

PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States

Evaluation and Performance Measurement Plan (EPMP) and Work Plan:

Component A

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**Project Period**: TBD

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**Version 2.0 (September 2, 2021)**

Note: PS20-2010 EPMP Version 2.0 applies to Component A and should not be completed for Component B or Component C.

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# **Program Description**

## Section 1: Logic Model

If you have adopted the CDC PS20-2010 logic model (Appendix A) without modifications, then you will not need to complete the table below. If you made modifications to the CDC logic model, please provide an abbreviated logic model for PS20-2010 Component A that reflects your projects strategies and outcomes in Table 1 below.

| **Table 1. Abbreviated PS20-2010 Logic Model – Ending the HIV Epidemic** | | |
| --- | --- | --- |
| **Activities** | | **Outcomes** |
| **Diagnose** |  |  |
| **Treat** |  |  |
| **Prevent** |  |  |
| **Respond** |  |  |

## Section 2: Program Activities

In the tables below, please provide a description of the program activities to be implemented under PS20-2010. Activities described in this section should align with the strategies and outcomes noted in the logic model provided in Appendix A. Your description for Year 1 should be a summary and should convey enough detail to ensure the understanding of program goals and activities (note: this should not be a copy/paste of program activities from the application). Your description of Years 2-5 should be a high-level summary of the activities.

**Note:** If you need assistance, please contact your PS20-2010 CDC Joint Monitoring Team (JMT).

| **Table 2. Diagnose** | | | |
| --- | --- | --- | --- |
| **Strategy/Activity** | **Program Activities for Year 1 and Years 2-5** | | |
| **Strategy 1A.** Expand or implement routine opt-out HIV screening in health care and other institutional settings in high prevalence communities | | | |
| **1A.1** Conduct routine HIV testing in health care settings | ***Please describe how health care facilities that are not already implementing routine opt-out HIV testing will be identified and selected in Year 1 and Years 2-5. In your response, please address 1) how health care facilities have or will be selected and prioritized to conduct routine HIV testing (e.g., what criteria are used for designating health care settings as routine opt-out HIV testing locations); 2) strategies that have or will be implemented to help routinize HIV testing (e.g., automated HIV test orders, modifications to electronic medical record); and 3) how routine HIV screening is or will be conducted in each of the PS20-2010 health care facilities.*** | | |
| **Year 1** | |  |
| **Years 2-5** | |  |
| **1A.2** Conduct routine HIV testing in jails and correctional facilities in high prevalence communities | ***Please describe how routine opt-out HIV testing will be promoted and conducted in selected jails and correctional facilities during Year 1 and Years 2-5. In your response, please address 1) how jails and correctional facilities have or will be selected and prioritized to conduct routine HIV testing (e.g., what criteria are used for identifying jails and correctional facilities for routine opt-out HIV testing); 2) strategies that have or will be implemented to help routinize HIV testing (e.g., automated HIV test orders, modifications to electronic medical record, use of ‘champions’ or key staff); and 3) how routine opt-out HIV screening will be conducted in each of the PS20-2010-funded jail and correctional facilities.*** | | |
| **Year 1** |  | |
| **Years 2-5** |  | |
| **1A.5** and **1B4.3** Link persons who inject drugs (PWID) who are screened in health care settings (1A5.1) and non-health care settings (1B4.3) to syringe services program (SSP) | ***Please describe how rapid linkage (within 7 days) to syringe services programs will be supported and implemented for persons screened in health care settings and non-health care settings during Year 1 and Years 2-5 of the program.*** | | |
| **Year 1** |  | |
| **Years 2-5** |  | |
| **Strategy 1B.** Develop locally tailored HIV testing programs to reach persons in non-health care settings  **Strategy 1C.** Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in health care and non-health care settings | | | |
| **1B.1** Promote HIV testing in non-traditional health care and non-health care venues | ***Please describe how HIV testing will be promoted in non-traditional health care venues and/or non-traditional non-health care venues during Year 1 and Years 2-5 of the program. In your response, please list and briefly describe the non-traditional health care and/or non-health care venues where PS20-2010-funded HIV testing will be conducted.*** | | |
| **Year 1** |  | |
| **Year 2-5** |  | |
| **1B.2** and **1C.4** Promote rapid HIV self-testing in non-health care settings (1B.2) and in health care settings (1C.4) | ***Please describe how rapid HIV self-testing in health care and non-health care settings will be promoted during Year 1 and Years 2-5 of the program. In your response, please explain how HIV self-test kits will be distributed to or ordered by testers and if and how test results will be shared with health departments.*** | | |
| **Year 1** |  | |
| **Year 2-5** |  | |

| **Table 3. Treat** | | | | |
| --- | --- | --- | --- | --- |
| **Strategy/Activity** | **Program Descriptions for Year 1 and Years 2-5** | | | |
| **Strategy 2A.** Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV | | | | |
| **2A.1** Develop a robust network (supported by interagency/facility agreements) for rapid linkage to clinical care and essential support service | ***Please describe the process for conducting rapid linkage (linkage within 7 calendar days) to HIV medical care during Year1 and Years 2-5. In your response please indicate and briefly describe if and how the following are or will be used to support rapid linkage to HIV medical care during Year 1 and Years 2-5: 1) establishing or expanding secured electronic systems; 2) implementing and maintaining on-call hotlines (or warm lines) for reporting new HIV diagnosis; 3) leveraging other networks, partnerships, or programs to support rapid linkage to HIV medical care.*** | | | |
| **Year 1** | | |  |
| **Years 2-5** | | |  |
| **2A.3.** Conduct rapid needs assessment for all persons newly diagnosed with HIV and link to a disease intervention specialist and/or case manager as needed | ***Please describe how rapid needs assessments will be conducted for persons newly diagnosed with HIV and the process for linking these individuals to care during Year 1 and Years 2-5 of the program.*** | | | |
| **Year 1** | |  | |
| **Years 2-5** | |  | |
| **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP) | | | | |
| **2B.1.** Develop, expand and scale up Data to Care programs using surveillance data and other data sources to identify patients not in care and develop re-engagement strategies | ***Please describe your Data to Care (D2C) program. In your response please 1) describe D2C activities newly implemented under PS20-2010; 2) identify and describe the expansion of existing activities implemented under PS18-1802; and 3) describe how D2C data are collected and entered into eHARS to support the evaluation of key D2C indicators (see Treat Pillar indictors below).*** | | | |
| **Year 1** |  | | |
| **Years 2-5** |  | | |

| **Table 4. Prevent** | | | |
| --- | --- | --- | --- |
| **Strategy/Activity** | **Program Descriptions for Year 1 and Years 2-5** | | |
| **Strategy 3A.** Accelerate efforts to increase preexposure prophylaxis (PrEP) use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP | | | |
| **3A.1** Deliver PrEP services in health care settings and non-health care settings in communities with the highest HIV prevalence | ***Please describe how PrEP services will be supported and delivered in clinical settings (e.g., STD clinics) and non-health care settings during Year 1 and Years 2-5 of the program. In your response please indicate the 1) number of clinicians and locations prescribing PrEP; and 2) provision of PrEP trainings and technical assistance to clinical and non-clinical providers.*** | | |
| **Year 1** | |  |
| **Years 2-5** | |  |
| **Strategy 3B.** Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs) | | | |
| **3B.1** and **3B.3-3B.4** Ensure that SSPs provide standard services in addition to the provision of or active referral to infectious disease prevention, detection, care, and treatment; substance use disorder care and treatment; and essential support services for PWID | ***Please describe how SSPs operate in your jurisdiction and how they will be supported to maintain or expand services. In your response please include the following: 1) description of the services provided (please indicate which are standard services, i.e., sterile provision of needles, syringes, and other injection equipment, condoms, syringe disposal, HIV and HCV testing, linkage to HIV and HCV care, linkage to PrEP, naloxone distribution, and linkage to medication-assisted treatment); 2) use of incentives and/or PrEP navigators; 3) PrEP uptake support for Blacks/African Americans and Hispanics/Latinos.*** | | |
| **Year 1** |  | |
| **Years 2-5** |  | |

