in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, PLWH and persons at higher risk for infection. Understanding the populations affected by HIV provides the basis for setting priorities, identifying appropriate interventions and services, allocating HIV prevention and care resources, planning programs, and evaluating programs and policies. The overview should be based on available data for the jurisdiction.

For this SCSN/Needs Assessment, the jurisdiction should submit an Epidemiologic Overview based on the “Integrated Guidance for Developing Epidemiologic Profiles: HIV Prevention and RWHAP Planning” issued by CDC and HRSA in August 2014. The Epidemiologic Overview may be taken directly from the most recent application submitted to CDC DHAP and HRSA HAB, with the addition of any information listed below that is currently not included in the submission.

The Epidemiologic Overview should focus on the most recent year for which data are available; when presenting trends, a minimum of 5 years of data are recommended.

This section should:

- a. Describe (map and/or narrative) the geographical region of the jurisdiction (i.e., Metropolitan Statistical Area/Metropolitan Division, Transitional Grant Area/Eligible Metropolitan Area, and States/Territories) with regard to communities affected by HIV infection.
- b. Describe (table, graph, and/or narrative) the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area, including the following, as available in the geographical region of the jurisdiction:
 - i. Demographic data (e.g., race, age, sex, transmission category, current gender identity)
 - ii. Socioeconomic data (e.g., percentage of federal poverty level, income, education, health insurance status, etc.).
- c. Describe (table, graph, and/or narrative) the burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV (i.e., number of PLWH, rates, trends, populations most affected, geographic concentrations, deaths, etc.).
- d. Describe (table, graph, and/or narrative) the indicators of risk for HIV infection in the population covered by your service area using the following, as available in the jurisdiction:
 - i. Behavioral surveillance data, including databases, such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity,

- healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)
- ii. HIV surveillance data, including HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees; CDC HIV testing data) and Clinical data (e.g., CD4 and viral load results)
- iii. Ryan White HIV/AIDS Program data (Ryan White HIV/AIDS Program Services Report; ADAP Data Report)
- iv. Other relevant Demographic data (i.e., Hepatitis B or C surveillance, STD surveillance, Tuberculosis surveillance, and Substance use data)
- v. Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)
- vi. Vital statistics data (e.g., state office of vital statistics, National Death Index, Social Security Death Master File).
- vii. Other Relevant Program Data: (e.g. Community Health Center program data).

B. HIV Care Continuum

The HIV Care Continuum is a model that is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PLWH across the entire HIV Continuum of Care. The HIV Care Continuum has five main “steps” or stages including: HIV diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression. State and local agencies should also use a model to identify issues and opportunities related to improving the delivery of services to high-risk, uninfected individuals, such as: HIV testing and linkage to appropriate prevention services, behavioral health, and social services.

The HIV Care Continuum provides a framework that depicts the series of stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication. It shows the proportion of individuals living with HIV who are engaged at each stage. The HIV Care Continuum allows grantees and planning groups to measure progress and to direct HIV resources most effectively. The development and analysis of a comprehensive HIV Care Continuum involves collaboration across HIV care and treatment, prevention, and surveillance partners and will inform program planning. Grantees and planning groups need to develop an HIV Care Continuum for their jurisdiction as a part of the SCSN/needs assessment process.

To develop the HIV Care Continuum for the jurisdiction, it is essential to determine the approach that will be used. The CDC currently uses two different approaches to construct the HIV Care Continuum, the HIV prevalence-based continuum and the HIV diagnosed-based continuum; both are essential to monitor progress and identify key HIV prevention and care needs. The difference between the two approaches is the base number used to determine the percentage of the subsequent steps of the continuum.

The *prevalence-based* HIV Care Continuum shows each step of the continuum as a percentage of the total number of PLWH (i.e., HIV prevalence). HIV prevalence includes the number of people who have been diagnosed with HIV and the estimated number of those who have not been diagnosed with HIV. Thus, the prevalence-based approach may not be possible in

all jurisdictions at this time, as some may not have reliable estimates of those with undiagnosed HIV; however, there are jurisdictions that are able to implement this approach.

