PENNSYLVANIA DEPARTMENT OF HEALTH

ANNUAL PERFORMANCE REPORT
January 1, 2020 – June 30, 2020
2020 Grant Renewal Application for "Integrated HIV Surveillance and Prevention"
Funding Opportunity Announcement #CDC-RFA-PS18-180203CONT21
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(January 1, 2021 – December 31, 2021)

Introduction

Since the inception of the HIV epidemic, Pennsylvania (PA) has been very committed in the fight to contain the impact of HIV disease on its residents through proactive HIV surveillance and prevention strategies. As of the end of December 2019, a total of 62,681 HIV cases have been reported in PA since reporting began and approximately 36,000 people are currently living with HIV. Nationally, PA currently ranks 8th in the burden of HIV disease. While there has been a steady and measurable decline in the number of new diagnoses since the peak in the mid-1990s, the number of people living with HIV (PLWH) continues to grow as survival times have increased. During the last five years, approximately 1,000 new infections were diagnosed annually in PA. The decline in new diagnoses has not been uniform across all demographic groups. There are recent increases in the number of new infections in men who have sex with men (MSM) in the 20 to 29 age group. The advent of social media has enabled at risk persons to more easily find sex and injection drug partners. As HIV infection now appears to be a life-long disease, with about 36,000 PLWH, HIV disease remains a major public health problem in PA.

In PA, reportable disease information is received through the PA-NEDSS. Regulations for HIV reporting in PA were promulgated in June 2002 and became effective on October 18, 2002. As more HIV cases continue to maintain undetectable levels of viral loads as well as CD4 counts above the reportable limit of 200 cells/uL or 14%, we have proactively made recommendations in our current regulation to allow for reporting of all viral load (including undetectable) and CD4 test results. These recommendations have reached advanced stage in the approval process. It is anticipated the revised regulations that incorporates universal reporting of viral load and CD4 tests results will be approved. PA remains committed to leveraging available resources and opportunities to reducing HIV burden on its residents. In the subsequent sections, we will describe progressed made and proposed surveillance and prevention activities to further reduce the impact of HIV in PA.

Strategy 1. Systematic collection, analysis, interpretation, and dissemination of HIV data for surveillance and prevention program monitoring and evaluation.

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   For decades, the PADOH has developed and maintains a network of hospitals, community health centers (CHC), correctional facilities, private physician offices, clinics, laboratories, and County/Municipal Health Departments (CMHD) that identifies and reports persons with diagnosed HIV infection across the state. We leveraged on this established network to implement both active and passive surveillance activities to ensure more complete case reporting.

   The HIV Surveillance Program (HSP) completed the matching of HIV cases to the PA Death Registry (PADR) in April 2020. This was necessary to update case vital status and ensure accuracy in determining the population of individuals currently living with HIV infection in the Commonwealth. We have locally developed a specific SAS program for this purpose that works well. The eHARS data was matched to the PADR using social security number (SSN), first name, last name and date of birth to update case vital status. We also have a few individuals who had HIV indicated on their death record but who had not been reported previously to our surveillance system. Current PA HIV reporting regulations does not permit matching to the National Death Index data.

   The HSP conducted Routine Intrastate De-Duplication Review to minimize duplicate records. During the funding cycle our duplicate rate was less than 0.1%. PA-NEDSS, as a "Patient-Centric reporting system", allows the prevention and identification of duplicate cases by the HIV field investigators and central office staff. PA-NEDSS has built-in de-duplication functionality that is used routinely. A search is conducted foreach new report received in PA-NEDSS before anew case investigation is created. Using this functionality allows the investigator to eliminate the potential duplicate report before starting a new investigation.

HSP has participated in the Routine Interstate De-Duplication Review (RIDR) since its inception. RIDR cases presented to PADOH in January 2020 have been fully reviewed, resolved and subsequently transmitted to CDC. HSP will continue to process new RIDR files received in a timely fashion and transmit results to CDC.

During this funding cycle, HSP ensured that reported HIV cases have sufficient HIV risk factor information within 12 months of the date of the initial report. The HSP conducted regular medical record reviews as well as made contacts with providers to ensure more complete case finding and better ascertainment of risk factor information. Monthly review of PA-NEDSS was implemented to determine HIV cases with missing risk factor information. Identified cases were assembled for timely follow up with the reporting facility. In addition, monthly reports are run in eHARS that identify cases with missing risk factor information.

Over the past 15 years, the HSP has worked with the PADOH's Electronic Laboratory Reporting (ELR) team to on-board many laboratories conducting HIV-related laboratory tests. In 2019, ELR accounted for 96% of all HIV reports received. This initiative has enhanced the volume and speed of laboratory reporting and lessened the burden of manual data entry and processing paper-based laboratory reports. Over the entire funding cycle, we will work to identify additional laboratories that can be converted to ELR and assist them in making this transition.

PADOH places high importance on the quality of data that is collected and maintained, and we ensure that the HIV surveillance and prevention practices make data quality a central part of our routine activities. HSP employed multiple layers of data validation processes, including PA-NEDSS internal item validity functionality, PA-NEDSS menu driven edit checks, eHARS menu driven edit checks, and use of the local SAS program option. PA-NEDSS has item validity and internal consistency functionalities based on logic rules. Incoming records with one or more errors are placed in an "error folder" and reviewed separately by staff daily. Staff contacts the reporting laboratory first, or the medical provider if necessary, to obtain missing information on a new error report to move it into the system transaction phase.

HSP assessed surveillance data periodically to identify cases missing CDC critical fields. Program staff reviewed cases submitted by Local Morbidity Reporting Offices (LMROs) for critical fields missing required information. This periodic review resulted in re-abstraction efforts and evaluation of data quality. These cases were investigated to obtain the missing information and eHARS and PA-NEDSS databases were updated accordingly.

The identification of Cases of Public Health Importance (COPHI) triggers appropriate investigations. In the past years, HSP has investigated a number of potential COPHI cases. In the current funding cycle, HSP staff reviewed the eHARS database on a weekly basis to identify probable COPHI. No COPHI case was identified during the first six months of this funding cycle.

Evaluation of the HIV surveillance system has been implemented because of the importance we place on knowing how the system is performing. The HSP has many levels in the reporting chain. Each level has a built-in mechanism for evaluation. The LMRO is a central point in the surveillance chain. The LMROs accepted HIV reports and conducted case investigations through the PA-NEDSS. HSP Central Office staff monitored LMRO performances at the end of each month through routine review of in-boxes in PA-NEDSS to assess case reporting and completeness of investigation. In addition, we used the CDC supplied SAS program to assess our data and make corrections where necessary.

For many years, we have been successful in gaining access to a number of data sources to improve both completeness and quality of HIV data, including Sexually Transmitted Diseases (STD), tuberculosis (TB), hepatitis C virus (HCV), CAREWare, AIDS Drug Assistance Program (ADAP), pharmacy, death registry, and birth registry data. We are in the process of obtaining access to the Medicaid data.

HSP continued to incorporate analytic and data processing tools to refine our data products. We have staff who are epidemiologists and other data professionals proficient in such platforms as the

SAS language, as well as collaborating partners at local universities. These resources were used to support these program activities during the funding cycle.

HSP worked with the Bureau of Informatics and Information Technology (BIIT) staff to add functionality in PA-NEDSS that would allow for the reporting of HIV genotype results. BIIT went through the process of developing the functionality and testing for suitability before it was deployed. With this enhancement, PADOH is now receiving molecular sequence data and have obtained access to HIV Secure-Trace to identify and monitor new clusters. As a result, some HIV clusters were identified within the first six months of this year.

For time-space monitoring for unusual increase in new HIV cases, HSP has developed and established baseline number of cases for each county in PA based on three-year historical data. HSP is now running the time-space analysis periodically to monitor unusual increase in new HIV cases. These steps have greatly enhanced PADOH's ability to identify clusters in a timely manner.

The PADOH has an existing integrated statewide data Security and Confidentiality Policy covering the HSP, HIV prevention program (HPP), STD prevention program, TB prevention program, and HCV prevention program. This policy is reviewed each year and made available to all staff and stakeholders. Each staff member took the training before the funding cycle as a condition of renewing their access to HIV data.

HSP has collaborated with a variety of partners in the use of HIV surveillance data to support local-, state- and Federal-funded prevention, treatment and care programs such as CDC's prevention programs or the Ryan White Care Act. Reports of aggregate surveillance data are regularly released for epidemic monitoring, education of the public and reporting sources, and to promote the use of the data and assist public and private partners in using HIV data as a guide for allocating HIV prevention and care resources. More specifically, HSP produces an Annual HIV Surveillance Summary Report as well as an HIV Epidemiology Profile every five years.

HSP has in-house capacity to geocode all newly diagnosed HIV cases in PA. We have also established a Memorandum of Agreement (MOA) to submit geocoded data to CDC for the 5-year funding period.

HPP staff, in collaboration with STD program staff, worked with the contracted laboratory to change the laboratory requisition system to reflect the required data variables. Data collection began July 1, 2020.With this change, we will be able to report on more data variables, assess performance, and use the information to inform program enhancements. Additionally, a date field is being added to the syphilis investigation for Partner Service (PS) data collection. We will be able to report on linkage to care within 30 days for clients who are coinfected with syphilis.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

Although, we onboarded most of the commercial laboratories that perform genotype sequence testing, the remaining laboratory has been difficult to onboard. We have been working to onboard the laboratory since last year and still no success.

The emergence of COVID-19 pandemic has even introduced additional challenges in the laboratory ability to make the necessary changes needed. However, we are continuing to work with the laboratory to resolve this reporting issue before December 2020.

Obtaining Medical Assistance data has been a longstanding interest in the HSP, but we have had difficulty getting approval from the Department of Human Services which has custody of the data. We are in need of the Medicaid data to improve our data reporting. Current HIV regulations in PA does not allow for complete reporting of all HIV-related test results. We use other data sources such as Medical Assistance to augment this limitation. A justification and Memorandum of Understanding has been sent to the Department of Human Services for access and we are still waiting for the approval.

Current PA HIV reporting regulations does not allow the reporting of all HIV-related test results. We have made recommendations for the current regulation to be changed to include the reporting of all CD4 and Viral Load test results. The recommendation was submitted and a regulatory package with the requested changes has been developed and is moving through the required approval steps. We are hopeful that an approval can be secured before the end of the year.

HPP data will not reflect all the required data variables for clinical HIV testing because we were unable to change the requisition system for the contracted laboratory until this reporting period. The new laboratory contract took effect in the February 2020, and it took much of the reporting period to get the changes ready for implementation. Consequently, the required data variables were only collected starting July 1, 2020.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in approach, contracts, objectives, staffing/personnel, funding resources, etc.).

   An important change we anticipate is the replacement of our current PA-NEDSS. We use PA-NEDSS as the portal for all infectious disease reporting and have developed a system to move data from PA-NEDSS to eHARS on a daily basis. We plan to transition to the CDC NEDSS Base System (NBS) in the next 18 months. This will be a major project to implement NBS as well as develop interfaces to our eHARS application.

   HPP will finally be able to accurately report on linkage to care within 30 days based on the date of the first medical appointment. Beginning with the next data submission, we can now collect the date of first medical appointment for all individuals who are newly diagnosed, including those co-infected with syphilis. HPP will continue incorporating a data dashboard in order to capture high-level information outlining all critical Key Performance Indicators. This data dashboard will offer program key insights on up-to-date progress and real time measurements in order to implement specific action plans to improve procedures supporting needed HIV prevention efforts.