| **Table 5. Respond** | | | | |
| --- | --- | --- | --- | --- |
| **Strategy/Activity** | **Program Descriptions for Year 1 and Years 2-5** | | | |
| **Strategy 4A.** Develop partnerships, processes, data systems, policies to facilitate robust, and real-time cluster detection and response | | | | |
| **4A.1** Establish new/expand existing standing committee that meets routinely to guide cluster response | ***Please describe the development of your new/expanded standing committee that meets routinely to guide cluster response during Year 1 and Years 2-5, including membership, oversight, and process for reviewing data, prioritizing clusters, and guiding cluster response activities.*** | | | |
| **Year 1** | | |  |
| **Years 2-5** | | |  |
| **4A.2** Implement approaches to rapidly analyze, integrate, visualize, and share data from diverse sources in real time | ***Please describe the development and maintenance of a comprehensive data system or other approach to rapidly analyze, integrate, visualize, and share data from diverse sources in real time in your jurisdiction during Year 1 and Years 2-5.*** | | | |
| **Year 1** | | |  |
| **Years 2-5** | | |  |
| **4A.3** Create and maintain flexible funding mechanisms capable of supporting cluster response efforts | ***Please describe the development of flexible funding mechanisms to allow reallocation of resources for a response within one month in your jurisdiction during Year 1 and Years 2-5.*** | | | |
| **Year 1** | | |  |
| **Years 2-5** | | |  |
| **Strategy 4B.** Investigate and intervene in networks with active transmission | | | | |
| **4B.1** Train key staff to implement methods to identify and understand the entire network | ***Please describe processes and mechanisms you have developed to establish or expand methods to identify and understand the entire network using approaches including enhanced partner services, social network strategies, rapid ethnographic assessment, and other innovative approaches, and staff training on how to implement these approaches, during Year 1 and Years 2-5.*** | | | |
| **Year 1** | |  | |
| **Years 2-5** | |  | |
| **4B.2** Provide critical services to network members | ***Please describe processes and mechanisms to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, are prioritized and expedited for people in networks with active HIV transmission in your jurisdiction during Year 1 and Years 2-5.*** | | | |
| **Year 1** | | |  |
| **Years 2-5** | | |  |
| ***Please describe processes and mechanisms to ensure appropriate linkage to care activities (including medical and non-medical services) for PWH in networks with active HIV transmission in your jurisdiction during Year 1 and Years 2-5.*** | | | |
| **Year 1** | |  | |
| **Years 2-5** | |  | |
| **Strategy 4C.** Identify and address gaps in programs and services revealed by cluster detection and response | | | | |
| **4C.1** Identify and address specific gaps in services revealed by cluster response | ***Please describe processes and mechanisms you have developed in year 1 and years 2-5 to systematically and routinely review cluster information to identify and address specific gaps in testing, care, PrEP, partner services, SSPs, other support services, collaborations, and communication both during and after a response.*** | | | |
| **Year 1** |  | | |
| **Years 2-5** |  | | |

## Section 3: Population Groups

Please describe below 1) 3-5 population groups you will prioritize to receive HIV prevention services under your PS20-2010 program; 2) needs identified for each population group listed; and 3) program strategies and activities planned to address the identified needs. The population groups described should be congruent with those identified in your PS19-1906 Component B EHE plan. Please only describe population groups served under PS20-2010.

| **Table 6. Population Groups** | | | |
| --- | --- | --- | --- |
| **Population Groups** | **Identification in PS19-1906 Component B EHE Plan (i.e., page numbers)** | **Identified Need** | **Primary Strategies & Activities to Address Need\*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

\*Please reference program strategies by their number and letter (e.g., 1A, 1B, etc.).

# **Cross-Jurisdiction Evaluation Plan**

## Section 4: Cross-Jurisdiction Activities, Indicators, and Guidance

The cross-jurisdiction indicators presented in this section will be used to monitor and evaluate PS20-2010-funded activities. These indicators will be reported in addition to the NHM&E HIV Testing and Partner Services Requirements. Please note any challenges with reporting data for any of the cross-jurisdiction indicators in Section 5.

| **Cross-Cutting Strategy** | | | |
| --- | --- | --- | --- |
| **Activity** | **Indicator** | **Reporting** | **Guidance** |
| **CC.1** Activity not specified | **CC1.1**New HIV Infections: Estimated number of new HIV infections among persons aged ≥13 years that occurred during the evaluation period (assessed twelve months after the evaluation period)  **Numerator:** Not applicable **Denominator:** Not applicable | **Indicator:**Existing  **Data Source:**Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | This is one of the six core indicators for EHE. This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use the CD4 model SAS program provided by CDC to monitor progress locally. The CDC calculated results are available on the AHEAD dashboard (<https://ahead.hiv.gov/data>). |
| **CC.2** Increased participation in HIV partner services among persons newly diagnosed with HIV, identifiedthrough PS20-2010-funded testing activities | **CC2.1** Percentage of persons newly diagnosed with HIV who are interviewed for HIV partner services through PS20-2010-funded HIV testing activities  **Numerator:** Number of persons in the denominator who are interviewed for partner services  **Denominator:** Number of persons newly diagnosed with HIV identified through PS20-2010 funded HIV testing activities | **Indicator: Existing  Data:** Test-level **Source:** NHM&E  **Frequency:** Twice a year | Reporting: Partner services (PS) data reported for indicator 5A1.1 are limited to PS interviews conducted among persons who received a new HIV diagnosis from a PS20-2010-funded HIV test. |