The second approach is the *diagnosis-based* HIV Care Continuum. This approach shows each step of the continuum as a percentage of the number of PLWH who were only diagnosed. The diagnosed-based continuum informs steps that can be taken to get individuals with HIV into care and get them to viral suppression. All grantees should have access to data needed to develop a diagnosed-based HIV Care Continuum.

Prior to developing the HIV Care Continuum, assess what approach is most feasible and will most effectively inform service delivery planning. In some cases it may be best to use both approaches as the information can provide a more complete assessment of the jurisdiction. A thorough discussion of the approach chosen and reason for using this approach should be included in the narrative for this section.

This section should:

- a. Provide a graphic depiction and a descriptive narrative of the HIV Care Continuum of the jurisdiction using the most current calendar year data. The definitions of the numerator and the denominator must be clearly stated for each step. In addition to developing the HIV Care Continuum, include a discussion on the acquisition of data needed to develop it in the “Data: Use, Access, and Systems” section.

The steps of the *diagnosed-based* HIV Care Continuum using the HHS indicators are described below. If any updates are made to the HHS indicators or in the NHAS indicators that would impact the descriptions below, jurisdictions should use the most up-to-date indicator language. If using the *prevalence-based* approach, your continuum will have an additional first step that includes the undiagnosed HIV infected individuals in the jurisdiction and a different denominator for the other steps.

- i. **HIV-Diagnosed:** Diagnosed HIV prevalence in a jurisdiction; the known/reported cases of HIV infection, regardless of AIDS (stage 3 HIV infection) status; this number does not include the number of persons undiagnosed, and only includes the cumulative number of persons reported to the surveillance system through the end of a given year, minus the cumulative number of persons who were reported as having died.
- ii. **Linkage to Care:** The percentage of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load or CD4 tests within 3 months after diagnosis; this measure has a different denominator than all other measures in the continuum. The denominator is the number diagnosed with HIV infection (regardless of AIDS status) in a given calendar year.
- iii. **Retained in Care:** The percentage of diagnosed individuals who had two or more documented medical visits, viral load or CD4 tests, performed at least 3 months apart in the observed year.
- iv. **Antiretroviral Use:** The number of people receiving medical care and who have a documented antiretroviral therapy prescription in their medical records in the measurement year, (if available).
- v. **Viral Load Suppression:** The percentage of individuals whose most recent HIV viral load within the measurement year was less than 200 copies/mL.

- b. Provide a narrative (and graphic, if available) description of disparities in engagement among key populations (e.g., young MSM, IDU, African-American heterosexual women, etc.) along the HIV Care Continuum.
- c. Describe how the HIV Care Continuum may be or is currently utilized in (1) planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction, and (2) improving engagement and outcomes at each stage of the HIV Care Continuum.

C. Financial and Human Resources Inventory

This section of the SCSN/Needs Assessment will provide an inventory of the financial and service delivery provider resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of its population as well as resource gaps. This section will describe the CDC-funded high impact prevention services and the HRSA-funded core medical and support services. Other funding sources (e.g., Substance Abuse and Mental Health Administration [SAMHSA] Office of Rural Health Policy, and Housing and Urban Development [HUD] Housing Opportunities for People with AIDS [HOPWA]) in the jurisdiction should also be described. This section will also describe the HIV workforce capacity in the jurisdiction and how it impacts the HIV service delivery system. While it may be a challenge to capture all public and private investments in HIV prevention and care services in the service area, planners should make reasonable efforts to identify existing resources in the jurisdiction. Planners should engage stakeholders to ascertain a full picture of all HIV resources available in the jurisdiction. By identifying existing resources, deficits in resources will be more evident and communities can make better informed planning decisions. Please refer to *Appendix A* for assistance in identifying other federal HIV funding sources in the jurisdiction.