4. Complete Laboratory Reporting

a. Has the jurisdiction implemented and maintained activities to support complete laboratory reporting of all HIV-related tests? ☒Yes ☐ No
b. Was the volume of CD4 and viral load laboratory test results received between January-June 2020 similar (≤ 5% change) to the volume received for the six months prior (July-December 2019)? ☐ Yes ☒ No
c. Were all CD4 and viral load laboratory test results reported to the Health Department between January-June 2020 submitted to CDC each month? ☒ Yes ☐ No

If you responded "No" to questions 4a, b or c above, please explain

During the period of January to June 2020 compared to the period of July-December 2019, we witnessed a reduction of approximately 25% in overall volume of CD4 and viral load tests reported. The reduction in volume is not unconnected to the COVID-19 pandemic and appeared to be more pronounced in the Philadelphia jurisdiction.

5. Evaluation Performance Measurement Plan
   a. Please use the CDC template to update and upload your Year 3 Evaluation Performance Measurement Plan (EPMP) as a miscellaneous attachment with your APR to www.grantsolutions.gov by the due date, September 14, 2020.

6. Describe the impact of COVID-19 on surveillance activities.

In early March, the Governor of PA progressively began to require individuals to stay at home on a county by county basis. A statewide stay at home order was issued on March 16, 2020. In anticipation of the stay at home order we set up the administrative and technical processes to enable teleworking. We shifted all surveillance staff to full teleworking and were operational by March 17, 2020. We had established virtual private networks (VPN) and functioning on March 16th enabling surveillance staff to access all confidential and non-confidential data and resources as determined by need to have access. We purchased Commonwealth owned smart phones for those required to conduct official business by telephone and other staff used Skype business resources to conduct voice communication.

We have in place security and confidentiality declarations for all staff with access to protected health information and had all staff sign and submit new security and confidentiality declarations to include teleworking. Prior to the COVID-19 emergency we had already begun piloting the use of teleworking for selected staff. Initially we witnessed a reduction of new diagnoses as medical

and laboratory providers closed their offices. For the previous two years, we had an average of 81 new diagnoses per month. Beginning in March 2020, the number fell to less than 60. New diagnoses began to pick up in late May and rose to 85 new diagnoses in June 2020. The volume of laboratory reports also fell by approximately 25% although the reduction of laboratory reports was more prominent for cases investigated in Philadelphia County.

The largest impact of COVID-19 pandemic for HIV surveillance has been in working with other stakeholders such as other state and local jurisdictions that have not been able to fully conduct their own activities such as record checks, RIDR and CIDR and medical chart abstractions that are done by others.

7. Describe the impact of COVID-19 on NHM&E activities.

   Testing and Partner Services activities were impacted by COVID-19.

   The HPP and STD program collaborated to provide guidance to our contractual HIV and STD testing and treatment services providers considering the challenges with the COVID-19 pandemic. The guidance suspended all HIV testing activities in non-healthcare settings for most of March and April 2020. Additionally, HPP and STD developed guidance for PS activities. Priorities were adjusted to allow for CMHDs and PADOH staff to assist with COVID-19 responses while continuing to conduct HIV surveillance and PS activities on the highest priority cases. Conducting PS for clients identified as newly diagnosed with HIV remained a priority throughout this challenging period.

Strategy 2. Identification of persons with HIV infection and uninfected persons at risk for HIV infection.

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   PADOH continue to face challenges related to elicitation of partners. In an effort to identify barriers to partner elicitation and to identify strategies to increase partner elicitation, we convened a workgroup consisting of representatives from the PADOH field staff, CMHD staff and the Philadelphia Department of Public Health STD Control program. This group has had several

meetings to date and will play a vital role in enhancing our partner services program. This workgroup is also part of our Jurisdictional Capacity Building Plan.

The HPP finalized the development of a partner services client brochure which is currently going through the PADOH internal approval process. It is hoped that the brochure will provide additional educational information to clients to help them better understand their role and the PADOH role in partner elicitation.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

The HPP and STD program collaborated to provide guidance to our contractual HIV and STD testing and treatment services providers considering the COVID-19 response and impact in PA. This guidance suspended all HIV testing activities in non-healthcare settings for most of March and April 2020. As PA began to open up in May 2020, guidance was provided which allowed for HIV testing in non-healthcare settings and consistent following the Governor's re-opening guidance and any applicable PADOH or CDC guidance. Clinical HIV testing continued at a decreased rate during the months of March and April2020, but with a focus on high priority individuals. HIV testing at the CMHD STD clinics were also impacted as staff resources were diverted to assist with COVID-19 public health response.

The HPP, along with STD and Tuberculosis (TB) programs issued a guidance to the CMHD that suspended Data to Care (D2C) activities and narrowed the focus of HIV testing services and partner services. The CMHDs were informed that it was the HPP expectations that HIV testing and partner services be provided in accordance with the HIV prevention grant issued to CMHD. As capacity and resources were limited, HIV testing may be limited to high risk individuals as outlined under the HIV Prevention grant. This guidance also outlined referral options to our HIV testing providers and Federally Quality Health Centers for HIV testing. As we are now in the second six-month period of the 2020 budget, we continue to support the provision of continued

HIV testing in healthcare and non-healthcare settings consistent with the Governor's re-opening guidance and any applicable PADOH or CDC guidance.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts, target populations, recruitment strategies, testing technologies or algorithms, objectives, staffing/personnel, funding resources, etc.).

   We have been working to implement an HIV Self-testing (HST) program this past year. There were multiple areas that we needed to address including confidentiality, partnerships, testing resources, distribution, etc. Challenges from the pandemic have made the need for HST more critical and we put this initiative on the fast track. We were able to identify partners, tapping into our existing relationships with the PA Expanded HIV Testing Initiative (PEHTI) and the HIV Prevention and Care Project (HPCP). We anticipate that the HST program will be implemented by the end of 2020 with a modification of the PEHTI purchase order which will allow for the purchase and distribution of HIV test kits, A Memorandum of Understanding (MOU) between HPCP and PEHTI for the provision of technical support and social media outreach to clients will be established. HPP will issue guidance to HPCP and PEHTI so that they a clear understanding of HPP's expectations of the HST program

4. For HIV testing related activities associated with Strategy 2, your submitted National HIV Monitoring and Evaluation (NHM&E) data in EvaluationWeb will be used to assess the jurisdiction's progress for Q1 and Q2 during Year 3. Please include any additional comments and/or clarifications for the submitted NHM&E data and/or the PS18-1802 Data Tables within EvaluationWeb. Also, include any justification(s) for partial/late data submission. Information provided will be used for consideration during the review process.
   ☒ No additional comments and/or clarifications needed.
   ☐ Additional comments and/or clarifications
5. If you have an HIV self-testing strategy or approach, describe the impact of HIV self-testing strategies in place. Also, describe any plans in place or being created to scale up HIV self-testing activities.
   a. If your jurisdiction conducted HIV self-testing during the reporting period, please provide the following information: **Not applicable**
      i. Total number of test kits distributed as part of your HIV self-testing program
      ii. Total number of people who received at least one HIV self-testing kit

6. If you do not have an HIV self-testing strategy or approach, have you considered HIV self-testing as a strategy?
   We anticipate implementation of an HST program in the second half of 2020. It is our expectation that we will have some preliminary data to share in our End of Year report for 2020.

Strategy 3. Development, maintenance, and implementation of plans to respond to HIV transmission clusters and outbreaks.

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.
   - Attended the HIV Planning Group (HPG) bi-monthly meetings. The meeting consists of Division of HIV Disease staff, other PADOH staff, Planning Partners, community members and stakeholders from across the state of PA. The goal of these meetings is to bring a diverse population of people into the HIV planning process to ensure equity and effective disease prevention strategies.
   - Ensured that HIV cluster data security and confidentiality procedures are followed and maintained during HIV cluster investigation.
   - Formed a cluster monitoring and investigation team composed of HIV surveillance, HIV prevention, partner services staff, STD, HIV care and Ryan White leadership or staff. Local county and municipality health departments and authorities are consulted when the cluster is identified in a specific geographic area.
   - Conducted ongoing in-house training of central office staff and Local Morbidity Reporting Organization (LMRO) staff to improve and expand skill sets especially in detecting and responding to HIV clusters and outbreaks.
   - Developed standard operating procedures for molecular and time-space cluster identification using HIV surveillance data.
   - Detected and investigated two priority time-space transmission clusters. The first cluster was identified in February 2020 while the other in May 2020.

   We developed a process where every week a data report is run by the HPP Data Manager and any changes in data is shared with the cluster team. Any adverse changes in the data would require a case to be moved into a high priority level of investigation. Between January and June 2020, we moved several cases from high priority level to low priority due to improvements in their clinical

experiences. In addition, we have expanded the participation at the cluster meetings to include the field staff supervisors since the response component to the cluster investigations involve the Bureau of Communicable Diseases field staff.

The HPP received permission at the end of the December 2019 to add a Public Health Program Assistant Administrator (PHPAA) to the staff complement that will assist with cluster investigations utilizing RW rebate funds.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?
    - As a result of the COVID-19 pandemic, it has been difficult in getting cluster case information from other jurisdictions. Provider offices were shut down or had limited hours of operations and different priorities.
    - There was limited field staff availability for HIV cluster response. The staff were required to contribute time towards the COVID-19 activities and had less time for cluster response activities.
    - There were some hurdles in getting genotype data from some commercial laboratories. Some of the labs have shifted their priorities to COVID-19 response, reduced or suspended operations related to HIV genome testing and reporting and have limited dedicated staff.

    The primary challenge for HPP during this period was staffing resources to devote time to HIV cluster investigations. We currently do not have a staff member dedicated to cluster investigations. Our Testing and Partner Services Administrator is the lead on cluster investigations but can only devote a small amount of time, given the broad scope of his testing and partner services responsibilities. While the HPP was approved to increase staff complement to include a PHPAA to work on cluster investigations, there has been multiple delays in adding the position to the complement.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts, target populations, testing technologies or algorithms, implementation strategies, objectives, staffing/personnel, funding resources, etc.).

It is anticipated that the HPP will have the PHPAA position added to the staff complement during the second half of 2020. Once this position is added to the complement, a request to hire will be submitted seeking approval to fill the position during a hiring freeze period.

Additional anticipated changes include:

- Potential approval for the proposed changes in the PA HIV regulations for reporting of all CD4 and viral load test results.
- Working with stakeholders on how to improve the HIV cluster identification and response in the era of the COVID-19 pandemic.

4. During the reporting period, did your program identify any:
   a. Molecular clusters involving the jurisdiction that meet CDC's national priority criteria*? ☐ Yes ☒ No
      If yes, please provide a brief summary.
   b. Time-space clusters involving the jurisdiction**?** ☒ Yes ☐ No
      If yes, please provide a brief summary.

PADOH detected and responded to two time-space clusters from January 2020 to June 2020.

Time-space cluster # 1

This HIV cluster was identified in February in a county in the southwest region of the state. It has twelve cases. All 12 individuals are males and alive.

Five persons are between the ages of 20 and 29 years old, four between 30 and 39 and two between 50 and 59, and one over 60 years old. Seven individuals are MSM, four MSM-IDU and one heterosexual. By race/ethnicity, 11 cases are Hispanic and one African American. Three persons are not virally suppressed as of June 30, 2020. Partner services were offered to all 12 cases at the time of diagnosis and they all were in care.

Time-space cluster # 2

This HV cluster was detected in May 2020 and has seven cases in a county in the northeast region of the state. They are 5 males and 2 females. All individuals are alive. By mode of transmission, three individuals are MSM, one IDU, one MSM/IDU, and 2 heterosexuals. By race/ethnicity, six persons are White and one Hispanic. Three individuals are between the ages of 20 and 29 years old, one between 30 and 39, and three are between 40 and 49. All seven

individuals were in medical care. Two individuals out of the seven are not virally suppressed as of the end of June 2020. Partner services were offered to every case at the time of diagnosis.

Strategy 4. Comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH).