\*Use state or local HIV surveillance data in eHARS

| **Diagnose** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Activity** | | **Indicator** | **Reporting** | | **Guidance** |
| **1X.1** Activity not specified | | **1X1.1**HIV diagnoses**:** Number of persons aged ≥13 years who received laboratory or clinical confirmation of HIV infection during the evaluation period and who were living in the jurisdiction on the date of diagnosis (assessed twelve months after the evaluation period)  **Numerator:** Not applicable **Denominator:** Not applicable | **Indicator:** Existing  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | | This is one of the six core indicators for EHE. This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use the Epi Profile SAS program provided by CDC to monitor progress locally. The CDC calculated results are available on the AHEAD dashboard (https://ahead.hiv.gov/data). Please note, jurisdictions will only be evaluated on results based on provisional data, not preliminary. |
| **1X.2** Activity not specified | | **1X2.1** Knowledge of status: Estimated percentage of persons aged ≥ 13 years with HIV who received an HIV diagnosis by (insert evaluation year) (assessed twelve months after the evaluation period) (EHE target: at least 95% by 2025**)**  **Numerator:** Number of persons aged ≥ 13 years living with diagnosed HIV at the end of a calendar year  **Denominator:** Estimated number of persons aged ≥ 13 years living with diagnosed or undiagnosed HIV at the end of a calendar year | **Indicator:** Existing  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | | This is one of the six core indicators for EHE. This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use the CD4 model SAS program provided by CDC to monitor progress locally. The CDC calculated results are available on the AHEAD dashboard (https://ahead.hiv.gov/data). |
| **1A.1** Conduct routine HIV testing in health care settings | **1A1.1** Percentage of persons tested in health care facilities identified as a priority for routine opt-out HIV screening  For each health care facility that has been prioritized for routine opt-out testing, please provide the following:  **Numerator:** Number of persons in the denominator who are tested for HIV  **Denominator:** Number of persons served at facilities identified as priority for routine opt-out HIV screening | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** Each recipient will use their own criteria to determine which of their PS20-2010-funded health care facilities are a priority for routine opt-out screening. Recipients will need to provide a separate denominator (# of persons served at the facility) and numerator (number of persons tested) count for each of the prioritized health care facilities. Counts for the number of persons tested should include those that are directly and indirectly funded by PS20-2010 (e.g., funding, test kits, personnel, training and technical assistance, laboratory support, electronic medical record enhancements).  In the denominator, the ‘number of persons served at the facility’ refers to all persons who attended at least one medical appointment at the health care facility regardless of age during the reporting period.  Data for this indicator will be collected in aggregate via an Excel Spreadsheet wherein the testing outcomes will be stratified by age such that data reported for persons aged 15-65 years can be isolated. These data will be submitted as an attachment to the APR and EOY reports and will need to include a brief description of the recipient’s criteria for determining which facilities are a priority for opt-out screening. Refer to aggregate data tables for routine testing in prioritized health care settings for additional reporting guidance.  Note: The prioritized health centers should be funded by PS20-2010. |
| **1A1.2** Percentage of persons who received an HIV-positive test result in a health care facility that was identified as a priority for routine opt-out HIV screening  For each health care facility that has been prioritized for routine opt-out testing, please provide the following:  **Numerator:** Number of persons in the denominator with an HIV-positive test result **Denominator:** Number of persons who are tested for HIV at a health care facility that has been prioritized for routine opt-out HIV screening | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Each recipient will use their own criteria to determine which of their PS20-2010-funded health care facilities are a priority for routine opt-out screening. The denominator for 1A1.1B should be the same as the numerator for 1A1.1A (# of persons tested for HIV). An aggregate count for the numerator and denominator for each of the prioritized health care facilities should be reported separately. The numerator for each prioritized health care facility should include all positive tests.  Data for this indicator will be collected in aggregate via an Excel spreadsheet wherein the testing outcomes will be stratified by age such that data reported for persons aged 15-65 years can be isolated. These data will be submitted as an attachment to the APR and EOY reports. Please include a brief description of the recipient’s criteria for determining which facilities are a priority for opt-out screening as indicated in Section 1 of the EPMP. Refer to aggregate data tables for routine testing in prioritized health care settings for additional reporting guidance. |
| **1A1.3** Percentage of persons newly diagnosed with HIV in a health care facility that was identified as a priority for routine opt-out HIV screening  For each health care facility that has been prioritized for routine opt-out testing, please provide the following:  **Numerator:** Number of persons in the denominator with a new diagnosis of HIV  **Denominator:** Number of persons who are tested for HIV at a health care facility that has been prioritized for routine opt-out HIV screening | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Each recipient will use their own criteria to determine which of their PS20-2010-funded health care facilities are a priority for routine opt-out screening. The denominator for 1A1.1C should be the same as the numerator for 1A1.1A (# of persons tested for HIV). An aggregate count for the numerator and denominator for each of the prioritized health care facilities should be reported separately. The numerator for each prioritized health care facility should only include new diagnoses of HIV. New diagnoses that have been confirmed in surveillance will be collected and reported separately from new diagnoses determined by self-report or provider report. Refer to aggregate data tables for routine testing in prioritized health care settings for additional reporting guidance. |
| **1A.2** Conduct routine HIV testing in jails and correctional facilities in high prevalence communities | **1A2.1** Percentage of persons incarcerated in jails and correctional facilities who are tested for HIV  For each high prevalence jail and correctional facility that has been prioritized for routine opt-out testing, please provide the following:  **Numerator:** Number of persons in the denominator who are tested for HIV  **Denominator:** Number of persons incarcerated in jails and correctional facilities | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Jails and correctional facilities funded under PS20-2010 for testing should be located in high prevalence communities. Each recipient will use their own criteria to determine which of their PS20-2010-funded jails and correctional facilities are a priority for routine opt-out testing. Includes person who received at least one HIV test during their detainment or incarceration. Testing can occur at intake, release, or any time during detainment or incarceration. Recipients will need to provide a separate denominator (# of persons incarcerated) and numerator (# of persons tested) count for each of the prioritized jails and correctional facilities. Counts for the number of persons tested should include those who are directly and indirectly funded by PS20-2010 (e.g., enhancements to EMR systems to include flags to promote routine testing).  Data for this indicator will be collected via an Excel spreadsheet and submitted as an attachment to the APR and EOY report. Recipients will also need to include a brief description of their criteria for determining which facilities are a priority for routine opt-out HIV testing. Testing in these facilities should be routinized to eliminate the need for risk assessments. Refer to aggregate data tables for routine testing in prioritized jails and correctional facilities for additional reporting guidance.  Note: Jails and correctional facilities located in the seven states with disproportionate occurrences of HIV in rural areas may use PS20-2010 funds to support testing in places with high HIV prevalence or yield. |
| **1A2.2** Percentage of persons incarcerated in jails and correctional facilities with a HIV-positive test result  For each high prevalence jail and correctional facility that has been prioritized for routine opt-out testing, please provide the following:  **Numerator:** Number of persons in the denominator with an HIV-positive test result  **Denominator:** Number of persons incarcerated in jails and correctional facilities who were tested for HIV | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** The denominator for 1A2.1B should be the same as the numerator for 1A2.1A (# of persons tested for HIV). Recipients will need to provide a separate denominator (# of incarcerated persons tested) and numerator (# of HIV-positive persons) count for each of the prioritized jails and correctional facilities. The numerator for each prioritized jail and correctional facility should include all positive tests. Data for this indicator will be collected via an Excel spreadsheet and submitted as an attachment to the APR and EOY report. Refer to aggregate data tables for routine testing in prioritized jails and correctional facilities for additional reporting guidance. |
| **1A2.3** Percentage of persons incarcerated in jails and correctional facilities with a new diagnosis of HIV  For each high prevalence jail and correctional facility that has been prioritized for routine opt-out testing, please provide the following:  **Numerator:** Number of persons in the denominator with a new diagnosis of HIV **Denominator:** Number of persons incarcerated in jails and correctional facilities who were tested for HIV | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** The denominator for 1A2.1C should be the same as the numerator for 1A2.1A (# of persons tested for HIV). Recipients will need to provide a separate denominator (# of incarcerated persons tested) and numerator (# of new HIV-diagnoses) count for each of the prioritized jails and correctional facilities. The numerator for each prioritized jail and correctional facility should only include new diagnoses of HIV. New diagnoses that have been confirmed in surveillance will be collected and reported separately from new diagnoses determined by self-report or provider report.  Data for this indicator will be collected via an Excel spreadsheet and submitted as an attachment to the APR and EOY report. Refer to aggregate data tables for routine testing in prioritized jails and correctional facilities for additional reporting guidance. |
| **1A.3** Link persons who inject drugs (PWID) who are screened in health care settings and non-health care settings and linked to SSP | **1A3.1** Percentage of persons who inject drugs (PWID) tested for HIV in an STD clinic who are linked to a syringe services program (SSP)  **Numerator:** Number of PWID in the denominator who are linked to SSP **Denominator:** Number of PWID who are tested for HIV in an STD clinic  **1A3.2** Percentage of persons who inject drugs (PWID) tested for HIV in a non-health care settings who are linked to a syringe services program (SSP)  **Numerator:** Number of PWID in the denominator who are linked to SSP **Denominator:** Number of PWID who are tested for HIV in a non-health care setting | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Persons who are linked to an SSP are those who attend an appointment at the SSP where they are seen by a provider. Linkage to an SSP may be determined by provider report, record review, or client self-report. SSP programs (e.g., anonymous programs) that cannot report aggregate counts for linkage to SSP may report data for active referrals to SSP. Active referrals to SSP may include but are not limited to activities such as making appointments for the client, providing transportation, using a case manager or peer navigator to help with access to services, and providing the organization to which the client is referred with information collected about the client. Syringe services programs that can report data for linkage should also report data for referrals. Data for this indicator will be collected via an Excel spreadsheet and will be submitted as an attachment with the APR and EOY. Refer to aggregate data tables for Linkage to SSP for additional reporting guidance. |
| **1B.1** Promote HIV testing in non-traditional venues | **1B1.1** Percentage of HIV tests conducted in non-traditional venues identified as a priority for EHE testing services  For each non-traditional venue category (i.e., retail, pharmacy, mobile, etc.) that has been prioritized for EHE testing services, please provide the following:  **Numerator:** Number of tests in the denominator that were conducted in non-traditional venues identified as a priority for EHE testing services **Denominator:** Number of HIV tests conducted in non-health care settings  **1B1.2** Percentage of HIV tests conducted in non-traditional venues identified as a priority for EHE testing services  For each non-traditional venue category (i.e., retail, pharmacy, mobile, etc.) that has been prioritized for EHE testing services, please provide the following:  **Numerator:** Number of tests in the denominator that were conducted in non-traditional venues identified as a priority for EHE testing services **Denominator:** Number of HIV tests conducted in health care settings | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** Non-traditional venues are venues that the recipient has not traditionally used to promote HIV testing. Non-traditional settings for HIV testing may include pharmacies, retail venues, and mobile units. Each recipient will determine which of their testing venues are non-traditional. The numerator and denominator for indicators 1B1.2A and 1B1.3 should be reported for each non-traditional venue category. For example, a recipient conducting HIV testing in 6 different non-traditional pharmacy venues (e.g., CVS, Walgreens, Rite AID, etc.) and 7 different retail venues (e.g., Ross, Marshalls, Dollar General) would report aggregate numerator and denominator counts for two non-traditional venue categories—pharmacy and retail. Recipients will not need to report individual aggregate counts for each of the 13 venues noted in the example. Data for this indicator will be collected via an Excel Spreadsheet and will be submitted as an attachment with the APR and EOY. Recipients will need to list and briefly describe their non-traditional venues and the criteria used to select these venues for EHE testing. Refer to aggregate data tables for Testing in Non-Traditional Venues for additional reporting guidance. |
| **1B1.3** Percentage of HIV-positive test results in non-traditional venues identified as a priority for EHE testing services  For each non-traditional venue category (i.e., retail, pharmacy, mobile, etc.) that has been prioritized for EHE testing services, please provide the following:  **Numerator:** Number of HIV-positive test results in the denominator  **Denominator:** Number of HIV tests conducted in non-traditional venues identified as a priority for EHE testing services | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Non-traditional venues are venues that the recipient has not traditionally used to promote HIV testing. Non-traditional settings for HIV testing may include pharmacies, retail venues, and mobile units. Each recipient will determine which of their testing venues are non-traditional. The numerator and denominator for indicator 1B1.2B should be reported for each non-traditional venue category. For example, a recipient conducting HIV testing in 6 different non-traditional pharmacy venues (e.g., CVS, Walgreens, Rite AID, etc.) and 7 different retail venues (e.g., Ross, Marshalls, Dollar General) would report an aggregate numerator and denominator count for two non-traditional venue categories—pharmacy and retail. Recipients will not need to report individual aggregate counts for each of the 13 venues noted in the example. The denominator for 1B1.2B should be the same as the numerator for 1B1.2A (# of HIV tests conducted in non-traditional venues). An aggregate count for the numerator and denominator for each of the prioritized venues should be reported separately. The numerator for each prioritized non-traditional venue should include all positive tests. Data for this indicator will be stratified by non-traditional health care venues and non-traditional non-health care venues. Refer to aggregate data tables for Testing in Non-Traditional Venues for additional reporting guidance. |
|  | **1B1.4** Percentage of new HIV-positive tests in non-traditional venues identified as a priority for EHE testing services  For each non-traditional venue category (i.e., retail, pharmacy, mobile, etc.) that has been prioritized for EHE testing services, please provide the following:  **Numerator:** Number of new HIV diagnoses in the denominator  **Denominator:** Number of HIV tests conducted in non-traditional venues identified as a priority for EHE testing services | | | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Non-traditional venues are venues that the recipient has not traditionally used to promote HIV testing. Non-traditional settings for HIV testing may include pharmacies, retail venues, and mobile units. Each recipient will determine which of their testing venues are non-traditional. The numerator and denominator for indicator 1B1.2B should be reported for each non-traditional venue category. For example, a recipient conducting HIV testing in 6 different non-traditional pharmacy venues (e.g., CVS, Walgreens, Rite AID, etc.) and 7 different retail venues (e.g., Ross, Marshalls, Dollar General) would report an aggregate numerator and denominator count for two non-traditional venue categories—pharmacy and retail. Recipients will not need to report individual aggregate counts for each of the 13 venues noted in the example. The denominator for 1B1.2C should be the same as the numerator for 1B1.2A (# of HIV tests conducted in non-traditional venues). An aggregate count for the numerator and denominator for each of the prioritized venues should be reported separately. The numerator for each prioritized non-traditional venue should only include new diagnoses of HIV. New diagnoses that have been confirmed in surveillance will be collected and reported separately from new diagnoses determined by self- report or provider report. Data for this indicator will be stratified by non-traditional health care venues and non-traditional non-health care venues. Refer to aggregate data tables for Testing in Non-Traditional Venues for additional reporting guidance. |