This section should:

- a. Provide in a table format a jurisdictional HIV resources Inventory, that includes: (1) public and private funding sources for HIV prevention, care, and treatment services in the jurisdiction, (2) the dollar amount and the percentage of the total available funds in fiscal year (FY) 2016 for each funding source; (3) how the resources are being used (i.e., services delivered); and (4) which components of HIV prevention programming and/or steps of the HIV Care Continuum is (are) impacted. At a minimum, the table should contain the following information:
 - i. Funding Sources (e.g., Ryan White HIV/AIDS Program (RWHAP) Parts A-F, including Special Projects of National Significance (SPNS) and the AIDS Education and Training Centers (AETC) Program, CDC HIV Prevention and Surveillance Programs, Minority AIDS Initiative (MAI), SAMHSA, HUD/HOPWA, Medicaid expenditures, Bureau of Primary of Health Care, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, Administration for Children and Families, and other public and private funding sources);

- ii. Funding Amount (\$)
 - iii. Funded Service Provider Agencies
 - iv. Services Delivered
 - v. HIV Care Continuum Step(s) Impacted (*please see Section I. B. HIV Care Continuum*)
- b. Provide a narrative description of the HIV Workforce Capacity in the jurisdiction and how it impacts the HIV prevention and care service delivery system. The jurisdiction must define the workforce (e.g. licensed providers, community health workers, paraprofessionals) as applicable to the jurisdiction.
 - c. Provide a narrative description of how different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.
 - d. Provide a narrative description identifying any needed resources and/or services in the jurisdiction which are not being provided, and steps taken to secure them.

D. Assessing Needs, Gaps, and Barriers

This section of the Integrated SCSN/Needs Assessment will describe the process used to develop a collaborative and coordinated needs assessment that will result in greater alignment and access to HIV prevention, care, and treatment services. The goals of the needs assessment process are to: (1) identify and describe HIV prevention and care services that currently exist and those that are needed; (2) enhance the quality of services for persons at higher risk for HIV and PLWH, based on stakeholder feedback; and (3) identify barriers that impede access to existing services. Needs assessments determine needs for specific populations, such as:

- PLWH who know their HIV status, but are not in care;
- Persons at higher risk for HIV infection;
- Disparities in access to care for certain populations and underserved groups; and
- Coordination among HIV prevention, care, and treatment programs, as well as other necessary services (e.g., substance abuse, mental health, housing, etc.).

This section should:

- a. Describe the process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed); this process description should include how various strategies were used to target, recruit, and retain participants in the HIV planning process that represent the myriad of HIV-infected populations and persons at higher risk for HIV infection, other key stakeholders in HIV prevention, care, and related services, and organizations that can best inform and support the development and implementation of the Integrated HIV Prevention and Care Plan.
- b. Describe the HIV prevention and care *service needs* of persons at risk for HIV and PLWH.

- c. Describe the *service gaps* (i.e., prevention, care and treatment, and necessary support services e.g. housing assistance and support) identified by and for persons at higher risk for HIV and PLWH.
- d. Describe *barriers* to HIV prevention and care services, including, but not limited to:
 - i. Social and structural barriers (e.g., poverty, cultural barriers, stigma, etc.);
 - ii. Federal, state, or local legislative/policy barriers (e.g., the changing health care coverage landscape, policies on HIV testing or lab reporting, etc.);
 - iii. Health department barriers (e.g., political landscape, staff capacity, etc.);
 - iv. Program barriers (e.g., infrastructure capacity, access to data, data sharing, inadequate health information systems, availability of funding, etc.);
 - v. Service provider barriers. Discuss any stakeholder(s) that are not involved with planning for HIV services that need(s) to be involved in order to address gaps in components of HIV Prevention programming and/or along the HIV Care Continuum more effectively (e.g., lack of specialized resources or specialty care providers.); and
 - vi. Client barriers (e.g., transportation, homelessness/housing instability, inability to navigate the system, poverty, stigma, comorbid conditions, etc.).