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.
   During the reporting period, the main objective was to create quality data reporting tools for the providers offering Anti-Retroviral Treatment and Access to Services (ARTAS) and HIV Navigation Services (HNS)working with our HIV care section and the RW Part B regional grantees developed a tool that was approved for use through the internal communications process. Additionally, with more focused efforts on HNS and ARTAS, we have additional providers interested in offering these services at Lancaster General Hospital Comprehensive Care and Pinnacle Health REACCH clinic, both of whom are infectious disease providers that offer comprehensive HIV and STD testing and treatment and PrEP. These providers are both established within their communities and have been working with the RW regions for many years. They bring a wealth of knowledge and resources to implement HNS and ARTAS.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?
   As mentioned above, the primary challenge experienced with implementing prevention services were the restrictions related to COVID-19 pandemic. In-person prevention services were either suspended or drastically limited from March through June 2020. The HPP has been working on developing policies for implementing virtual HNS sessions to make the service available to those concerned about attending in-person and giving our providers an opportunity to resume or increase HNS.

   The HPP identified a gap in the western part of the state for ARTAS and HNS. To address this, the HPP is writing a fee-for-service Participating Provider Agreement (PPA) for ARTAS, HNS and other evidence-based interventions that will allow providers outside of the RW region network to

contract with the PADOH and offer prevention services across the commonwealth. This prevention PPA will also allow for more data collection and identification of needs among a larger network of providers.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts, target populations, recruitment strategies, testing technologies or algorithms, objectives, staffing/personnel, funding resources, etc.).
   Beginning July 1, 2020, HNS and ARTAS will be the only prevention interventions supported by the HPP outside of testing services. The RW regional grantees were notified of this change in 2019 through a guidance that was disseminated outlining the HPP's plan to focus resources on a limited number of interventions that will have the greatest impact on priority populations. We anticipate that by supporting ARTAS and HNS it will allow for better quality monitoring, data collection and leverage of available financial resources. While the HPP will continue to fund ARTAS and HNS through the RW regions, we will continue with moving forward with a PPA for these interventions to enhance access to these interventions by the end of 2022.

4. Describe if there have been any changes to your jurisdiction's processes for linking PLWH to care.
   a. Specifically, describe any changes made to the definition/criteria used for identifying persons "not-in-care (NIC)" or "linked to care."
      i. Linked-to-care definition is now able to be recorded within 30 days based on the date of the client's first medical appointment. The HIV PS and syphilis investigations were revised to capture this date.
      ii. In the absence of a documented date of first medical appointment, we were still able to determine linkage to care if there was a viral load test conducted within 30 days of diagnosis.
   b. Specifically, describe any challenges experienced with reporting D2C NIC investigation data to CDC through eHARS.

      We have not had any challenges in reporting NIC investigations data to CDC. However, the entire D2C project was suspended due to the COVID-19 pandemic. Now that the Governor has re-opened the state, we are the process of reconnecting with our providers to

assess their readiness to restart the process of generating the preliminary list. We anticipate that D2C activities will resume in the second part of the CDC grant year.

5. Describe the impact of COVID-19 on comprehensive HIV-related prevention services for PLWH (i.e., linkage to care, tracking initial infection, etc.).
   COVID-19 had an impact on staffing resources due to re-direction of efforts to COVID-19 response activities at the provider and CMHD level. In addition, the ability to provide certain services were restricted due to the state-wide stay at home orders from the Governor. However, HIV prevention services continued to be provided to those individuals considered high risk for HIV infection and also for PLWH to ensure timely linkage to HIV medical care.

Strategy 5. Comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   The creation and approval of the data reporting tools mentioned under strategy four also apply to strategy five as they are for HNS. The additional focus on capacity building and resources on HNS allowed for several new providers to be onboarded through the RW regions, including Lancaster General Hospital Comprehensive Care and Pinnacle Health REACCH.

   In addition, the nine CMHDs continue to offer HNS and have improved their recruitment and implementation strategies after additional technical assistance was provided through HPCP and the HPP. For example, the Allegheny County Health Department has improved communication with their STD clinicians regarding referrals to HNS and they greatly enhanced their documentation of HNS activities.

   HPP also established two additional PrEP PPAs with Pinnacle Health REACCH and Planned Parenthood of Western PA. Pinnacle Health REACCH will be providing PrEP services to participants at GLO Harrisburg and the LGBTQ drop-in center. Planned Parenthood of Western PA has plans to engage women at risk for HIV for PrEP services at their seven locations.

Implementation of tele-PrEP has been a priority for the HPP. To date, we have met with Louisiana to learn their methodology and the University of Rochester is offering to gather information from other jurisdictions, such as Iowa and New Jersey, for comparison. In addition, HPP will host a PrEP Institute later in 2020to engage private providers, large medical systems, FQHC, and other PrEP stakeholders to expand PrEP services, encourage providers to implement PrEP services, discuss the implementation of tele-PrEP, and allow for networking among PrEP providers in different geographic areas.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

   While in-person prevention services were suspended for a period of time due to the COVID-19 health crisis, there were numerous opportunities for capacity building available virtually through HPCP that proved to be very valuable for our providers. The HPP has been working on developing policies for implementing virtual HNS sessions to make the service available to those concerned about attending in-person and giving our providers an opportunity to resume or increase HNS.

   Due to COVID-19, there was a decrease in the number of PPA PrEP visits during the reporting period. The providers that continued to operate from March through May 2020 were limiting their services to existing patients, while some using tele-health to encourage PrEP adherence. By mid-May 2020, all providers were fully operational again with social distancing measures in place.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts, target populations, recruitment strategies, testing technologies or algorithms, objectives, staffing/personnel, funding resources, etc.).
   Beginning July 1, 2020, HNS and ARTAS became the only prevention interventions supported by the HPP, outside of testing services. This will allow for more quality monitoring, data collection and use of available financial resources. While both ARTAS and HNS are still being funded through the RW regions, the goal will be to implement the new prevention contract by the end of Year 4 of the grant cycle.

4. Briefly describe which populations and what activities you supported for high-risk HIV-negative individuals during the reporting period.
   The following effective interventions were supported during the reporting period: MPowerment, HNS, CLEAR, VOICES/VOCES, Community PROMISE, condom distribution programs, PrEP access through the PPAs, in addition to testing in healthcare and non-healthcare settings. The populations that were prioritized for the effective interventions include: MSM of color and young MSM, persons who inject drugs (PWID), women of color, and minority populations in high morbidity geographical areas. Additionally, private providers, FQHCs, drug and alcohol providers and other community-based organizations were targeted for outreach to increase awareness of PrEP, PEP, routine HIV testing, and Hepatitis C.

5. Describe the impact of COVID-19 on comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection (i.e., PrEP, other prevention activities, etc.).

   Many prevention activities, particularly effective interventions, were suspended or severely diminished due to the COVID-19 mitigation recommendations and restrictions. Capacity building activities were conducted virtually to allow for planning and technical assistance, and they were well received. Many community-based organizations closed for the months of March through May and as a result no in-person prevention activities occurred. Several of the PPA PrEP providers that were able to remain open continued to serve their existing patients but were not seeing new patients. However, by mid-May 2020 all those services were restored, in part, to allow for in-office visits and new patient services. To date, most providers are still limiting their walk-in services and spacing appointments to meet social distancing recommendations.

Strategy 6. Perinatal HIV prevention and surveillance activities

If you are implementing <u>any</u> of the perinatal HIV prevention and surveillance activities, please respond to the following questions (1-3):

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   HSP has made tremendous efforts to enhance perinatal HIV surveillance activities. Recent efforts on enhancing perinatal HIV prevention and surveillance activities have led to initiation of Mother-

to-Child HIV prevention and surveillance activities from late 2019 to present. These activities incorporated establishing solid working relationships with appropriate providers to support surveillance efforts. HSP has collaborated with HPP, TB, and STD programs to create awareness on the impact of TB, STD and HIV on women of childbearing age (15-44) in PA during a conference on Pregnant Women with Opioid Use Disorders in March 2020. HSP focused the awareness presentation on the age groups with the highest number of HIV perinatal live births in PA; which are ages 25-29, 30-34 and 20-24. To further this strategy, a patient-provider friendly flyer is scheduled to be released towards the end of 2020 on Mother-to-Child HIV Transmission prevention.

Timeliness and completeness of investigation are primary goals in perinatal HIV exposed case finding. HSP conducts matches with vital records birth certificates twice a year. The preliminary match for 2020 was completed in February and the second match will be implemented later this year. Missed perinatal HIV exposed cases are identified through the matches and the missing variables are captured during follow-up investigations. Completeness of perinatal exposure variables for cases in PA has improved to 100% in the first quarter of 2020; especially the 'date of the mother's first positive test'. In 2019, 5.1% of PA perinatal HIV exposed cases were missing 'date of the mother's first positive test'. The improvement from 2019 record has helped in showcasing a sustained surveillance effort to maintain timely data capture. Similarly, surveillance efforts are geared towards maintaining a completeness standard of ≥90% from the date of diagnosis into the following year. This completeness standard has been accomplished for 2018 and 2019 perinatal HIV exposed infants.

For initial follow-ups to be accomplished within the 30-day window, proper communication and enforcements were necessary. In January 2020, HSP organized a meeting with key stakeholders which included the two PADOH field staff supervisors, HPP manager, and STD program manager. This meeting was necessary because the same field investigators assist the programs represented in the meeting and a uniform message on field operations was desirable. The resolution from the meeting covered the following areas: perinatal HIV surveillance follow-up, data entry, and identification of pregnant HIV positive women.

From the end of 2019 to the first quarter of 2020, HSP identified and met with some of the major pediatric HIV clinics to discuss the perinatal HIV project and increase provider support in the areas of testing, reporting, clinical follow-up and quality assurance. These facilities were selected because they provide prenatal care services and some of them were identified as key birthing facilities for perinatally exposed children.

To properly target provider facilities, HSP used birthing facilities from PADOH Bureau of Health Statistics. Of the 95 birthing facilities, 46% has been categorized by HSP as facilities that also provide prenatal care services. The 2018, 2019 and 2020 number of births per birthing facility helped in guiding the categorization and prioritization. Appropriate categorization of these facilities makes our data collection process and identification of cases more seamless; especially the identification and follow-up of pregnant HIV positive women and their HIV exposed infants.

The decline in the occurrence of HIV positive perinatal cases is helping to bring PA closer to ending the HIV epidemic. In 2018, PA data (excluding Philadelphia) had only one positive perinatal HIV case out of 62 exposed infants. In 2019, there was no case detected. Additionally, in the first quarter of 2020 there has been no cases of perinatal HIV transmission. To further eliminate HIV positive perinatal transmission, HPP monitors providers to ensure pregnant women who test positive for HIV are referred to appropriate care facilities for HIV treatment. HPP has leveraged this opportunity by collaborating with the PADOH D2C coordinator to include pregnancy status in the D2C questionnaire. HIV positive perinatal cases mostly occur as a result of missed opportunities. Early identification of pregnancy status and linkage-to-care of the HIV infected pregnant woman will help to reduce missed opportunities.

HSP case surveillance work for 2019-2020 has improved through early identification of pregnant HIV positive women from different data sources. This includes identifying and monitoring of pregnant HIV positive women in PA-NEDSS and eHARS. In addition, some of the providers we have established contacts with now routinely report HIV positive women who are pregnant and receiving clinical care in their facilities. This progress and the utilization of various data sources

such as the Special Pharmaceutical Benefit Program (SPBP) data have enhanced our prospective data. We have used SPBP data to select markers for identifying pregnant HIV positive women of childbearing age (15-44 years). The markers include age and whether the women are on prenatal vitamins.

The HSP staff has access to the SPBP data weekly in the data warehouse and it has become a useful resource. In the first quarter of 2020, a sample of 33 SPBP cases were reviewed, 56% were identified as HIV positive mothers who gave birth in 2019 and 22% were identified to be currently pregnant. In addition, our eHARS first quarter data revealed that 15 HIV perinatally exposed babies were from HIV mothers who were pregnant in 2019. As of June 2020, our maternal tracking data recorded about 21 known HIV positive pregnant women. Most of these women will deliver their babies this year. PA (excluding Philadelphia) annually records between 60 to 70 perinatal HIV exposed infants. With current available data, more than half of the year 2020 HIV perinatally exposed infants are already known.