\*Use state or local HIV surveillance data in eHARS

| **Treat** | | | |
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| **Activity** | **Indicator** | **Reporting** | **Guidance** |
| **2A.1** Promote rapid HIV self-testing in non-health care settings and in health care settings | **2A1.1** Number of HIV self-test kits distributed in non-health care settings   **Count:** Number of self-test kits distributed in non-health care settings  **2A1.2** Number of HIV self-test kits distributed in health care settings  **Count:** Number of self-test kits distributed in health care settings | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet **Frequency:** Twice a year | **Reporting:** Rapid HIV self-test kits are those that can produce a test result within 20 minutes and can be conducted entirely by the tester often at home or in a private location. Mail-in HIV self-test kits are excluded from the numerator and denominator of this indicator. Data for this indicator will be stratified by distribution type (health care vs. non-health care settings). Refer to aggregate data tables for HIV Self-Test for additional reporting guidance. |
| **2A1.3** Number of persons who received at least one HIV self-test kit from a non-health care setting  **Count:** Number of persons who received at least one HIV self-test kit from a non-health care setting  **2A1.4** Number of persons who received an HIV self-test kit from a health care setting  **Count:** Number of persons who received at least one HIV self-test kit from a health care setting | **Indicator:** Existing  **Data:** Aggregate **Source:** Excel Spreadsheet **Frequency:** Twice a year  **Stratification:** setting type | **Reporting:** Rapid HIV self-test kits are those that can produce a test result within 20 minutes and can be conducted entirely by the tester often at home or in a private location. Mail-in HIV self-test kits are excluded from the numerator and denominator of this indicator. Data for this indicator will be stratified by distribution type (health care vs. non-health care settings). Refer to aggregate data tables for HIV Self-Test for additional reporting guidance. |
| **2B.1** Conduct rapid linkage to HIV medical care in health care settings and non-health care settings | **2B1.1** Percentage of persons newly diagnosed with HIV in health care settings who are linked to HIV medical care within 7 days of diagnosis   **Numerator:** Number of newly diagnosed persons in the denominator who are linked to HIV medical care within 7 days of diagnosis  **Denominator:** Number of persons with a new diagnosis of HIV in health care settings  **2B1.2** Percentage of persons newly diagnosed with HIV in non-health care settings who are linked to HIV medical care within 7 days of diagnosis   **Numerator:** Number of newly diagnosed persons in the denominator who are linked to HIV medical care within 7 days of diagnosis **Denominator:** Number of persons with a new diagnosis of HIV in non-health care settings | **Indicator:** Existing  **Data:** Test-level **Source:** EvalWeb  **Frequency:**  Twice a year **Stratification:** setting type | **Calculation:** Rapid linkage to care should occur within 7 calendar days of date of diagnosis. Rapid linkage to HIV medical care will be calculated using date of diagnosis and date linked to HIV medical care. Data for this indicator will be reported at the test-level and submitted via EvaluationWeb. |
| **2C.1** Develop a robust network (supported by interagency/facility agreements) for rapid linkage to clinical care and essential support service | **2C1.1** Linkage to HIV medical care:Percentage linked to HIV medical care (i.e., received ≥1 CD4 or HIV-1 viral load test) ≤1 month of diagnosis among persons aged ≥13 years with HIV diagnosed during [insert evaluation period] (assessed twelve months after the evaluation period)  **Numerator:** Number of persons aged ≥13 years with HIV diagnosed in the evaluation period who had ≥1 CD4 or HIV-1 viral load test within one month of HIV diagnosis (assessed twelve months after the evaluation period) **Denominator:** Number of persons ≥13 years with HIV diagnosed during the evaluation period and who were living in the jurisdiction on the date of diagnosis | **Indicator:** Existing  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | This is one of the six core indicators for EHE. This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use Monitoring Care Outcomes SAS program provided by CDC to monitor progress locally. The CDC calculated results are available on the AHEAD dashboard (<https://ahead.hiv.gov/data>). Please note, jurisdictions will only be evaluated on results based on provisional data, not preliminary. |
| **2C1.2** Percentage received HIV medical care (i.e., received ≥1 CD4 or HIV-1 viral load test) among persons aged ≥13 years with HIV diagnosed by [insert beginning date of evaluation period] and alive and residing in the jurisdiction on [insert end date of evaluation period] (assessed twelve months after the evaluation period)  **Numerator:** Number of persons aged ≥13 years who received ≥1 CD4 or HIV-1 viral test during the evaluation period (assessed twelve months after the evaluation period) **Denominator:** Number of persons aged ≥13 years with HIV diagnosed before the beginning of the evaluation period and who were alive and residing in the jurisdiction at the end of the evaluation period | **Indicator:** Existing  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | This is a secondary EHE indicator*.* This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use Monitoring Care Outcomes SAS program provided by CDC to monitor progress locally. The CDC calculated results are available on Atlas Plus (<https://www.cdc.gov/nchhstp/atlas/index.htm>). |
| **2C1.3** Percentage of persons with HIV viral suppression (i.e., had a HIV-1 viral load result of <200 copies/mL) ≤6 months of diagnosis among persons aged ≥13 years with HIV diagnosed during [insert evaluation period](assessed twelve months after the evaluation period)  **Numerator:** Number of persons aged ≥13 years who had a HIV-1 viral load result of <200 copies/mL at any time during the six months after diagnosis (assessed twelve months after the evaluation period) **Denominator:** Number of persons aged ≥13 years with HIV diagnosed during the evaluation period and who were living in the jurisdiction on the date of diagnosis. | **Indicator:** New **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | This is a secondary EHE indicator. This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use Monitoring Care Outcomes SAS program provided by CDC to monitor progress locally. The CDC calculated results are available in the Monitoring Selected Care and Prevention Objectives Using Surveillance Data reports (<https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>). |
| **2C1.4** HIV viral suppression: Percentage with HIV viral suppression (i.e., had a HIV-1 viral load result of <200 copies/mL) at most recent test during [insert evaluation period] among persons aged ≥13 years with HIV diagnosed by [insert beginning of evaluation period] and alive and residing in the jurisdiction on [insert end of evaluation period] (assessed twelve months after the evaluation period)  **Numerator:** Number of persons aged ≥13 years who had a viral load result <200 copies/ml at the most recent viral load during the evaluation period (assessed twelve months after the evaluation period)  **Denominator:** Number of persons aged ≥13 years with HIV diagnosed before the beginning of the evaluation period and who were alive and residing in the jurisdiction at the end of the evaluation period. | **Indicator:** Existing  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | This is one of the six core indicators for EHE. This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties), and 2) the Phase 1 county level, as applicable and feasible.  This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients.  Jurisdictions can use Monitoring Care Outcomes SAS program provided by CDC to monitor progress locally. The CDC calculated results are available on the AHEAD dashboard (<https://ahead.hiv.gov/data>). |
| **2C1.5** Percentage of presumptively not-in-care persons with HIV (PWH) with an investigation opened (initiated) during a specified 6-month evaluation time period, who were confirmed within 90 days after the investigation was opened not to be in care  **Numerator:** Of those in the denominator, the number confirmed within 90 days after the investigation was opened not to be in care (assessed  five months after the evaluation period) **Denominator:** Number of presumptively not-in-care PWH with an investigation opened (initiated) during a specified 6-month evaluation time period who were alive and residing in the EHE jurisdiction at the end of the evaluation period. | **Indicator:** New  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | The data to calculate this indicator must be entered by jurisdictions into eHARS on the Follow-up Investigation tab. At a minimum, this must be done by the June and December data transfers. Based on the transmitted data, CDC will calculate this indicator. CDC will provide a SAS program to allow jurisdictions to also monitor progress at the local level. More information on D2C evaluation can be found in “Data-to-Care Reporting Guidance” available on PS20-2010 website (<https://www.cdc.gov/hiv/funding/announcements/ps20-2010/attachments.html>). |
| **2C1.6** Percentage of persons with HIV who were confirmed to not be in HIV medical care during a specified 6-month evaluation period, who were then linked to HIV medical care within 30 days  **Numerator:** Of those in the denominator, the number linked to HIV medical care within 30 days after being confirmed not to be in care (assessed three months after the evaluation period) **Denominator:** Number of PWH confirmed during a specified 6-month evaluation time period not to be in care who were alive and residing in the EHE jurisdiction at the end of the evaluation period | **Indicator:** New  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | The data to calculate this indicator must be entered by jurisdictions into eHARS on the Follow-up Investigation tab. At a minimum, this must be done by the June and December data transfers. Based on the transmitted data, CDC will calculate this indicator. CDC will provide a SAS program to allow jurisdictions to also monitor progress at the local level. More information on D2C evaluation can be found in “Data-to-Care Reporting Guidance” available on PS20-2010 website (<https://www.cdc.gov/hiv/funding/announcements/ps20-2010/attachments.html>). |
| **2C1.7** Percentage of persons with HIV linked to HIV medical care during a specified 6- month evaluation period, who achieved HIV viral suppression within six months (180 days) after being linked to care  **Numerator:** Of those in the denominator, the number who achieved HIV viral suppression within six months (180 days) after being linked to HIV medical care (assessed eight months after evaluation period)  **Denominator:** Number of PWH linked to HIV medical care during a specified 6- month evaluation time period who were alive and residing in the EHE jurisdiction at the end of the evaluation period | **Indicator:** New  **Data Source:** Calculated by CDC usingsurveillance datareported to CDC by state and local health departments | The data to calculate this indicator must be entered by jurisdictions into eHARS on the Follow-up Investigation tab. At a minimum, this must be done by the June and December data transfers. Based on the transmitted data, CDC will calculate this indicator. CDC will provide a SAS program to allow jurisdictions to also monitor progress at the local level. More information on D2C evaluation can be found in “Data-to-Care Reporting Guidance” available on PS20-2010 website (<https://www.cdc.gov/hiv/funding/announcements/ps20-2010/attachments.html>). |
| **2D.1** Conduct rapid needs assessment for all persons newly diagnosed with HIV and link to a disease intervention specialist and/or case manager as needed | **2D1.1** Percentage of all persons with a new HIV diagnosis who were screened for social services needs.  **Numerator:** Of those in the denominator, the number of persons who were screened for social services needs  **Denominator:** Number of persons with a new diagnosis of HIV | **Indicator:** Existing **Data:** Test-level  **Source:** EvalWeb  **Frequency:**  Twice a year | **Reporting:** Persons included in the numerator should be screened for social services include housing, transportation, domestic violence intervention, and employment. Data for this indicator will be reported at the test-level and submitted via EvaluationWeb. |
| **2D1.2** Percentage of persons with a new HIV diagnosis, in need of social services, who were provided or referred to one or more social services.  **Numerator:** Of those in the denominator, the number of persons who were provided or referred to one or more social services  **Denominator:** Number of persons with a new diagnosis of HIV who were in need of one or more social services | **Indicator:** Existing **Data:** Test-level  **Source:** EvalWeb  **Frequency:**  Twice a year | **Reporting:** Data for this indicator will be reported at the test-level and submitted via EvaluationWeb. |