E. Data: Access, Sources, and Systems

Identifying relevant data sources and data systems is vital to ensuring the SCSN/Needs Assessment section of the Integrated HIV Prevention and Care Plan is as complete as possible. Collaboration among state/local health department colleagues from HIV Surveillance, HIV Prevention, Ryan White HIV/AIDS Programs, and other public health stakeholders, including private entities to identify the main data sources and data systems that are most appropriate for developing the plan is essential.

This section should:

- a. Describe the main sources of data (e.g., RSR data, qualitative data, and surveillance data) and data systems (e.g., CAREWare, eHARS) used to conduct the needs assessment, including the development of the HIV Care Continuum.
- b. Describe any data policies that facilitated and/or served as barriers to the conduct of the needs assessment, including the development of the HIV Care Continuum.
- c. Describe any data and/or information that the planning group would like to have used in conducting the needs assessment including developing the HIV Care Continuum and the plan, but that was unavailable.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The Integrated HIV Prevention and Care Plan development is a joint effort between jurisdictions and planning bodies that engages persons at higher risk for HIV infection, PLWH, service delivery providers, and other community stakeholders. It sets forth the jurisdiction's commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to addressing HIV. The Integrated HIV Prevention and Care Plan establish the blueprint for achieving HIV prevention, care, and treatment goals. The Integrated HIV Prevention and Care Plan should include:

- **Goals:** a broad statement of purpose that describes the expected long-term effects of efforts consistent with the National HIV/AIDS Strategy and covering a period of 5 years
- **Objectives:** measurable statements that describe results to be achieved;
- **Strategies:** the approach by which the objectives will be achieved
- **Activities:** describing how the objectives will be achieved
- **Resources:** committed toward implementing the activities

In this section, grantees and planning bodies will use the National HIV/AIDS Strategy (NHAS) as the organizing framework for the Integrated HIV Prevention and Care Plan to achieve a more coordinated jurisdictional response to the local HIV epidemic. The Integrated HIV Prevention and Care Plan should respond to the needs identified in Section I of the Integrated HIV SCSN/Needs Assessment guidance and align with the three NHAS goals: (1) reducing new HIV infections; (2) increasing access to care and improving health outcomes for PLWH; and (3) reducing HIV related disparities and health inequities.

This section should:

- a. Identify at least two objectives (using the SMART format – specific, measurable, achievable, realistic, and time-phased) that correspond to each NHAS goal.
- b. For each objective, describe at least three strategies that correspond to each objective.
- c. For each strategy, describe the activities/interventions, targeted populations, responsible parties, and time-phased, resources needed to implement the activity. Identify any activities specifically aimed at addressing gaps along the HIV Care Continuum.
- d. Describe the metrics (e.g., number of HIV tests performed, medical visits, mental health screenings, HIV positivity rate, etc.) that will be used to monitor progress in achieving each goal outlined in the plan. Metrics should be consistent with the most current HHS Core Indicators and the NHAS Indicators.
- e. Describe any anticipated challenges or barriers in implementing the plan.

Below is an example of a response that corresponds to an NHAS goal:

2010 – 2015 NHAS Goal: Reducing New HIV infections

2010 – 2015 SMART Objective (National): By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).

2017 – 2021 SMART Objective (Local): By 2021, lower the annual number of new infections by 10 percent (from 100 to 90).