Since late 2019, HSP has been meeting with other PADOH Programs that are implementing strategic plans for women of childbearing age. Such Programs include Hepatitis C and Zika. Since June 2020, this meeting has become routine strategic meeting where each program shares public health ideas and outcomes; providing opportunity for dialogue and better insights in resolution of public health challenges.

While the HPP cannot cite successes under this strategy for this reporting period, we continue to require the CMHDs through grant language to promote that pregnant women receive routine, early HIV screening. We monitor the CMHDs annually to ensure they have a process in place that addresses this issue. We also require, through the grants funding, that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of perinatal transmission and monitor how the CMHDs meet this requirement. During our monitoring site visits we specifically review what collaborations exists between the CMHDs and medical providers that serve pregnant women. Further we have continued to allow for HIV prevention

funds to be used to promote HIV/STD screening for pregnant women through social marketing campaigns. Lastly, we provide health alerts periodically that remind all healthcare providers the importance and guidelines for screening pregnant women for HIV infection, as well as STDs and hepatitis.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

   A major challenge to our Perinatal HIV Exposure Reporting (PHER) is limitation in the current PA HIV reporting regulations language. Providers have raised privacy concerns regarding disclosing pregnancy status without being mandated by state law. To improve prospective data, pregnancy status of the HIV positive woman should be provided to HSP. However, the PA HIV regulations requires reporting after the birth of the infant. Clinical follow-up with PHER is handicapped without knowing the pregnancy status of the HIV positive women in advance of their delivery.

   Furthermore, PA HIV regulations fall short in allowing PADOH to collect accurate diagnostic status of perinatal HIV exposed cases. After the initial negative nucleic acid amplification test (NAAT), the law does not clearly obligate the provider to report enough tests to complete the perinatal diagnosis. Recommendations for specimen collection for pediatric HIV testing are as follows: within 48 hours after birth, two weeks of age, four to six weeks of age and four to six months of age. Receiving only the initial negative NAAT test will not be enough for a seroreveter status. Also, there is a learning curve for some providers who may not be following appropriate CDC testing guidelines for a perinatally HIV exposed infant; they use the wrong type of test or do not follow the recommended testing timelines.

   The bedrock of clinical follow-up with PHER is chart abstraction which is the second step in a fetal-infant mortality program, after case identification. Efforts to expand chart abstraction to more provider facilities was hampered by the COVID-19 pandemic.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts or partnerships, target populations, testing technologies or algorithms, objectives, staffing/personnel, funding resources, etc.).

   The HSP is in the process of replacing PA-NEDSS with NBS. The HSP team is working to implement electronic data collection questionnaire in NBS that are currently missing in the PA NEDSS database such as facility of the mother's prenatal care and facility of pediatric follow-up care. These additional features will help us capture and monitor reports associated with pregnant HIV positive women, prenatal care, and infant treatment history after birth.

   To address the privacy concerns expressed by some providers, HSP will continue to engage the PADOH legal counsel. In addition, clinical follow-up based on available retrospective data will be applied as we explore the possibility of requesting medical records mailed to us based on our list of all HIV infected women of childbearing age who have been identified to have gone to the affected provider facilities. This can be a long and tedious method of prospectively identifying the HIV infected pregnant women who go to the provider facilities with the privacy concerns.

   By the end of the year the Mother to Child HIV Transmission flyer will be published and distributed to providers. The flyer will put more emphasis on the need to follow CDC's recommended testing guidelines for perinatal HIV exposed babies and their mothers.

Strategy 7. Community-level HIV prevention activities

☐ Not applicable if opt-out approved

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   Within this reporting period GLO-Harrisburg (GLO), a Project Silk Diffusion site, offered an array of programming options and events for the priority population prior to the COVID-19 pandemic. These programs and events included an HIV Myth Busters program, a Resiliency 101 program, karaoke nights, movie and show screenings and game nights. GLO also hosted its first

HIV testing event in honor of National Black HIV and AIDS Awareness Day on February 7th, 2020. At this event GLO staff tested seven individuals.

GLO began this reporting period by adding five new participants to its CAREWare system by the end of January 2020 for a total of 14 unique participants in the system. Participation and referrals to GLO increased. GLO's number of participants doubled in February 2020 to 28 participants and continued to increase through May 2020 despite GLO closing its physical location due to the COVID-19 pandemic.

In March 2020 GLO successfully transitioned to a virtual platform in response to the COVID-19 pandemic. In this transition staff were able to continue to engage priority population members, provide programming as well as social media check-ins and case management services. During this period GLO provided four programming sessions a week via Zoom and eight check-ins a week using social media. GLO's Case Manager continued to keep in touch with participants, make referrals to resources and receive referrals from other providers. To meet the needs of staff during this transition to a virtual platform and a work from home order, a Staff Support Plan was developed to assist the Director of Youth Programs in addressing barriers and challenges staff were experiencing as a result of this transition.

During the social unrest experienced throughout the nation during this reporting period, GLO had the unique challenge of balancing self-care and supporting the priority community. Following these events, GLO hosted a week of "Take One Day at a Time" programming which created a space for GLO's priority community to discuss their thoughts and share their emotions about the current political climate. This programming was a success and GLO continued to host a safe space every Thursday specifically for race-based discussions, venting sessions and gaining support. As a result of these programs, presently every Thursdays GLO hosts "I Ain't Code Switching" which is an interactive support group for GLO's priority community. Within the reporting period following the events across the nation many organizations and businesses within Harrisburg began reaching out to donate goods, services and money. GLO partnered with local organizations and businesses

who fundraised and provided donations which allowed GLO to start a donation-based Emergency Housing Fund aimed at assisting the priority population with emergency housing needs such as costs to avoid eviction, moving costs and emergency hotel stays.

With PA beginning to reopen and some of GLO's partnering agencies returning to in-person services GLO staff and partners began developing a Transition Plan. This plan would allow staff to safely return to the office on a limited basis to provide services that were not available virtually including HIV testing, some case management services, access to GLO's food and hygiene pantry and use of GLO's many other amenities. This plan has been implemented and staff returned to the office on a limited basis in late July 2020.

From an operations standpoint GLO has had increased participation from select Youth Advisory Board (YAB) members who have been assisting GLO by hosting GLO's virtual check-ins on social media four times a week. Within the reporting period GLO was able to begin the search and interview process to hire two new staff members to engage with the priority population and provide services. Following the end of the reporting period GLO was able to extend offers to two individuals who are reflective of the priority population. The final success of this reporting period is that Project Silk, Project Silk Lehigh Valley and GLO were able to meet virtually to collaborate on ways to work together in the future. Each site's YAB came together to form a panel where they can share ideas, get feedback and plan events together. Currently all three sites host a YAB conference every Friday evening for collaboration.

a. Online Outreach Program

The online outreach project continues to provide four basic resources:

- Internet Outreach for at-risk populations in PA - Online sexual health resources targeting MSM (primarily via the Website *m4mHealthySex.org*, the *Pitt Men's Study* Website, the *LGBTQpgh.com* blog and corresponding Facebook pages) and minority women and youth at risk (Need2Know campaign including the Need3Know Website/Blog and Facebook page).
- Online Partner Services – Conducting Partner Services in Internet-based venues.
- Health Alerts – Health Alert bulletins regarding sexual health posted on HPCP Websites/blogs, Facebook pages and a subscription-based list service.

- Online Sexual Health Education – Sexual health educators providing real time, one-on-one HIV and STD testing information, HIV care and PrEP referrals, and general sexual health information through Internet-based venues.

Jan – June 2020 successes include:

- Overall - There were 16 social marketing/public information campaigns ("Health Alerts") conducted in the first half of 2020 through the Online Outreach Program. The eight venues utilized for those campaigns consist of four Facebook pages, three Website/Blogs, and one-on-one sexual health information education conducted by HPCP staff. The total reach of all social marketing projects—targeting at-risk communities—is an estimated 367,000 impressions, up from 286,000 from the same time period in 2019, with an estimated 7,800 engagements (views, likes, and shares).
- Internet Outreach Programs – There were 6,383 combined views of the *m4mHealthySex.org, Kneed2know.com and PittMensStudy.com* Blog/Websites in the first half of 2020, up from 5,625 from the same time period last year. The Blog/Websites' corresponding Facebook pages (including the LGBTQ Pittsburgh Facebook page) added 1,483 followers, boosting the current total to 5,300.
- Health Alert Service for MSM – A total of 16 messages were sent between January and June of 2020. The number of impressions is estimated to be 367,000, up from 286,000 from the same time period in 2019, with an estimated 7,800 engagements (views, likes, and shares). Health Alert topics included: *New Interim NIH Guidelines for people living with HIV regarding the COVID-19 pandemic; Young men unaware of risks of HPV infection and need for HPV vaccination;* and *Why are Hispanic/Latino men 4 times more likely to get HIV than white men?*
- Online Sexual Health Educator – Conversations conducted using Internet-based venues continues to be the primary focus of the outreach program. In the first half of 2020, sexual health educators engaged 207 individuals, down from 371 in the same time period in 2019. Of the 207 conversations, an estimated 70% were referred to local HIV/STD testing clinics, 20% were referred to PrEP providers, and ten percent had general sexual health questions.

b. HIV Prevention and Care (HPCP) Website/Blog.

Program Description: The HPCP Website serves as a hub for community-oriented news and resource listings related to HIV/STIs and sexual health. It also provides in-depth, consumer-oriented information regarding other HPCP community initiatives such as *Acceptance Journeys, Project Silk, Online Outreach to At-Risk Populations, and HPCP-related Capacity Building and Planning*. In short, www.HIVPreventionAndCareProject.com is a community resource designed to reach out to stakeholders and the general public regarding all-things HIV/STD-related in the commonwealth. The Website also has a corresponding Facebook page designed to build an audience of online followers who then represent a percentage of the state population able to receive important HIV and STD health information.

Jan – June 2020 successes include:

Quantitative and qualitative successes experienced with this program during the January to June 2020 reporting period include just over 43,000 individual post impressions (Website and Facebook page combined). Of the total number of impressions, there were more than 4,000 engagements (likes, shares, messages, views). The Facebook page nearly tripled the number of followers in the first six months of 2020, going from 209 followers at the end of 2019 to 627 at the end of June of this year.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

Prior to the COVID-19 pandemic GLO was gaining momentum with participation in programs, events and services. Closing GLO's physical location and switching to a virtual platform proved to be a challenge especially being that GLO is such a new organization within the Harrisburg community. Throughout GLO's transition to the virtual platform there have been challenges in getting participants to engage in virtual programming. Some programs have been successful in engaging participants while others have not been able to draw in any participation. With schools being closed due to the COVID-19 pandemic outreach to youth 14-17 years old has proven to be a challenge as well. GLO has also struggled with program participation from YAB members.

Despite involvement in YAB meetings the members of YAB have not been consistent with attending and promoting GLO's virtual programs and events. GLO is addressing these challenges by adding more promotion for programming, creating more innovative programming ideas including contracting guest facilitators and requesting feedback and ideas for programming through various surveys and questionnaires to participants and YAB members. Outreach to local youth programs, case management services and other services has been helpful in engaging youth who have not been accessible due to the school closures. GLO will continue to collaborate with these organizations. Another challenge GLO has experienced within this reporting period is implementing a streamlined documentation process to accommodate the changes from in-person to virtual services. Documenting program and live attendance required creating a new tracking system and workflow for staff. Prior to GLO's physical location closing GLO staff provided the vast majority of services in-person so transitioning to logging remote services was a learning curve as well. To address the challenges with proper documentation GLO staff now has accessible links to systems they need to use to document, deadlines have been introduced for documentation and documentation is reviewed weekly to ensure all services are being captured.