\*Use state or local HIV surveillance data in eHARS

| **Prevent** | | | |
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| **Activity** | **Indicator** | **Reporting** | **Guidance** |
| **3A.1** Deliver PrEP services in health care settings and non-health care settings in communities with the highest HIV prevalence | **3A1.1** Percentage of persons testing negative for HIV who are screened for PrEP eligibility  **Numerator:** Number of persons in the denominator who are screened for PrEP elgibility **Denominator:** Total number of persons who tested negative for HIV | **Indicator:** Existing **Data:** Test-level **Source:** EvalWeb and Excel spreadsheet  **Frequency (Eval Web):**  Twice a year  **Frequency (Excel spread sheet):**  Twice a year | **Reporting in EvalWeb:** PrEP data submitted via EvaluationWeb should only include PrEP services associated with PS20-2010-funded HIV tests. Variables should not be interpreted as a cascade (e.g., a person may be given a referral without being screened or a person may be screened and then visit their primary care provider) and should be considered as independent variables.  **Reporting in Excel spreadsheet:** PrEP data submitted via Excel spread sheet should include all PrEP services funded by PS20-2010 regardless of the funding source for the HIV test. PrEP data will be reported as a cascade and will be calculated as specified in the numerator and denominator for each indicator. |
| **3A1.2** Percentage of persons who are screened and eligible for PrEP referral identified in STD clinics  **Numerator:** Number of persons in the denominator who are eligible for PrEP referral **Denominator:** Number of persons screened for PrEP who were identified in a STD clinic  **3A1.3** Percentage of persons who are screened and eligible for PrEP referral identified in non-health care settings  **Numerator:** Number of persons in the denominator who are eligible for PrEP referral **Denominator:** Number of persons screened for PrEP who were identified in a non-health care setting | **Indicator:** Existing **Data:** Test-level **Source:** EvalWeb and Excel spreadsheet  **Frequency (Eval Web):** Twice a year  **Frequency (Excel spread sheet):**  Twice a year | **Reporting in EvalWeb:** PrEP data submitted via EvaluationWeb should only include PrEP services associated with PS20-2010-funded HIV tests. Variables should not be interpreted as a cascade (e.g., a person may be given a referral without being screened or a person may be screened and then visit their primary care provider) and should be considered as independent variables.  **Reporting in Excel spreadsheet:** PrEP data submitted via Excel spread sheet should include all PrEP services funded by PS20-2010 regardless of the funding source for the HIV test. PrEP data will be reported as a cascade and will be calculated as specified in the numerator and denominator for each indicator.  **Note:** PrEP eligibility refers to a person’s status with regard to whether or not the person meets appropriate criteria for using PrEP; specifically, whether or not the person is HIV-negative and at risk for HIV, as defined locally or by CDC guidelines for PrEP (<https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>). |
| **3A1.4** Percentage of persons eligible and referred to a PrEP provider identified in STD clinics  **Numerator:** Number of persons in the denominator who are referred to a PrEP provider  **Denominator:** Number of persons eligible for PrEP referral who were identified in STD clinic  **3A1.5** Percentage of persons eligible and referred to a PrEP provider identified in non-health care settings  **Numerator:** Number of persons in the denominator who are referred to a PrEP provider  **Denominator:** Number of persons eligible for PrEP referral who were identified in a non-health care setting | **Indicator:** Existing **Data:** Test-level **Source:** EvalWeb and Excel spreadsheet  **Frequency (Eval Web):**  Twice a year  **Frequency (Excel spread sheet):**  Twice a year | **Reporting in EvalWeb:** PrEP data submitted via EvaluationWeb should only include PrEP services associated with PS20-2010-funded HIV tests. Variables should not be interpreted as a cascade (e.g., a person may be given a referral without being screened or a person may be screened and then visit their primary care provider) and should be considered as independent variables.  **Reporting in Excel spreadsheet:** Data should include all PrEP services funded by PS20-2010 regardless of the funding source for the HIV test. PrEP data will be reported as a cascade and will be calculated as specified in the numerator and denominator for each indicator.  **Note:** PrEP eligibility refers to a person’s status with regard to whether or not the person meets appropriate criteria for using PrEP; specifically, whether or not the person is HIV-negative and at risk for HIV, as defined locally or by CDC guidelines for PrEP (<https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>). |
| **3A1.6** Percentage of persons referred to a PrEP provider who are assisted with linkage to a PrEP provider identified in STD clinics  **Numerator:** Number of persons in the denominator who are assisted with linkage to a PrEP provider **Denominator:** Number of persons referred to a PrEP provider in a STD clinic  **3A1.7** Percentage of persons eligible for PrEP who are assisted with linkage to a PrEP provider identified in non-health care settings  **Numerator:** Number of persons in the denominator who are assisted with linkage to a PrEP provider **Denominator:** Number of persons referred to a PrEP provider in a non-health care setting | **Indicator:** Existing **Data:** Test-level **Source:** EvalWeb  **Frequency:** Twice a year | **Reporting in EvalWeb:** PrEP data submitted via EvaluationWeb should only include PrEP services associated with PS20-2010-funded HIV tests. Variables should not be interpreted as a cascade (e.g., a person may be given a referral without being screened or a person may be screened and then visit their primary care provider) and should be considered as independent variables.  **Reporting in Excel spreadsheet:** Data should include all PrEP services funded by PS20-2010 regardless of the funding source for the HIV test. PrEP data will be reported as a cascade and will be calculated as specified in the numerator and denominator for each indicator. |
| **3A1.8** Percentage of persons who are referred and linked to a PrEP provider   **Numerator:** Number of persons in the denominator who are linked to a PrEP provider **Denominator:** Number of persons testing negative for HIV who are referred to a PrEP provider | **Indicator:** New **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency (Excel spread sheet):**  Twice a year | **Reporting in Excel spreadsheet:** Data should include all PrEP services funded by PS20-2010 regardless of the funding source for the HIV test. PrEP data will be reported as a cascade and will be calculated as specified in the numerator and denominator for each indicator.  **Note:** A PrEP provider is a health care professional (e.g., physician, advanced practice nurse, physician assistant) who conducts evaluations for pre-exposure prophylaxis (PrEP) eligibility and clinical appropriateness, prescribes PrEP, and provides comprehensive management of persons taking PrEP. Refer to aggregate data tables for Linkage to a PrEP Provider for additional reporting guidance. |
| **3A1.9** **PrEP Coverage:** Percent of persons using PrEP (defined as classified as having been prescribed PrEP ) among those with indications for PrEP (EHE target: at least 50% by 2025)   **Numerator:** Number of persons ≥16 years who were classified as having been prescribed PrEP in a calendar year  **Denominator:** Estimated number of persons with indications for PrEP in a calendar year | **Indicator:** New  **Data:** HHS **Source:** Numerator: National pharmacy data (IQVIA). Denominator: American Community Survey of US Census (ACS); National Health, Nutrition and Examination Survey (NHANES); National HIVSurveillance System (NHSS); and Puerto Rico Community Survey (Puerto Rico only) | **Reporting:** This indicator is calculated for each jurisdiction by CDC and does not require any additional data from recipients. Although the PrEP Coverage indicator is reported as a percentage, this indicator uses multiple data sources; therefore, it is unknown whether the numerator is contained in the denominator.The data source for the PrEP coverage numerator is the National pharmacy data (IQVIA) which provides the number of persons classified as having been prescribed PrEP. The data sources for the PrEP coverage denominator are the American Community Survey of US Census (ACS) (used for all US States and territories except PR); the National Health, Nutrition and Examination Survey (NHANES); the National HIV Surveillance System (NHSS); and the Puerto Rico Community Survey (used only for Puerto Rico). The CDC calculated results for this indicator are available on the AHEAD dashboard (<https://ahead.hiv.gov/data>). |
| **3B.1** Ensure that SSPs provide standard services | **3B1.1** Number of SSPs operating in the jurisdiction  **Count:** Number of SSPs operating in the jurisdiction | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** This is a population-level indicator and should reflect data from all SSPs regardless of funding source. The indicator is stratified by SSP service site, fixed or outreach. Fixed site SSPs are stationary service delivery locations that require the community to come to a specific location to receive services. Outreach sites are mobile and bring SSP services into the community and may include mobile units or delivery services that drop off requested supplies. Data for this indicator will be collected via an Excel spreadsheet and will be submitted as an attachment with the APR and EOY reports. Refer to aggregate data tables for Syringe Services Program (SSP) Locations and Service Provision for additional reporting guidance. |
| **3B1.2** Number of encounters related to at least one standard service by an SSP  **Count:** Number of encounters related to at least one standard SSP service | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** Encounters represent unique visits served by the SSP. They may not reflect unique persons; a person can have multiple encounters with an SSP. It is preferred that the number of encounters reported represent exact counts, however this number can be estimated if unable to report exact counts. Data for this indicator is stratified by service provided by the SSP and SSP location (e.g., fixed vs. Outreach). SSPs may directly provide or actively refer persons to the following: infectious disease prevention, detection, care, and treatment; substance use disorder care and treatment; and essential support services. Data for this indicator will be collected via an Excel spreadsheet and will be submitted as an attachment with the APR and EOY reports. Refer to aggregate data tables for Syringe Services Program (SSP) Locations and Service Provision for additional reporting guidance. |
| **3B.2** Ensure that SSPs provide or actively refer PWID to infectious disease prevention, detection, care, and treatment; substance use care and treatment; and essential support services | **3B2.1** Percentage of SSPs that directly provide or actively refer to key services   **Numerator:** Number of SSPs in the denominator that directly provide or have active referral to key services  **Denominator:** Number of SSPs operating in the jurisdiction | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** This is a population-level indicator and should reflect data from all SSPs regardless of funding source. Key SSP services are (1) infectious disease prevention, detection, care, and treatment; (2) substance use care and treatment; and (3) essential support services. Data for this indicator will be stratified by each of the 3 key services. Active referrals for SSP are enhanced referrals that consist of specific actions designed to aid referral completion. Data for this indicator will be collected via an Excel spreadsheet and will be submitted as an attachment with the APR and EOY reports. Refer to aggregate data tables for Syringe Services Program (SSP) Locations and Service Provision for additional reporting guidance. |
| **3B.3** Promote SSPs across communities with the highest number of new HIV diagnoses attributed to injection drug use, highest number of new HCV diagnoses, and/or highest rates of drug overdose | **3B3.1** Number of encounters served by SSPs  **Count:** Number of encounters served by SSPs | **Indicator:** New  **Data:** Aggregate **Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** This is a population-level indicator and should reflect data from all SSPs regardless of funding source. Data for this indicator will be collected via an Excel spreadsheet and will be submitted as an attachment with the APR and EOY reports. Refer to aggregate data tables for Syringe Services Program (SSP) Locations and Service Provision for additional reporting guidance. |