Strategy: Intensify HIV prevention efforts in communities where HIV is most heavily concentrated.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	Ryan White Part A Early Intervention Service Providers	Deliver intensified HIV testing, referral services to eliminate barriers to care, health literacy and linkage to core medical services	Young Men who have Sex with Men (MSM)	<ul style="list-style-type: none"> • Number of HIV tests performed • HIV Positivity Rate • Number linked to medical care
By the end of 2021:	CDC-funded Health Department	Deliver expanded partner services and HIV testing for partners of those infected.	MSM	<ul style="list-style-type: none"> • Number of HIV tests performed • Number of newly diagnosed HIV positive persons

B. Collaborations, Partnerships, and Stakeholder Involvement

Collaboration among stakeholders is critical to maximizing resources and efficiencies in serving PLWH. As jurisdictions continue to develop high-quality, coordinated prevention and care and treatment for PLWH, collaboration will become even more important and will be paramount to providing services that fully address each component of the HIV care continuum.

This section should:

- a. Describe the specific contributions of stakeholders and key partners to the development of the plan
- b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum

- c. Provide a letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the planning body and the health department representatives (*Appendix B*)

C. People Living With HIV (PLWH) and Community Engagement

Key principles of the Integrated HIV Prevention and Care Plan development process supported by CDC and HRSA are inclusion of at-risk groups and representation of people living with HIV (PLWH). This process must include representatives of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics reflecting the experiences and expertise of those impacted by HIV in the jurisdiction. CDC and HRSA recognize the essential role of PLWH, especially those who are consumers of RWHAP services, in planning and implementing programs to successfully serve targeted populations. CDC and HRSA believe that HIV planning processes involving the at-risk, affected, and infected community working together to develop specific strategies to enhance coordination, collaboration, and seamless access to HIV prevention, care, and treatment services are necessary to achieve the goals of the National HIV AIDS Strategy.

The inclusion of community stakeholders in the development of the Integrated HIV Prevention and Care Plan helps ensure that HIV prevention and care activities are responsive to the needs in the service area. Community stakeholders include, but are not limited to, HIV service providers, PLWH, and at-risk groups.

This section should:

- a. Describe how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction.
- b. Describe how the inclusion of PLWH contributed to the plan development.
- c. Describe the methods used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.
- d. Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

Section III: Monitoring and Improvement

Monitoring the Integrated HIV Prevention and Care Plan will assist grantees and planning bodies with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information; and analyzing information to inform decision-making and improve HIV prevention, care, and treatment efforts within the jurisdiction.

This section should:

- a. Describe the process for regularly updating planning bodies and stakeholders on the progress of plan implementation, soliciting feedback, and using the feedback from stakeholders for plan improvements.
- b. Describe the plan to monitor and evaluate implementation of the goals and SMART objectives from Section II: Integrated HIV Prevention and Care Plan.
- c. Describe the strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum which will be used to impact the quality of the HIV service delivery system, including strategic long-range planning.

Section IV: Submission and Review Process

Funded entities are expected to submit the Integrated HIV Prevention and Care Plan to HRSA and CDC by September 30, 2016 to meet the legislative and programmatic requirements of HRSA's and CDC's programs. For CDC, submit the Plan to: PS12-1201@cdc.gov and send a courtesy copy to your project officer. For HRSA, submit the Plan through the appropriate portal in the Electronic Handbook.

HRSA and CDC will conduct a joint review of the jurisdiction's Integrated HIV Prevention and Care Plan and will provide joint feedback to the funded programs, as appropriate to the type of plan submitted.

If applicable to HRSA or CDC requirements, updates to the Integrated HIV Prevention and Care Plan will be submitted on an annual basis through the progress report. CDC and HRSA will provide further instructions to jurisdictions, as needed.

ⁱ Health Resources and Services Administration. About the Ryan White HIV/AIDS Program: Legislation. <http://hab.hrsa.gov/abouthab/legislation.html>. Accessed March 23, 2015.

ⁱⁱ The White House Office of National AIDS Policy. National HIV/AIDS strategy for the United States. 2010. <http://www.whitehouse.gov/administration/eop/onap/nhas>. Accessed March 23, 2015.

ⁱⁱⁱ The Affordable Care Act: About the Law. U.S. Department of Health and Human Services. <http://www.hhs.gov/healthcare/rights/>. Accessed March 23, 2015.