Staffing has also been a challenge within this reporting period. At the beginning of the reporting period GLO's part-time Peer Engagement Specialist left their position to pursue higher education. This left GLO with only one full-time Peer Engagement Specialist. Hiring to fill this position has been a challenge due to COVID-19 and also barriers with the hiring agency's policy and procedure. Many candidates were ineligible due to factors that are common within GLO's priority population such as criminal histories, drug testing in conjunction with offering low wages. GLO staff and community partners are addressing this by examining these policies and procedures as well as reclassifying the Peer Engagement Specialist position, reassigning job duties to the position and renaming the position to allow for individuals within the position to be paid a higher wage.

a. Online Outreach Program

- Online Sexual Health Educator - Stigma associated with HIV creates a well-documented, ongoing barrier to prevention and care. In addition, chat room venues and list moderators present a unique set of barriers that include regulations placed on outreach personnel and

outright bans on health-related outreach. The COVID-19 pandemic had a decided effect on the number of one-on-one conversations due to social distancing requirements, especially between March and June. In short, fewer men where using "hookup" aps and Websites due to a fear of coronavirus infection and state-Imposed restrictions related to social distancing. Finally, as other organizations (such as the PADOH, CDC, and more local organizations like AIDS Free Pittsburgh) increase awareness regarding HIV/STD testing and PrEP, the need for one-on-one chat room conversations by HPCP staff, to promote testing and prevention, is reduced over time.

- Internet Partner Notification – Restrictions created by the Website venues are an on-going obstacle in reaching out to individuals who may have been exposed to a sexually transmitted infection. For example, messages sent via Facebook rarely reach individuals who do not accept the senders "friend" request. Also, the lack of search functions on cell phone aps makes finding sexual partners nearly impossible.

  Responses to these challenges:

- Internet Outreach Program – In the first half of 2020, 112 new posts (concerning HIV/STD testing, prevention and treatment, and sexual health information) were added to outreach-related blogs (M4MHealthySex.org, Need2Know.com and PittMensStudy.com), along with updates to links, images and HIV/AIDS prevention information, testing and educational materials to mitigate a reduction of contacts in other program areas.
- Health Alerts – In addition to HPCP testing and prevention campaigns, a new emphasis was added to CDC-related campaigns such as *Start Talking Stop HIV, HIV Care is Prevention,* and *#StopHIVStigma.*
- Online Sexual Health Educator for MSM – Emphasis on outreach conducted via Internet platforms and smart phone applications (including Facebook, Grindr, Jack'd and Scruff) continues to be the central focus of the Online Outreach Program. Beginning in 2020, one additional part-time contractor was eliminated from the project due to lack of success in reaching one-on-one online (sexual health education) contacts. It was the consensus of the HPCP program manager and the HPCP director that the funds allocated to the contractor

would better serve women and youth at risk if those funds were diverted to a broader advertising campaign.

b. HIV Prevention and Care (HPCP) Website/Blog.

There were no undue challenges experienced with this program between January and June of 2020, including possible setbacks resulting from the COVID-19 pandemic.
Proactive changes made to the Website and Facebook page include updates to HIV/AIDS and STD information, news, and research relevant to HIV/STD stakeholders and the general population. There were an additional 50 health-related posts added to the archive of 323 posts from the previous year. Emphasis was added to messaging designed to address HIV-related stigma, testing, prevention and care, and to CDC-related campaigns specifically.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts, target populations, recruitment strategies, objectives, staffing/personnel, funding resources, etc.

Within the next 6 months**:**
The anticipated changes to GLO's services include offering STI testing and treatment on-site at GLO through Hamilton Health Center. Offering linkage to PrEP Navigation Services through UPMC Pinnacle REACCH Program. Future changes to staffing include reclassifying, renaming and reassigning job duties to the current Peer Engagement Specialist role to allow for higher wages and hiring a part-time staff person and a full time staff person for this new role as well as transitioning GLO's current full time Peer Engagement Specialist into this role for a total of two full time staff members and one part-time staff member in this role.

Within the next 12-18 months:
We also anticipating changes in developing and implementing a funding contingency plan for GLO in preparation for the transition from University of Pittsburgh funding.
GLO's priority population will continue to be transgender women of color and men who have sex with men of color ages 14 to 29 but following the completion of GLO's current funding source the

program will begin to broaden its scope of practice by serving LGBTQ+ People of Color with an emphasis and focus on the original priority population.

Indicate whether this task is on-track, scaled back, or interrupted.
GLO's services were scaled back due to the COVID-19 pandemic. GLO moved to an entirely virtual platform from March 2020 through June 2020 therefore services such as HIV testing and use of the drop-in space were unavailable. Staff utilized referrals to other health resources in order to accommodate participant's needs for HIV testing. In June 2020, GLO began creating a Transition Plan to bring staff back to the office on a limited basis to offer these in-person services starting July 2020.
Despite not being able to provide in-person services for almost four full months of the reporting period GLO was able to continue offering programming, case management services, referrals and staff continued to be accessible to participants through various virtual platforms including phone calls, emails, Zoom, Facebook Live and Instagram Live. Since the end of this reporting period GLO staff has returned to the physical location on a limited basis and HIV testing and use of the space is now available to participants.

Number of target population members (e.g., young men of color who have sex with men; young trans women of color) tested for HIV: Five individuals from the priority population were tested for HIV within this reporting period.

Number of target population members receiving HIV positive test results: There were no individuals who received an HIV positive result during the reporting period.

Number of verifiably new HIV diagnoses among target population members receiving HIV testing: There were no individuals who received a verifiably new HIV diagnosis due to there not being any positive HIV results given within the reporting period.

Number of target population members with verifiably new HIV diagnoses who are successfully linked to medical care and supportive social services: There were no individuals

linked to medical and/or social services due to there being no positive HIV results within the reporting period.

Number of target population members who have been previously tested HIV positive who are successfully re-engaged in medical care: There were no individuals identified that previously tested HIV positive and needed to be re-engaged in medical care.

Number of target population members who have been previously tested HIV positive who are successfully engaged in supportive social services: GLO's Case Manager successfully linked one person who is living with HIV to supportive services within the reporting period. GLO's Case Manager made a total of six referrals for this one participant.

Number of target population members with verifiably new HIV diagnoses who are successfully referred to Partner Services: There were no individuals linked to partner services due to there being no positive HIV results within the reporting period.

Number of total target population members who are successfully engaged in supportive social services: GLO's Case Manager successfully linked 19 participants to social services. GLO's Case Manager observed an increase in need due to the COVID-19 pandemic providing 42 referrals to 19 participants within the reporting period.

Number of target population members tested for sexually transmitted infections (STI): There were no individuals tested for STIs within this reporting period due to STI testing not being available at GLO. It is projected that STI testing will be available at GLO by the end of 2020.

Number of target population members receiving positive STI results: There were no individuals that tested positive for STIs within this reporting period due to STI testing not being available at GLO.

Number of target population members who receive positive STI results and are successfully linked to medical care: There were no individuals that tested positive for STIs within this reporting period due to STI testing not being available at GLO.

Number of target population members who utilize the recreation-based safe space: There were 15 individuals from the priority population who accessed the recreation-based safe space.

Number of target population members who are successfully linked to PrEP providers: There were no individuals linked to a PrEP provider due to a lack of services in the area. PrEP Navigation Services will be available for referral at UPMC Pinnacle REACCH Program by the end of 2020.

Any other outcomes data related to project success: Despite GLO's physical location closing for nearly four months within the reporting period the recreational drop-in space was accessed 98 times. Within the reporting period GLO served 42 participants and provided 331 services

a. Online outreach program:
   - Internet Outreach Program for at-risk Communities – The *m4mHealthySex.org* and the Need2Know Websites/blogs continue to evolve, to meet the needs of an ever-changing communities at risk. New breakthroughs regarding HIV/STD prevention will be promoted as well as on-going updates to regional testing, prevention, and care providers.
   - Online Sexual Health Educators – Referrals to HIV/STD testing and PrEP providers will continue to be a focus of the online outreach staff. Efforts to reach out in new venues will evolve as those venues continue to grow and change.

b. HIV Prevention and Care (HPCP) Website/Blog
   There are no major changes anticipated for the near future; new content will continue to be updated to reflect the needs and interests of impacted communities in PA.

4. Describe the impact of COVID-19 on community-level HIV prevention activities (i.e., social marketing campaigns, condom distribution, syringe services programs, etc.).

   As was mentioned above, the impact of COVID-19 on community-level HIV prevention activities has been that activities have slowed somewhat in their progress as new and creative ways for providing them have needed to be developed and implemented. It should be noted that PADOH state has continued to move forward with these activities even though COVID-19 has slowed their progress at times.

Social Marketing Campaigns

5. Did you promote and/or support any CDC social marketing campaign during the reporting period?
   ☒ Yes ☐ No. If yes, please specify *Start Talking Stop HIV, HIV Care is Prevention,* and *#StopHIVStigma*

6. Were other social marketing campaigns utilized? ☐ Yes ☒ No
   If yes, please describe

7. During the reporting period, what kinds of activities did you conduct as part of your social marketing efforts? *(Please check all that apply).*
   ☒ Blogs
   ☒ Materials Distribution
   ☐ Events
   ☒ Internet/Digital Advertising
   ☐ Traditional Advertising (e.g., print, TV, radio, billboards)
   ☒ Social Media (e.g., Facebook, Instagram, Twitter)
   ☒ Email Blasts
   ☒ Other (DefeatHIV Facebook and StopHIV Twitter; 759 engagements)
   ☐ None. We did not conduct any social marketing activities.

Condom Distribution

8. Provide the total number of condoms distributed overall during the reporting period

   A total of 248,450 condoms were distributed. In addition, we made available and distributed dental dams and personal lubricants as part of our Condom Distribution program.

Syringe Services Programs (SSP)

9. For Syringe Services Programs, please provide the following information:
   Does the jurisdiction already have a Determination of Need (DON) in place?☒Yes ☐ No

If no, does the jurisdiction plan to submit a DON for Syringe Services Programs (SSP)? ☐Yes ☐ No

a. Describe SSP and harm reduction activities conducted during the reporting period for high-risk or vulnerable populations.
HPP continue to provide risk reduction interventions through the RW regional grants targeting both PLWH and high-risk populations. We also provide free condoms to our publicly supported sites as well as point of care HIV tests to those sites conducting non-healthcare targeted testing and to SSPs.

b. Provide the number of SSPs funded within the jurisdiction, location of services, and the number of clients served, if available (regardless of funding source).
There are two local health authorities that have endorsed syringe access in the state; Allegheny County (Pittsburgh) and Philadelphia. There are several other undergrounds, volunteer-run, street-based programs that operate in the state with private funding and local consent; however, these entities are vulnerable, and dependent upon the local political climate. It is not readily known the number of individuals served through any of these SSPs.

c. Provide the amount of PS18-1802 funding for SSP and harm reduction activities.
Using the amounts associated with the harm reduction activities that we provide with the distribution of condoms, dental dams, and test kits the total spent on harm reduction activities is $32,180. This is substantially less than previous six-months period as COVID 19 impacted our non-healthcare testing and distribution of condoms. In other words, we were not receiving as many requests for these items.

d. If PS18-1802 funding is not being used for SSPs and harm reduction services, provide the other funding sources.
It is not known what funding is being used to support these individual SSPs. There are no state funds or other federal funds under the scope of the Department of Health that are being used to support SSPs.