| **Respond** | | | | |
| --- | --- | --- | --- | --- |
| **Activity** | **Indicator** | **Numerator/Denominator** | **Reporting** | **Guidance** |
| **Strategy 4A.1** Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response | **4A1.1** Of all persons with diagnosed HIV infection whose diagnoses were first entered into the local HIV surveillance system during the evaluation period, ≥75% were first entered ≤30 days after the date of diagnosis  **Numerator:** Number of persons in the denominator whose diagnoses were first entered into the local HIV surveillance system ≤30 days after the date of diagnosis  **Denominator:** Number of persons with diagnosed HIV infection residing in the jurisdiction at diagnosis whose diagnoses were first entered into the local HIV surveillance system during the evaluation period | | **Indicator:** New  **Data:** Aggregate and jurisdiction level **Source:** State or local eHARS\*  **Frequency:** Annual | This indicator is intended to measure progress toward updating mechanisms or processes to expedite reporting and entry of case data into surveillance systems to ensure accurate surveillance data for real-time decision making.  This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties) and 2) the Phase 1 county level, as applicable and feasible. The indicator will be reported on the annual HIV Surveillance Standards Evaluation Report. |
| **Strategy 4A.1** Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response | **4A1.2** Of all laboratory test results entered into the local HIV surveillance system during the evaluation period, ≥75% were entered ≤14 days after the date of specimen collection  **Numerator:** Number of laboratory test results in the denominator that were entered ≤14 days after the date of specimen collection  **Denominator**: Total number of laboratory test results entered into the surveillance system for persons with HIV. | | **Indicator:** New  **Data:** Aggregate and jurisdiction level **Source:** State or local eHARS\*  **Frequency**: Annual | This indicator is intended to measure progress toward updating mechanisms or processes to expedite reporting and entry of laboratory data into surveillance systems to ensure accurate surveillance data for real-time decision making.  This indicator will be assessed at both 1) the state level (except in the case of independently funded cities/counties) and 2) the Phase 1 county level, as applicable and feasible. The indicator will be reported on the annual HIV Surveillance Standards Evaluation Report. |

\*Use state or local HIV surveillance data in eHARS

## Section 5: Data Collection and/or Reporting Challenges for Cross-Jurisdiction Indicators

In this section, please use the table below to briefly describe any data collection delays or reporting challenges that may impact data reporting for the cross-jurisdiction indicators.

| **Table 7. Data Collection Delays and Reporting Challenges** | | |
| --- | --- | --- |
| **Delayed Activities and Related Indicators** | **Reason for Data Collection Delay or Reporting Challenge** | **TA and Capacity Building Needs** |
|  |  |  |
|  |  |  |

# **Jurisdiction-Specific Evaluation Plan**

## Section 6: Jurisdiction-Specific Activities, Indicators, and Guidance

The jurisdiction-specific activities and indicators presented in this section are optional; however, you are encouraged to report on indicators that align with program activities.

| **Diagnose and Prevent** | | | | |
| --- | --- | --- | --- | --- |
| **Activity** | | **Indicator** | **Reporting** | **Guidance** |
| **J1.** Integrated screening (e.g., HIV/viral hepatitis; HIV/TB; HIV/STD)  Integrated screening (e.g., HIV/viral hepatitis; HIV/TB; HIV/STD) implemented in:   * Health care settings as part of routine screening in urgent care centers, emergency departments, county health departments * Non-health care settings like homeless shelters, domestic violence centers, health fairs, pop-up events, or in mobile testing units, and mailed testing kits * Priority populations (e.g., MSM, homeless population and PWID) | | **J1.1** Percentage of HIV screenings conducted that are integrated with other screenings (e.g., viral hepatitis/TB/STD)    **Numerator:** Number of HIV screenings that were integrated with other screenings (e.g., viral hepatitis/TB/STD)  **Denominator:** Total number of HIV screenings conducted in health care and non-health care settings | **Indicator:** New  **Data Source:** Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** This indicator assesses the integration of HIV testing with one or more of the following health screenings: viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3862982/>. The integration of HIV testing with screenings for health conditions other than the ones previously mentioned are excluded. The denominator for this indicator includes ‘screenings conducted’ and does not include ‘screenings offered’. For example, if a recipient uses mail-in test kits to conduct integrating HIV screening, the denominator should only reflect test kits that were returned to the health department and for which the test results are known. Test kits that were not returned to the health department should be excluded from the denominator.  This indicator is relevant to the settings in which this activity is implemented. For example, if the activity is implemented only in health care settings, report the indicator only for those settings and note the settings in which the activity is implemented. |
| **J2.** TelePrEP (PrEP delivery via Telehealth)  Develop and implement a TelePrEP delivery model for uptake and expansion of telehealth PrEP services in health care and non-health care settings | | **J2.1** Percentage of persons who were linked to a TelePrEP provider    **Numerator:** Number of persons who were linked to a TelePrEP provider  **Denominator:** Total number of persons who were linked to a PrEP provider | **Indicator:** New  **Data Source:** Aggregate Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** The denominator for this indicator includes all persons who were linked (attended an appointment) to a PrEP provider. A PrEP provider is a health care professional (e.g., physician, advanced practice nurse, physician assistant) who conducts evaluations for pre-exposure prophylaxis (PrEP) eligibility and clinical appropriateness, prescribes PrEP, and provides comprehensive management of persons taking PrEP. The numerator for this indicator includes persons who were ‘linked to a TelePrEP provider’. TelePrEP appointments are those that are attended virtually with a provider via telehealth (e.g., video conferencing or phone appointment) to initiate PrEP. |
| **J3.** Navigator assistance for HIV screenings/PrEP/SSP    Navigators may identify persons at high-risk for HIV and refer them for screening; they may refer persons testing negative for HIV who are eligible for PrEP to services so that they can maintain their HIV-negative status; they may also link persons who inject drugs and are at risk for HIV to SSP services. | | **J3.1** Percentage of persons who were linked to HIV/STD screenings/PrEP/SSP with the assistance of a navigator  **Numerator:** Of the denominator, thenumber of persons who were screened for HIV/STD/linked to PrEP/SSP services  **Denominator:** Number of persons who were assisted by navigators for HIV/STD screenings, PrEP, and SSP | **Indicator:** New  **Data Source:** Aggregate Excel spreadsheet  **Frequency:** Twice a year | **Reporting:** Navigator activities that are uniquely associated with screening, with PrEP or with SSP in individual jurisdictions should be reflected appropriately in the numerator. |
| **J4.** Social Marketing Campaign for HIV/STD screenings, PrEP, and SSP: *Advertising Placements1*  Implement a media buying or advertising strategy as part of a social marketing campaign to increase HIV/STD screening; raise awareness and use of PrEP; and/or promote SSPs among specific priority groups3 e.g., MSM, youth, MSM of color, Hispanics/Latinos, Blacks/African Americans, Transgender persons etc. | **J4.1** Percentage of impressions from advertising conducted in HIV/STD screenings/PrEP/SSP (e.g., print; digital/internet-based; radio; television; out-of-home advertising2) social marketing campaign(s) targeting specified priority groups3e.g., MSM, youth, MSM of color, Hispanics/Latinos, blacks/African Americans, transgender persons etc.  **Numerator:**Number of advertising impressions in HIV/STD screenings/PrEP/SSP social marketing campaign by type (e.g., print; digital/internet-based; radio; television; out-of-home advertising)  **Denominator:** Estimated number of persons in the specified priority group e.g., MSM, youth, MSM of color, Hispanics/Latinos, blacks/African Americans, transgender persons etc. | | **Indicator:** New  **Data Source:** Aggregate excel spreadsheet  **Frequency:** Twice a year | **Reporting:**For this indicator, the numerator, number of impressions from advertising conducted in HIV/STD screenings/PrEP/SSP social marketing campaign, refers to the total number of impressions for advertising activities targeted to the specific demographic group of interest in the campaign, given that advertising placements are conducted within a specified jurisdiction. The denominator is the number of persons in the specified priority group3 e.g., MSM, youth, MSM of color, Hispanics/Latinos, blacks/African Americans, transgender persons etc.  For each implemented campaign, recipients should report ‘overall impressions’ and ‘unique impressions’ separately (these data should be reported in their designated columns in the Excel reporting tool provided by CDC). Separate rows should also be used to report overall impressions by type of advertising placements and unique impressions by type of advertising placements. |

