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

Summary of CDC and HRSA Guidance Document

Section I: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

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

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 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 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 programing 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

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

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.

B. Collaborations, Partnerships, and Stakeholder Involvement

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

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

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.