Strategy 8. Partnerships for integrated HIV prevention and care planning

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

    a. Conducted a successful HPG meeting in February 2020, including new member orientation activities for the new members recruited to the HPG at the end of 2019.
    b. Converted the HPG meetings to an online format to continue the group's work while adhering to safety measures enacted in the Commonwealth to address the COVID-19 pandemic. In May 2020, we conducted subcommittee meetings for the Assessment and Evaluation subcommittees in this format.
    c. Launched a statewide survey to assess stigma among HIV positive consumers enrolled in the SPBP. As of June 30, 2020, 624 individuals completed the survey. A total of 16 of those individuals mentioned coronavirus in their responses.
    d. Staff worked with regional grantees across the Commonwealth to build a robust schedule of in person regional sessions for the Ryan White Part B Priority Setting Consumer feedback process. These 15 sessions would have reached all of the grantee regions, excepting AACO in order to minimize travel and other barriers for consumers in attendance. Due to the COVID-19 pandemic, our staff has quickly pivoted on this plan to take the entire process online by building a Priority Setting Survey which will be offered in both Spanish and English. Staff have also devised plans to make this survey available to those without reliable internet access or literacy, through a hard copy option and collaboration with providers.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

    The COVID-19 pandemic prevented the HPG from meeting in person for their planned meeting in May 2020. To address this, we modified the general HPG meeting so that it was an online meeting for the HPG subcommittees. We also had to cancel our June town hall meeting, as moving this to an online format would be ineffective for the purpose of the meeting.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes to the Plan, updates to the planning groups, uses of the Plan document, local funding resources, etc.).

    a. We intend to facilitate two listening sessions around the impact that the COVID-19 pandemic has had on PLWH and other stakeholders in the HIV prevention and care landscape.

        i. HPCP will use the responses from the sessions to develop a summary of the discussion, which can be disseminated to stakeholders and summarized at future HPG meetings. HPCP will also provide the summary to the Division, along with any recommendations that arise from the session that may affect HIV prevention and care programming in PA. HPCP will also update both the available resources list and mental health resources list after the session to include any relevant additions.

        ii. The feedback from these sessions will illuminate barriers and needs throughout the state, particularly in ancillary service delivery. This understanding will inform HIV planning throughout the jurisdiction and the new IHPCP. It may also serve as formative guidance for a future needs assessment on COVID-19 and HIV, should such work be requested by the HPG and the Division

    b. Future meetings in 2020, including the August HPG meeting, will be held entirely virtual with enhanced document distribution in advance of the meeting.

4. Did you make any changes to your Integrated HIV Prevention and Care Plan and/or planning group process during the reporting period? ☒ Yes ☐ No

5. Describe the impact of COVID-19 on integrated HIV prevention and care planning activities (i.e., HIV Planning Groups, etc.).

    COVID-19 affected our integrated HIV prevention and care planning activities in the following ways: moved HPG meetings online, moved priority setting sessions online, and canceled Town Hall events.

Strategy 9. Implementation of structural strategies to support and facilitate HIV surveillance and prevention.

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   We are currently in the process of reviewing PADOH HIV Security and Confidentiality Policy. Our transition to teleworking has necessitated a review of the HIV security and confidentiality procedures. We have implemented a temporary security and confidentiality agreement in order to enable teleworking and accommodate challenges imposed by the COVID-19 pandemic.

   As of January 2020, all disease investigators have competed the annual Security and Confidentiality training and signed a confidentiality declaration. Over 500 disease investigators have signed these declarations for 2020. All new disease investigators are required to complete the annual training.

   We are continuing the process of updating our reporting regulations to require the reporting of all CD4 and viral load tests. The process of regulation approval in PA requires multiple administrative steps. PADOH expects to obtain final approval for this regulation during the September 2020 meeting of the Independent Regulatory Review Commission (IRRC). During the final-form stage, the IRRC may vote to approve or disapprove the regulation or request further review after the Commission votes on the regulation. The Commission will schedule the regulation for consideration at a public meeting and will vote to approve or disapprove the regulation in its entirety. Upon approval of the final form regulation the IRRC will issue an order notifying the PADOH, the standing committees and the Legislative Reference Bureau of its approval. In most circumstances, the promulgating agency will then submit the approved regulation to the Office of the Attorney General for legal review. After the Attorney General approves the regulation, the agency will submit it to the Legislative Reference Bureau for publication in the PA Bulletin. The regulation becomes effective on the date it is published or on another date specified by the promulgating agency in the regulation or the rulemaking order.

PADOH has evaluated its disease reporting system (PA-NEDSS) as a vehicle for HIV surveillance and decided to move ahead with the development of new comprehensive disease surveillance system named PA Disease and Outbreak Reporting (PA-DORS) using NBS. PADOH is working with program staff (e.g., HSP, partner services, infectious disease epi, tuberculosis and STD), Information Technology staff, CDC and external partners to design and implement this new disease reporting platform with a go-live date expected for Jan 1,2020. We are currently developing an integrated HIV surveillance and Partner Services reporting page and working with BIIT partners to develop a data warehouse and other reporting capabilities. We are working on developing an interface from PA-DORS to eHARS like the interface we have developed between PA-NEDSS and eHARS.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

   The surveillance program participated in the development of an electronic case notification system to be integrated in the PA-NEDSS platform. Two external partners agreed to begin case notification for STD data on a pilot basis. However, with the decision to transition to PA-DORS a decision was made by management to suspend the implementation of all case notification activities until the new data platform is in place.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in venues, contracts, partnerships, target populations, existing policies and procedures, use of advance technology, objectives, staffing/personnel, funding resources, etc.).

   The most important anticipated change is the transition from PA-NEDSS to PA-DORS.

   There are no anticipated changes to venues, contracts, partnerships, or target populations.

4. Describe the **procedures** you are using or intend to use to ensure data are secured when stateno/cityno information is shared and stored and if there have been any changes in procedures. In your description, include a statement if you are not sharing stateno/cityno and do not intend to share this information.

Sharing of stateno information with Philadelphia is done via secure File Transport. Since the two jurisdictions share the same eHARS platform, is easy for Philadelphia to identify the case in eHARS using the stateno. The stateno is encrypted using PGP for any sharing of stateno information.

5. Describe any **changes** in security and confidentiality procedures/policies impacting the jurisdiction, funded local/state/tribal staff and contractors, and programmatic activities. For example, changes in policies and procedures related to working in a virtual environment (including telework capabilities, needed equipment, VPN access, security enhancements), data sharing (including sharing data between programs and between systems such as between eHARS and EvaluationWeb) or data sharing agreements.

   We have implemented VPN access for all surveillance staff. All work conducted via telework must be conducted in an environment that meets the physical access protections that were in place at the central office prior to the teleworking arrangements.

6. The **FY 2021SAS Licensing Request/Memorandum of Acceptance (MOA)** and **2021 List of Assigned SAS Users** are due with the 2020APR. For instructions on completing the SAS MOA and requesting additional SAS workstations/server licenses see **Appendix D-E** and **SECTION IV: BUDGET.**

For information on the data security and confidentiality guidelines, please refer to https://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf.

Strategy 10. Data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities.

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.
   We have succeeded in monitoring the completeness and accuracy of HIV case reporting for individual field staff and district offices through a variety of mechanisms including the following:
   - Running monthly Surveillance Evaluation Reports to monitor progress toward specific benchmarks such as completeness of address and facility information, risk reporting, viral load and CD4 reporting as well as previous negative results and use of anti-retroviral testing.
   - Systematic review of all newly diagnosed cases by central office staff to ensure completeness of critical data elements and identify gaps in surveillance data
   - Running deduplication routines to ensure that case information is de-duplicated internal through eHARS and using our own de-duplication reports

- Matching of data from other sources such as CareWare and SPBP and creating a crosswalk of cases from eHARS, PA-NEDSS and eHARS,
- Matching of eHARS data to birth data to identify perinatally HIV exposed infants in a timely manner
- Matching death data such as SSDMF and state vital statistics data for timely and complete death information including cause of death
- Running laboratory quality reports to monitor laboratory reporting volume by specific laboratory and test type
- Continuously geocoding new diagnoses and fix incomplete address data in order to obtain census tract information
- In January 2020 we updated eHARS to version 4.11 and are in the process of updating to version 4.11.5
- Monitor the IHPCP through the HPG's sub-committee structure

The HPP continued with the development of a work plan for 2020 incorporating the four pillars from the Ending the HIV Epidemic Initiative into our objectives. The work plan serves as a roadmap for HPP activities and is considered a "living" document. While a formal work plan as submitted with the original application is no longer required, HPP continues to use this as both a program direction tool and a management tool.

The HPP also created a quarterly data report that shows all prevention data, including PS, testing, PrEP, interventions, and D2C. The idea behind this report is to be transparent to partners and stakeholders on the prevention activities. It also provides quarterly data that is readily available upon requests from the PADOH leadership. The draft quarterly report is currently being reviewed for approval to disseminate.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

HSP had planned to conduct facility audit as well as laboratory survey during the summer of 2020. However, due to the COVID-19 pandemic we had to postpone these activities pending when conditions are more favorable.

Case specific monitoring of named contacts continues to be challenging because we found there were many contacts with only marginal information. It was difficult to find them within the system because of the lack of information and no investigations created to link the contact to the index client who named them. To mitigate this challenge, the data team will be meeting with the program team in determining how best to capture the needed information on named clients without manually accessing the investigations and linking them to the index client. The most important remedy is for the investigator to link the partner's investigation to the index patient. If this does not occur, the system creates a record that is not traceable. We have SAS codes that is pulling out partner records, but we have not implemented a quality assurance (QA) measure to determine if those unlinked partners are present in the PA-NEDSS and can be tracked. The development of a QA measure will move forward in Year 4 of the grant cycle.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in data sharing, venues, method of service delivery, contracts, target populations, partnerships, implementation strategies, objectives, staffing/personnel, funding resources, etc.).

   The primary data focus is the implementation of a new disease surveillance system. PADOH has decided to replace PA-NEDSS with NBS with a projected go-live date in early 2021. This is anticipated to be a huge undertaking in converting current data elements in PA-NEDSS into NBS for all the programs that are currently using the system. This will require the PS Priority Report (and other reporting tools) to be adjusted as well to accommodate table structure changes.

   Data sharing: We are developing a new data sharing agreement in order to permit sharing of data with other jurisdictions in light of planned deployment of PA-DORS.

   Venues: We are now teleworking to the extent possible

There are no other anticipated changes for the rest of the funded activities, excepting to fill vacant staff positions.

4. Describe how surveillance data was disseminated to inform prevention activities.
   HSP produces an annual HIV surveillance report as well as the HIV Epidemiologic Profile. These two data products are made available to guide HIV prevention and care activities statewide. Community-based organizations and HIV coalitions cross the state periodically send data requests to HSP for customized data reports. The information provided are used to direct their specific local HIV prevention needs. We also respond to multiple requests for summary data with crosstabulations of surveillance and other data such as CD4 and viral load reporting and other data to be used by our prevention partners.

5. Describe how the program disseminated its program monitoring and evaluation data and provided feedback to healthcare and non-healthcare providers and other community partners to inform and/or improve HIV prevention efforts.
   HSP produces the HIV epidemiology profile to guide HIV prevention activities in the state. The epidemiology profile has data at county and municipal levels as well as stratified into racial, age, and transmission groups. The profile is updated periodically, and we will continue to leverage the information provided during the grant period.
   Distribution of funding resources will be based on an analysis of the epidemiological profile of the state. In addition to the epidemiological profile, HSP produces an annual HIV surveillance report that is available and utilized. Those areas of the state that share a higher burden of HIV disease and STD identification will be given priority of resources.
   The HPP continues to disseminate data to the field staff, CMHDs and PPAs through monthly and bi-annual reporting, all of which were described in previous sections. Dissemination of the data assists providers in understanding their efforts and where improvements can be made. It also provides a point to start discussions with field staff, DIS and PPAs on technical assistance and capacity building needs.

6. **RESOURCE ALLOCATION (for HIV prevention funding only)**
   Please identify each city/MSA with at least 30% of the HIV burden within the jurisdiction. For directly funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV burden within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then

identify the top three MSAs, cities, or areas within the jurisdiction that have the greatest burden of disease. **See Appendix A: Resource Allocation.**

Strategy 11. Capacity building activities for HIV programs, epidemiologic science, and geocoding.