^{iv} The U.S. Department of Health and Human Services. AIDS.gov. HIV/AIDS Care Continuum. <https://www.aids.gov/federal-resources/policies/care-continuum/>. Accessed March 23, 2015.

^v Health Resources and Services Administration. About the Ryan White HIV/AIDS Program: Legislation. <http://hab.hrsa.gov/abouthab/legislation.html>. Accessed March 23, 2015.

^{vi} Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention. HIV Planning Guidance. http://www.cdc.gov/hiv/pdf/policies_funding_ps12-1201_HIV_Planning_Guidance.pdf. Accessed March 23, 2015.

^{vii} Health Resources and Services Administration, HIV/AIDS Bureau. Ryan White HIV/AIDS Program Part A Manual. <http://hab.hrsa.gov/manageyourgrant/files/happartamanual2013.pdf>. Accessed March 23, 2015.

^{viii} Health Resources and Services Administration, HIV/AIDS Bureau. Ryan White HIV/AIDS Program Part B Manual. <http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf>. Accessed March 23, 2015.

^{ix} EGM Consulting. HRSA Ryan White HIV/AIDS Program Part A, Part B, and CDC HIV Prevention Planning Bodies: Integrated HIV Prevention Care Activities. https://careacttarget.org/library/rwhap-cdc-integrated-planning-examples#_Information_Sharing

APPENDIX A: Federal HIV Funding Resources

This non-exhaustive list provides web sites to assist with identifying federal HIV funding resources in U.S. jurisdictions.

General

[USA Spending](#)

[Kaiser Family Foundation – Total Federal HIV/AIDS Grant Funding](#)

Health Resources and Services Administration (HRSA)

[Health Resources and Services Administration HIV/AIDS Programs – Grantee Allocations & Expenditures](#)

[Health Resources and Services Administration Federal Office of Rural Health Policy, Rural Assistance Center, Rural HIV and AIDS Funding & Opportunities](#)

U.S. Department of Housing and Urban Development (HUD)

[U.S. Department of Housing and Urban Development Community Planning and Development – Cross-Program Funding Matrix and Dashboard Reports](#)

[U.S. Department of Housing and Urban Development Community Planning and Development Program Formula Allocations for 2015](#)

Centers for Disease Control and Prevention (CDC)

[Centers for Disease Control and Prevention Division of HIV/AIDS Prevention – HIV Funding Awards by State and Dependent Area \(FY 2012\)](#)

Substance Abuse and Mental Health Services Administration (SAMHSA)

[Substance Abuse and Mental Health Services Administration – Grants Related to HIV, AIDS, and Viral Hepatitis](#)

[Substance Abuse and Mental Health Services Administration – Grant Awards by State 2014/2015](#)

U.S. Department of Health and Human Services, Office on Minority Health (OMH)

[U.S. Department of Health and Human Services Office on Minority Health – FY 2014 Competitive Grant Awards](#)

APPENDIX B: Sample Letter of Concurrence or Concurrence with Reservations between Planning Body and State or Local Health Department or Funded Agency

CDC/HRSA Project Officer

Dear (Name):

The [insert name of Planning Body, e.g. planning council, advisory council, HIV planning group, planning body] [insert *concur* or *concur with reservations*] with the following submission by the [insert name of State/Local Health Department/ Funded Agency] in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body, e.g. planning council, advisory council, HIV planning group, planning body, has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body [insert *concur* or *concur with reservations*] that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

[Insert the process used by the planning body to provide input or review the jurisdiction's plan.]

[If applicable, insert how jurisdictions with directly funded states and cities plan to coordinate their HIV Planning process.]

The signature(s) below confirms the [insert *concurrence* or *concurrence with reservations*] of the planning body with the Integrated HIV Prevention and Care Plan.

Signature:

Date:

Planning Body Chair(s)