1 The specific advertising buys that are conducted with different vendors or channels.

2 Out-of-home (OOH) advertising is also known as outdoor advertising or outdoor media and is generally advertising experienced outside of the home. These include billboards, transit ads on buses or trains, wallscapes, and posters that may be seen while “on the go” or in the community. This may also include “place-based” advertising, such as those in medical centers, airports, stores, or other buildings or facilities.

3 MSM includes males who reported male-to-male sexual contact in the past 5 years. MSM/IDU includes males who reported both male-to-male sexual contact and injection drug use in the past 5 years. Persons who inject drugs (PWID) includes persons who reported injection drug use in the past 5 years.

# **Data Management Plan**

## Section 7: Data Management Plan (DMP)

Please ensure that personally identifiable information (PII) is appropriately collected, processed, stored, and protected to maintain compliance with public laws, federal regulations, and executive orders.

**Note**: The management, security, and confidentiality of data for the PS20-2010 should be addressed and updated in the PS20-2010 DMP. The DMP must be updated annually or when any significant change is made to a dataset or system to ensure that the DMP remains current throughout the lifecycle of the NOFO.

| **Table 8. Data Management Plan Elements** | | |
| --- | --- | --- |
| **Elements** | **Surveillance Data** | **NHM&E Data** |
| Description of data collected, and standards used. Include information on data sources or other databases if used (e.g., conforms to standards outlined in CDC technical guidance for HIV surveillance, etc.). |  |  |
| Data steward(s) |  |  |
| Mechanisms for within-agency limiting or sharing of data and justifications (e.g., data sharing agreements and process for using them). |  |  |
| Mechanisms for sharing data with partners (e.g., CPG, Ryan White) |  |  |
| Description of data release policies and procedures including precautions to protect confidentiality (e.g., data suppression criteria, other restrictions). |  |  |
| Mechanisms for making data available to the public (e.g., reports, epi profile, datasets, CDC Atlas plus). Include description of prerelease data quality reviews and validation, data suppression checks. Address access to identifiable and de-identified data. |  |  |
| Statement that procedures are in place to ensure all released data have appropriate documentation and any limitations described. |  |  |
| Description of steps taken to protect privacy and ensure confidentiality and security of data. Refer to applicable policies and statement signed by the overall responsible party (ORP) certifying program compliance with the NCHHSTP Guidelines. |  |  |
| Description of data archiving policies or provide explanation for why long-term preservation and access are not required. |  |  |

**Add any additional notes here:**

Click to enter text.

# **Targets and Local Objectives**

## Section 8: Targets and Local Objectives

Please insert your yearly targets and local objectives for your program activities and indicators below.

| **Table 9. Targets and Local Objectives** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Indicator** | **Local Program Objectives** | | | | | |
| **Baseline** | **Yr 1** | **Yr 2** | **Yr 3** | **Yr 4** | **Yr 5** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

# **Appendix A: CDC Logic Model**

Below is the CDC [logic model](#logicmodelComponentAAppendixA) for PS20-2010, including strategies, short-term outcomes (e.g., increased referral and linkage of persons with indications for PrEP), and intermediate outcomes (e.g., increased knowledge of HIV status).

| **PS20-2010 Logic Model – Ending the HIV Epidemic** | | | | |
| --- | --- | --- | --- | --- |
| **Strategies** | | **Short-Term Outcomes** | **Intermediate Outcomes** | **Long-Term Outcomes** |
| **Component A: Ending the HIV Epidemic Initiative (EHE) - Core** | | | | |
| **Diagnose** | * Expand or implement routine opt-out HIV screening in health care and other institutional settings in high prevalence communities * Develop locally tailored HIV testing programs to reach persons in non-health care settings * Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in health care and non-health care settings | * Increased routine opt-out HIV screenings in health care and other institutional settings * Increased local availability of and accessibility to HIV testing services * Increased HIV screening and re-screening among persons at elevated risk for HIV infection | * Increased knowledge of HIV status * Reduced new HIV diagnoses | Reduced new HIV infections |
| **Treat** | * Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV * Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs | * Increased rapid linkage to HIV medical care * Increased early initiation of ART * Increased immediate re-engagement to HIV prevention and treatment services for PWH who have disengaged from care * Increased support to providers for linking, retaining, and re-engaging PWH to care and treatment | * Increase viral suppression among persons living with diagnosed HIV |
| **Prevent** | * Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indication for PrEP * Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs) | * Increased screening for PrEP indications and linkage to PrEP providers among HIV-negative clients * Increased referral and linkage of persons with indications for PrEP * Increased access to SSPs | * + Increased PrEP prescriptions compared to number with indications (PrEP coverage) overall and in areas with high HIV diagnosis rates.   + Decreased racial and ethnic disparities in PrEP provision   + Increased knowledge about the services and evidence-base of SSPs in communities   + Increased quality of evidence-based SSP service delivery |
| **Respond** | * Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response * Investigate and intervene in networks with active transmission * Identify and address gaps in programs and services revealed by cluster detection and response | * Increased health department and community engagement for cluster detection and response * Improved surveillance data for real-time cluster detection and response * Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks | * Improved knowledge of networks to contain HIV transmission clusters and outbreaks   + Improved response to HIV transmission clusters and outbreaks   + Improved data systems for real-time cluster detection and response |
| **Component B: HIV Incidence Surveillance** | | | | |
| **Not Addressed in This EPMP** | * Work with stakeholders (e.g., community, laboratories, and providers) to identify best practices for implementing a recency-based incidence surveillance * Conduct recency-based HIV incidence surveillance in selected jurisdictions * Review incidence results from a CD4 depletion model and a recency-based assay model | * Improved coordination with stakeholders including community, laboratory, and clinical providers to develop recency-based incidence surveillance * Increased capacity to collect recency-based assays from all persons aged 13 years and older with a new HIV diagnosis | * Estimate HIV incidence in selected jurisdictions using a recency-based assay * Review HIV incidence using a CD4 depletion model and a recency-based assay model |  |
| **Component C: Scaling up HIV prevention services in STD clinics** | | | | |
| **Not Addressed in This EPMP** | * Conduct assessment of clinic infrastructure to document current HIV/STD prevention services, identify gaps, and assess service quality * Implement evidence-based approaches to scale up capacity for sexual risk assessments, self-collected STD testing, timely treatment, and HIV-related tests * Expand capacity of STD clinics to offer PrEP/nPEP and strengthen clinic and laboratory capacity for recommended follow-up visits * Optimize linkage to, retention in, and re-engagement in HIV medical care * Facilitate partnerships with community HIV clinical providers, health departments and community-based organizations for implementation of the EHE | * Increased identification of new HIV and STD infections in STD specialty clinics * Increased rapid linkage to care for individuals newly diagnosed with HIV at STD specialty clinic * Increased identification of virally unsuppressed people in STD specialty clinics * Increased re-engagement to care for persons living with HIV who are not virally suppressed * Increased screening for PrEP/nPEP indication in STD specialty clinics * Increased PrEP-eligible individuals in STD specialty clinics who are offered and initiate PrEP, if indicated | * + Increased knowledge of HIV status   + Increase viral suppression among persons living with diagnosed HIV   + Increase persons receiving PrEP/nPEP | Reduced new HIV infections |