1. Describe **successes** experienced with implementing this strategy and associated activities funded under Component A during the reporting period.

   HSP has geocoded more than 95% of all new diagnoses that were diagnosed in PA since 2010. We are currently finishing up address cleaning for 2019 cases and also periodically geocoding 2020 cases. We have developed SAS codes to identify specific documents and use the new document update feature in eHARS. HSP imported legacy address data with current addresses and use the data to make estimates of true prevalence based on current address information as opposed to address at diagnosis.

   HPCP developed, posted and disseminated a training schedule for this reporting period. Additionally, training reminder emails were developed by HPCP and disseminated by the Division to state funded HIV related service agencies. Trainings scheduled include: ARTAS, integrating Hep C into Your HIV Work, HIV navigation service, cultural humility, HIV testing in nonclinical settings, motivational interviewing, HIV testing in nonclinical settings One Day Refresher, and [Updated] HIV basics eLearning prerequisite.

   In March 2020, we started working with HPCP to develop another capacity building needs assessment survey to help in planning capacity building activities for 2021. The survey was sent to our partners in August 2020.

   A new training, Social Determinants and Health Equity, was added to our capacity building training schedule. The first offering was to be held April 2020 but was cancelled due to the COVID-19 pandemic and will now be part of the training scheduled for the first time in August 2020.

The HPP continued to work with two mental health trainers and were successful in getting them contracts with the Commonwealth so their services can be secured for trainings. We will offer Mental Health Awareness and Suicide Prevention trainings to our partners starting in the second half of 2020.

2. Describe **challenges** experienced with implementing this strategy and associated activities funded under Component A during the reporting period. What plans or actions have been taken to address the challenges?

   Geocoding requires accurate address information. As such data collected by surveillance partners and reporting providers and laboratories often requires cleaning or additional follow up with providers or disease investigators.

   COVID-19 has resulted in the inability to facilitate in person trainings and hampering of training of new trainer team members. This has been addressed through HPCP quickly adapting all capacity building offerings to operate in online/virtual settings.

   An increase in training demand has been challenging in that diverse statewide needs have increased capacity building training operations to their current limits. This could be addressed through increasing the number of Capacity Building team members or capping the number of trainings offered during the year.

3. Describe **anticipated changes** to the approach to this strategy and associated activities funded under Component A for Year 4 (including proposed changes in provision of capacity building assistance (CBA), types of CBA offered, contracts, partnerships, objectives, staffing/personnel, funding resources, etc.).

   We do not anticipate any changes to strategy or associated activities or in in provision of CBA, types of CBA offered, contracts, partnerships, objectives, staffing/personnel, and funding resources.

   While ensuring the fidelity of trainings, HPCP will continue to utilize the Zoom platform to offer trainings that include:

- Use of Breakout Rooms for group activities and practice with trainer present to observe and interject where appropriate
- Use of Knowledge Check-ins to measure comprehension of material in real time
- Use of chat and hand raise feature to capture and respond to questions and thoughts
- Use of White Board for brainstorm activities
- Group discussion
- Evaluation

We continue to add new trainers to expand our capacity building offerings. The PADOH will continue to offer virtual trainings to meet the needs of our partners. We plan to host virtual summits in 2021 as well as a state-wide HIV conference in 2021 (pending the ability to host in-person activities this could be virtual).

4. Did you access CBA/technical assistance (TA) services during the reporting period? ☒ Yes ☐ No
   Note: CBA accessed and provided via CDC-funded providers will be pulled via the CBA Tracking System (CTS).
   a. However, please explain (be specific) if any of the CBA/TA provided did not meet your needs/expectations.

      The CBA activity requested is still in progress.

5. Please provide the type of CBA/TA received and the name(s) of CBA/TA provider(s) for any non-CDC provided CBA to include training provided by your internal training unit (if applicable).

   The HIV Prevention and Care Project: Deb Dennison, CB Team Lead. Senior Trainer Scott Arrowood; Training team members Dr. Sarah Krier, Dr. Maura Bainbridge, Dr. David Givens, Corrine Bozich, and Michael Zolovich.

6. Please include CBA/TA needs for Year 4.
   For Year 4, we developed a Jurisdictional Plan with New York City Department of Health and Mental Hygiene for internal capacity building. The plan includes TA's for the following: working to implement HIV home testing, finalizing our cluster response plan, increase named partners during Partner Service activities, marketing strategies for PrEP services for women and MSM of

Color, and increase PEP awareness and access. We have started meeting with the University of Rochester on PrEP/PEP related goals. Additional needs would include updates for existing trainings.

7. Describe the impact of COVID-19 on capacity building activities for HIV programs, epidemiologic science, and geocoding.
   HPP cancelled in-person capacity building activities in March, April and May 2020 due to COVID-19 pandemic. We worked with the HPCP to adapt trainings to virtual offerings and started offering virtual capacity building activities in June 2020. We anticipate all our trainings will continue as virtual offerings until it is considered safe to host in-person trainings. The HPP also made the decision to cancel our 2020 HIV Summit, a state-wide conference that was to be held in September, due to uncertainty around the ability to host in-person meetings. The HPP has started to work towards a virtual event in early 2021 and hopes to be able to have a state-wide in-person event later in 2021.

SECTION II: COMPONENT B: Demonstration Projects for Integrated HIV Surveillance and Prevention

☐ Not applicable

Please select your Demonstration Project Focus Area:

- ☐ DatatoCare
- ☐ Data Sharing
- ☐ Data Use
- ☐ HIV Testing Models
- ☐ Outbreak Planning - PWID/HCV
- ☐ Partner Services Model
- ☒ PrEP
- ☐ Structural Interventions

Please provide responses to the following questions for your demonstration project under Component B.

1. Provide an **update on the implementation** of your main project activities and state whether the activities are fully implemented, partially implemented, or not yet implemented.

   The demonstration project was not implemented during this reporting period. This was due to a delay in CDC project determination and implementation approval was not received until June 10, 2020. This demonstration project is in collaboration with Allegheny County Health Department

(ACHD), and due to demands of their COVID-19 response, implementation was postponed until the beginning of August 2020.

2. Describe **successes achieved** during the reporting period.

   Despite the demonstration project implementation delay, we have achieved a number of planning successes during the reporting period. The University of Pittsburgh (University), in collaboration with the HPP, made the decision not hire an additional sexual health navigator and re-classify the project manager as the lead sexual health navigator and reallocate resources for the implementation of an intervention later in 2020. Additionally, the University and HPP collaborated on the responses to the technical review, project evaluation materials and data collection tools for CDC approval.

   The sexual health navigator has been conducting site visits with PrEP providers throughout Allegheny County in preparation for the project implementation and to determine the best interventions for improving provider-client relationships and existing PrEP recruitment and adherence activities. Project staff continue to participate in the AIDS Free Pittsburgh PrEP sub-committee meeting as a way to network with PrEP stakeholders in Allegheny County.

   Most significantly, we were able to obtain a letter of support from the ACHD for implementation and participation in the project and collaborate with their HNS staffers to serve as a referral source for project participants. As a result of COVID-19, the University and ACHD refined their implementation procedures to reflect remote working and social distancing guidelines, including the scripts for ACHD and the sexual health navigators, and to ensure compliance with data security requirements.

3. Briefly describe **implementation challenges** experienced as you were trying to implement the intervention and **strategies used to address each challenge**, and whether or not your strategies were successful.

   Implementation challenges tend to fit into the following categories: intervention characteristics (e.g., complexity), agency/setting (e.g., leadership support, existing procedures), external factors

(e.g., policies, collaborations), provider (e.g., attitudes/willingness, behaviors, skills, logistics/support), and client (e.g., access, needs, attitudes, skills).

Due to delay in CDC project determination approval, the demonstration project was not implemented during this reporting period, and as a result, there are no updates on implementation challenges from this reporting period.

4. Briefly describe **challenges that are not directly related to implementation** (e.g., planning, management, evaluation, or other factors), strategies used to address each challenge, and whether or not your strategies successfully addressed these challenges.

   The main challenges during this reporting period were meeting the requirements of the CDC project determination review panels requests leading up to the actual approval in June 2020, and the impact of COVID-19 on virtually all aspects of the project and the staff involved with the project.

5. Describe needs for **technical assistance (TA) or resources identified** for your project during the reporting period. Did you access TA services to address them? If yes, provide the type of TA received, the name(s) of TA provider(s), and indicate whether or not the TA provided met your needs/expectations.
   We did not receive any technical assistance or other resource requests at this time. We will know possible technical assistance needs once the demonstration project has been implemented and gaps established.

6. Describe **lessons learned** during the reporting period.
   The demonstration project was not implemented due to delay in CDC project determination approval during this reporting period. As a result, there are no updates on lessons learned for this reporting period.

7. Describe the impact of COVID-19 on Component B demonstration project activities.
   COVID-19 has impacted the demonstration project activities in a number of ways, including a postponement of the project start date and necessary modifications to project characteristics to

reflect remote work and social distancing guidelines of University (e.g., virtual enrollment, online surveys, phone interviews).

This demonstration project is in collaboration with ACHD, and due to demands of their COVID-19 response, implementation has been postponed to August 2020. To reflect virtual and social distancing guidelines related to COVID-19, the University staff have revised demonstration project scripts (recruitment, enrollment, follow-up), workflow, and procedures (e.g., electronic incentive) to reflect remote or online project implementation. In addition, we developed and refined a data security protocol for remote working and demonstration project implementation through consultation with University Data Security team.

8. Please complete additional Component B questions in **Appendix H: Component B Focus Area Questions**.

SECTION III: STAFFING AND MANAGEMENT

1. Were there any organizational and/or key staffing changes (i.e., health department staff responsible for implementing interventions and services for PS18-1802) that occurred during the reporting period?
   ☒ Yes ☐ No. If yes, please describe.
   The HPP Public Health Program Manager (PHPM), co-lead on the Integrated grant, became vacant due to the staff person being promoted to the position of Director for the Division. The former PHPM has been doing both the work of the PHPM and the Director position since April 2020. The PHPM position has been posted internally and externally and interviews continue at the time of this report.

   Organizationally, the Division created another section named Monitoring and Evaluation (M&E). The M&E section consists of both HIV prevention and HIV care project officers as well as data managers. A PHPM was hired in April 2020 utilizing Ryan White rebate funds to oversee the M&E section. To date, this new section continues to define itself by collaborating with the PHPM for the HIV Care Section and the Division Director. It is anticipated that it will take some time to delineate scope and responsibilities. However, the intent remains to have all project officers and data

managers within the Division report to one PHPM to ensure consistency in procurement, invoicing activities, data collection and analysis.

Approval was obtained to add three new positions to the HPP complement in January 2020. These positions include a Public Health Program Administrator (PHPA) and PHPAA for D2C and a PHPAA for cluster investigations. The HPP was able to leverage Ryan White rebates to fund these positions. Through this process it was determined that a vacant position existed on the HPP complement. This position was re-classified to a PHPAA for HIV/Hepatitis C testing.

2. Please indicate any vacant staff positions and provide a detailed plan with timeline for hiring/filling vacancies.

   The PHPM for the HPP became vacant in April 2020. An exception to the hiring freeze was requested and approved which allowed this position to be posted. Active recruitment continues. It is anticipated that a PHPM will be hired by the end of October 2020. In the meantime, the former PHPM who is now the Division Director will continue to oversee the requirements of the Integrated grant.

   The PHPAA continued to be vacant during this reporting period. This PHPAA serves as a project officer for CMHD grants and PPAs. An exception to the hiring freeze was requested and approved which allowed this position to be posted. Active recruitment continues. It is anticipated that a PHPAA will be hired by the end of October 2020.