# **CDC Defined Terms**

| **Term** | **Definition** |
| --- | --- |
| Active referral | This involves efforts beyond passive referral, in which the individual is only given contact information for the service(s) and is left to make their own contact. There are varying types of active referral. Active referral may include but is not limited to activities for the client such as: making appointments, providing transportation, using a case manager or peer navigator to help with access to services, providing the organization to which the client is referred with information collected about the client (including the professional assessment of the client’s needs), a “warm hand-off” – such as a ‘live’ three way conversation (individual/organization making the referral, individual/organization receiving the referral, and the client) – in person or by telephone – in which the client is introduced, and providing explanations about what has already been done to assist the client, and reason for referral. |
| Assisted linkage to a PrEP provider | An indication of whether the client/patient was provided navigation or linkage services to assist with linkage to a PrEP provider. |
| Essential support services | A service or intervention aimed at reducing risk for transmitting or acquiring HIV infection by modifying a factor (e.g., housing, transportation, employment assistance, and education) or combination of factors that can contribute to risk (e.g., health care benefits, behavioral health (see definition for behavioral health), and other medical and social services. |
| Health care setting | Health care setting represents a broad array of services and places where health care occurs, including acute care hospitals, urgent care centers, rehabilitation centers, nursing homes and other long-term care facilities, specialized outpatient services (e.g., hemodialysis, dentistry, podiatry, chemotherapy, endoscopy, and pain management clinics), and outpatient surgery centers. In addition, some health care services are provided in private offices or homes. [https://www.cdc.gov/eis/field-epi-manual/chapters/Health care-Settings.html](https://www.cdc.gov/eis/field-epi-manual/chapters/Healthcare-Settings.html) |
| HIV self-test | HIV self-testing allows people to take an HIV test and find out their result in their own home or other private location. |
| HIV-negative person | A person who has a negative test result based on the most recent HIV test conducted. |
| Indications for PrEP | PrEP is for people without HIV who are at risk for getting the virus from sex or injection drug use. The federal guidelines recommend that PrEP be considered for people who are HIV-negative who: have had anal or vaginal sex in the past 6 months and have a sexual partner with HIV (especially if the partner has an unknown or detectable viral load) or have not consistently used a condom or have been diagnosed with an STD in the past 6 months. PrEP is also recommended for people who inject drugs and have an injection partner with HIV or share needles, syringes, or other equipment to inject drugs (for example, cookers). PrEP should also be considered for people who have been prescribed non-occupational post-exposure prophylaxis (PEP) and report continued risk behavior or have used multiple courses of PEP <https://www.cdc.gov/hiv/basics/prep.html>. |
| Infectious disease prevention, detection, care, and treatment | Infectious disease prevention, detection, care, and treatment including HIV, viral hepatitis (HAV, HBV, and HCV), sexually transmitted infections (syphilis, gonorrhea, and chlamydia) and wound care. |
| Integrated Screening | Screening for STDs, viral hepatitis, and/or TB conducted in conjunction with HIV testing. |
| Interviewed for partner services | Indicates whether a client was interviewed for the purpose of HIV partner services by health department specialists or non-health department providers trained and authorized to conduct partner services interviews on behalf of the health department. Non-health department providers include public health providers who are 1) collecting data on behalf of the health department and 2) provide information to the health department for partner services follow-up. Interviews conducted by providers other than health department specialists are counted only if they can be verified (i.e., interview results are documented in writing and reported to the health department). |
| Linkage to a PrEP provider | The process through which a person at risk for becoming infected with HIV is helped to access a health care provider who offers evaluation and management of pre-exposure prophylaxis (PrEP). This is often an active process (e.g., providing transportation, accompanying the person to the appointment, having multiple contacts with the person to support them in accessing the PrEP provider). Linked to a PrEP provider refers to the outcome of the referral or linkage of a PrEP eligible person to a PrEP provider, as indicated by the person’s attendance of the first appointment. |
| Linked to HIV medical care | This term refers to the outcome resulting from referral or linkage of a person with HIV (PWH) to HIV medical care. A PWH is linked to HIV medical care if they are seen by a health care provider (e.g., physician, physician assistant, nurse practitioner) after HIV diagnosis for evaluation and management of their HIV infection. Determination of linkage status may be based on report from a health care provider, medical record review, review of other records or databases, reported HIV-related laboratory tests, filling of a prescription for anti-retroviral medication, or client/patient self-report. Linked to HIV medical care refers to the outcome that results from referral or linkage of a patient to care, as indicated by the patient’s attendance at the first HIV care appointment. Services during the visit may include evaluation of immune system function and screening, treatment, and prevention of opportunistic infections. For definitions of linkage and linked, refer to <https://www.cdc.gov/hiv/effective-interventions/index.html> |
| Linked to SSP | Persons who inject drugs are linked to an SSP if they are seen by a provider at the SSP following referral. Determination of linkage may be based on a report from the provider, record review, or client self-report. Linked to SSP refers to the outcome that results from the referral of the client as indicated by the client’s attendance at the SSP for services. Services during the visit may include needs-based access to sterile needles and syringes and other injection equipment (e.g., sterile water, cookers), condoms, syringe disposal, HIV and HCV testing, linkage to HIV and HCV care, linkage to PrEP, naloxone distribution, and linkage to medication-assisted treatment. |
| Mail-In Self-Test | A mail-in self-test includes a specimen collection kit that contains supplies to collect dried blood from a fingerstick at home. The sample is then sent to a lab for testing and the results are provided by a health care provider. |
| Navigator | Patient navigators are peers, volunteers, and staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals (e.g., RNs, LPNs).  Navigator role: The navigator may link persons at risk for HIV or living with HIV to screening, to PrEP services, or to SSP services as needed, including assistance with linkage to health care systems for these services, assisting with health insurance and transportation, identifying and reducing barriers to care, and tailoring health education to the client to influence his or her health-related attitudes and behaviors. |
| Newly diagnosed HIV infection | HIV infection in a person who: (1) does not self-report having previously tested positive for HIV; (2) has not been previously reported to the surveillance system as being infected with HIV; and 3) has no previous evidence of HIV infection in other records or databases. |
| Non-traditional setting/venue | Non-traditional venues are venues that the recipient has not traditionally used to promote HIV testing. Non-traditional settings for HIV testing may include pharmacies, retail venues, and mobile units. Each recipient will determine which of their testing venues are non-traditional. |
| Opt-out screening | Opt-out screening is defined as performing HIV testing after notifying the patient that the test will be performed, and although the patient may decline or defer testing, it is strongly recommended. Assent is inferred unless the patient declines testing. |
| Persons at risk for HIV infection | Groups or populations can be described as “vulnerable” or “key” or “groups [populations] at risk” if they are subject to societal pressures or social circumstances or engage in behaviors that make them vulnerable to HIV. |
| Pre-exposure prophylaxis (PrEP) | Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medication to prevent acquisition of HIV infection. PrEP is used by people without HIV who are at risk of being exposed to HIV through sexual contact or injection drug use. |
| PrEP Eligibility | PrEP Eligibility refers to a person’s status with regard to whether or not the person meets appropriate criteria for using PrEP; specifically, whether or not the person is HIV-negative and at risk for HIV, as defined locally or by CDC guidelines for PrEP. <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf> |
| PrEP provider | A health care professional (e.g., physician, advanced practice nurse, physician assistant) who conducts evaluations for pre-exposure prophylaxis (PrEP) eligibility and clinical appropriateness, prescribes PrEP, and provides comprehensive management of persons taking PrEP. PrEP providers are peers, volunteers, and staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals (e.g., RNs, LPNs). |
| PrEP Screening | The process of conducting an initial assessment regarding a person’s eligibility for pre-exposure prophylaxis (PrEP) (i.e., HIV testing and behavioral risk screening) and determining whether or not a more thorough evaluation is warranted. For further discussion on PrEP screening, see: Centers for Disease Control and Prevention: US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States—2017 Update: a clinical practice guideline. <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf> |
| Prescribed PrEP | Refers to a person who has been adequately evaluated and received a prescription for pre-exposure prophylaxis (PrEP). <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf> |
| Rapid HIV self-test | A Rapid Self-Test is done entirely by the tester often at home or in a private location and can produce results within 20 minutes. |
| Rapid Linkage to HIV medical care within 7 days of diagnosis | This occurs when a patient is seen by a health care provider (e.g., physician, a physician’s assistant, or nurse practitioner) to receive medical care for his/her HIV infection, within 7-days of diagnosis. Linkage to medical care can include specific referral to care services immediately after diagnosis and follow-up until the person is linked to long-term case management. Linkage may be based on HIV-related laboratory tests or other methods of verification. Services may include evaluation of immune system function and screening, treatment, and prevention of opportunistic infections. |
| Social Marketing Campaign | Social Marketing is the use of marketing theory, skills, and practice to achieve social change, promote the general health, raise awareness, and induce changes in behavior. Community mobilization models for HIV prevention include social marketing campaigns. |
| Social Services | Social services include housing, transportation, domestic violence intervention, and employment. |
| SSP Encounter | An interaction between a person with HIV or at risk for HIV infection and a Syringe Services Program (SSP) provider for the purpose of receiving services including access to sterile injection equipment (for persons who inject drugs), risk-reduction counseling, HIV, viral hepatitis, STD, and TB testing; hepatitis A and hepatitis B vaccination; linkage to care and treatment; naloxone; and referrals to substance use treatment. |
| Standard SSP Services | Provide access to sterile needles and syringes and other injection equipment (e.g., sterile water, cookers), condoms, syringe disposal, HIV and HCV testing, linkage to HIV and HCV care, linkage to PrEP, naloxone distribution, and linkage to medication-assisted treatment. |
| Substance use care and treatment | Substance use care and treatment; including low threshold medication-assisted treatment and evidence-based psychological and behavioral treatments (e.g., talk therapies). |
| TelePrEP | Telehealth: The use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.  PrEP: The use of antiretroviral medication by persons who are not infected with HIV, but are at risk for infection, to reduce their risk for becoming infected. |