   There have been multiple delays in adding the approved positions to the HPP complement. To date these positions have not been added to the complement. Given the hiring freeze, a single request for approval to hire for these additional positions along with filling the existing position will be submitted when the increase to the complement is made. It is anticipated these positions will be filled by the end of the 2020.

3. Were there any delays in executing contracts during the reporting period? ☐ Yes ☒ No.
   If yes, please explain and include any program implications.

4. If there have been any updates to contracts for indirectly funded service delivery entities (e.g., local health departments, community-based organizations [CBOs], etc.), please provide updates in **Appendix B: Contract Information for Indirectly Funded Service Delivery Entities.**

5. Describe the impact of COVID-19 on hiring/filling vacancies, changes in organizational structure, and current staffing.

   The Governor issued a hiring freeze during the reporting period. The HPP has been fortunate in that approval was given to proceed with the hiring of the PHPAA project officer and the PHPM.

SECTION IV: BUDGET

1. Did you submit a 424A form? *See Budget Information and Justification under the instructions section.*
2. Are you requesting new Direct Assistance (DA) in lieu of a portion of Financial Assistance (FA) for Year 4? If yes, please outline DA staffing needs. The FY 2021**SAS Licensing Request/Memorandum of Acceptance (MOA)** and **2021 List of Assigned SAS Users** are due with the APR, see **Appendix D- E.** **https://www.cdc.gov/stltpublichealth/GrantsFunding/direct_assistance.html**
3. Jurisdictions with eligible state and local (city or county) health departments must discuss: (1) the proposed program approach being implemented by the local health department and (2) how the state and local area will collaborate during the project period to ensure appropriate provision of services within the metropolitan area and document any agreements reached in a letter of agreement/letter of concurrence (LOA/LOC). Please submit current LOA with this submission. The current LOA will remain in place for the new budget period (Year 4: January 1, 2021 – December 31, 2021).

SECTION V: ASSURANCES OF COMPLIANCE

Instructions: Submit the completed forms for all materials used or proposed for use during the reporting period of **January 1, 2020 – December 31, 2020.** Attach the following Assurance of Compliance Forms to the application through the "Mandatory Documents" section of the "Submit Application Page" on Grants.gov. Select "Other Documents Form" and attach as a PDF file (**See Appendix C**).

SECTION VI: ADDITIONAL INFORMATION

1. Additional Information

Please provide any explanatory information or data that would be important for CDC to receive (e.g., additional coordination and collaborations to support PS18-1802, local processes or procedures impacting program implementation).

None.

APPENDICES

Appendix A: Resource Allocation

Identify each city/MSA with at least 30% of the HIV burden within the jurisdiction. For directly funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV burden, then identify the top three MSAs, cities, or areas within the jurisdiction that have the greatest burden of disease.

Reporting of MSAs/Cities/Areas with ≥ 30% of the HIV Epidemic within the Jurisdiction			
MSA/CITY/AREA	**Percentage of HIV Burden within the Jurisdiction**	**Percentage of PS18-1802 Funds Allocated**	**Strategies and Activities Funded**
Allegheny	17%	9.1%	HIV testing, PS, HNS, PrEP
Delaware	11%	5.4%	HIV testing, PS, HNS, PrEP
Montgomery	7%	2.0%	HIV testing, PS, HNS, PrEP

Appendix B: Contract Information for Indirectly Funded Service Delivery Entities

Please provide contract updates for indirectly funded Service Delivery Entities (e.g., local health departments, community-based organizations [CBOs], etc.), contract amount and the activities the contractor is funded to provide.

Name of Indirectly Funded Service Delivery Entities	Entity Type (e.g., LHDs, CBOs, Clinic, Hospitals, etc.)	Contract Amount $	Contract Activities Funded (e.g., HIV Testing, LinkagetoCare, Care and Treatment, Essential Support Services, PrEP, etc.)
Integrated Participating Provider Agreements (PPA)			
Tru Care Internal Medicine	Health Care Facility	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Kazi Islam MD	Health Care Facility	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP

A Women's Concern	Pregnancy Care Center	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Health Services Clarion	Hospital	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Life Choices dba/ My Choice Medical Clinic	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Pregnancy Care Center WCN	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
ChesPenn Health Services	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Planned Parenthood SE	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Lehigh Valley Hospital	Hospital	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
NOVUS Adult Care Center	Primary Care Center	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
St Luke's Hospital	Hospital	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Alder Health Services	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Caring Communities for AIDS	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Central Outreach Wellness Center	Primary Care Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Co-County Wellness Services	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Hamilton Health Center	Health Center	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Adagio Health	Health Care Provider	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
AIDS Resource Alliance	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Keystone Rural Health	Primary Care Facility	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
AIDS Care Group (ACG)	Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Wyoming Valley AIDS Council	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Allies for Health and Wellbeing	Medical Clinic	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
The Wright Center Medical Group PC	Health Center	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP

Women's Center Erie County	Pregnancy Care Center	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
New Direction Treatment Services	Behavioral Health Care Facility	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Community and Human Services	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Central Outreach Resource and Referral	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Lancaster Harm Reduction Project	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Spanish American Civic Assn. (SACA)	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Family Services of Montgomery County	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
Family & Community Services of Delaware County	CBO	Fee for service, State funding	HIV Testing, Linkage to Care, PrEP
County Municipal Health Departments (CMHD)			
Allegheny County Health Department	CMHD	State funding 01/1/20- 06/30/20 $253,351.50 CDC funding 01/1/2020- 6/30/2020 $144,148.50	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
Allentown City Bureau of Health	CMHD	State funding 01/1/20- 06/30/20 $117,475.00 CDC funding 01/1/20- 06/30/20 $67,525.00	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
Bethlehem Bureau of Health	CMHD	State funding 01/1/20- 06/30/20 $71,755.00 CDC funding 01/1/20- 06/30/20 $41,245.00	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.

Bucks County Health Department	CMHD	State funding 01/1/20- 06/30/20 $86,677.50 CDC funding 01/1/20- 06/30/20 $49,822.50	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
Chester County Health Department	CMHD	State funding 01/1/20- 06/30/20 $50,482.50 CDC funding 01/1/20- 06/30/20 $29,017.50	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
Erie County Health Department	CMHD	State funding 01/1/20- 06/30/20 $76,200.00 CDC funding 01/1/20- 06/30/20 $43,800.00	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
Montgomery County Health Department	CMHD	State funding 01/1/20- 06/30/20 $59,690.00 CDC funding 01/1/20- 06/30/20 $34,310.00	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
Wilkes Barre City Health Department	CMHD	State funding 01/1/20- 06/30/20 $64,452.50 CDC funding 01/1/20- 06/30/20 $37,047.50	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.
York City Bureau of Health	CMHD	State funding 01/1/20- 06/30/20 $86,677.50 CDC funding 01/1/20- 06/30/20 $49,822.50	The Grantee provide testing, partner services, HIV Navigation Services and Pre-exposure prophylaxis (PrEP) referrals.

Appendix C: Assurance of Compliance

ASSURANCE OF COMPLIANCE
with the
"PROGRAM GUIDANCE ON THE REVIEW OF HIV-RELATED EDUCATIONAL AND INFORMATIONAL MATERIALS FOR CDC ASSISTANCE PROGRAMS"

By signing and submitting this form, we agree to comply with the specifications set forth in the "Program Guidance on the Review of HIV-Related Educational and Informational Materials for CDC Assistance Programs," revised as of June 2016.

We agree that all written materials, audio visual materials, and pictorials, including social marketing and advertising materials, educational materials, social media communications (e.g., Facebook, twitter) and other electronic communications, such as internet/webpages will be submitted to a Program Review Panel. The Panel shall be composed of no less than five persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. See additional requirements in the referenced program guidance, especially section 2 (c-d)(1-5) regarding composition of Panel.

The Program Review Panel, guided by the CDC Basic Principles, set forth in 1(a-g), will review and approve all applicable materials before their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations, and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

CDC 0.1113 (E), Rev. 6/2016, CDC Adobe Acrobat DC Electronic Version, 6/2016

NAME	OCCUPATION	AFFILIATION
R. (Scott) Stephen	Public Health Program Administrator, Teacher and HIV/AIDS Educator	Office of the State Fire Commission, former PA Department of Health
Sharita Flaherty	HIV Program Manager, Bucks County Department of Health	HIV Planning Group Member
Rob Pompa	Behavioral Health Specialist/Prevention Coordinator, Lehigh Valley Hospital	HIV Planning Group Member
Matthew James	Public Health Program Assistant Administrator	PA Department of Health, Division of TB/STD **(Health Department Representative)**

Applicant/Recipient Name: Commonwealth of PA, Department of Health	**Grant Number (If Known):** NU62PS924544
Signature: Project Director	**Signature: Authorized Business Official**
Date:	**Date:**

Appendix D: SAS Licensing Request and Memoranda of Acceptance

1. Date:			
2. Recipient Award Number:			
3. Recipient Award Title:	PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments		
4. Recipient Award Period:	January 1, 2021 through December 31, 2021		
5. Recipient Institution (Legal Name):			
6. Jurisdiction Name:			
7. Principal Contact:			
8. Principal Contact email:		**Telephone:**	
9. Principal Contact's Mailing Address:			

10. Is this a new Grant: ☐ First Year X☐ Continuation (Years 2-5)

11. Media Type: License File Only

Funding Mechanism: (CDC Working Capital Fund or Direct Assistance [DA])	**Number of Workstations Requested (a)**	**Workstation(s) Type (b)**	**Workstation(s) SAS Product Version Requested (c)**
12. CDC Working Capital Fund	3	**64-Bit**	**Base SAS 9.4**
	1	**64-Bit**	
13. Direct Assistance (DA)		**Choose an item.**	**Base SAS 9.4**
Funding Mechanism: (CDC Working Capital Fund or Direct Assistance [DA])	**Number of Servers Requested (a)**	**Server(s) Type (b)**	**Server(s) SAS Product Version Requested (c)**
14. CDC Working Capital Fund	**2**	**64-Bit**	**Base SAS 9.4**
15. Direct Assistance (DA)		**Choose an item.**	**Base SAS 9.4**

16. Describe the "bona fide" need for SAS, and if requesting more than 3 licenses justification is required:

CDC requires all PS18-1802 recipient surveillance data be reported via their eHARS system. This system uses SAS software to develop, manage, and analyze all datasets. Additionally, all required performance evaluation programs are SAS based. The total number of workstations indicates the number of persons who spend 50% of their time processing, analyzing, and interpreting HIV case data.

17. CDC Program Official Responsible for Processing this Request (Print):

Program Consultant's Name: Keydra Oladapo

Memorandum of Acceptance of Responsibility for the Use of SAS Institute Products Provided by CDC

To: Keydra Oladapo
Centers for Disease Control and Prevention
1600 Clifton Rd NE (MS-E47)
Atlanta, GA 30329

Section I. CDC Partner Acceptance of Responsibility

Name: Godwin Obiri, DrPH, MS
Organization: PA Department of Health
I am an official of my organization, which has been awarded the CDC Grant or Cooperative Agreement designated:
Recipient Award Number: _____
Title: PS18-1802 Integrated HIV Surveillance and Prevention Programs for HDs
Current License Expiration Date: December 31, 2020
My role within the Grant or Cooperative Agreement is: **Co-Principal Investigator**

CDC has provided my organization access to certain SAS software products as described in the Enterprise License Agreement between DHHS and parties representing SAS Institute. I understand that the products must be used strictly in accordance with specific limitations set forth in the licensing terms. Specifically:

1. I agree to actively monitor the distribution and use the SAS products to assure that they are used to perform only CDC funded program activities as specified in the applicable Grant or Cooperative Agreement between CDC and the CDC Recipient.
2. **I agree to respond to CDC Surveys, and provide an annual detailed listing of software requirements for workstations and servers, the number of users and location information prior to CDC SAS product distribution.**
3. I will assure that my organization restricts access to the products to legitimate users and will avoid providing any opportunity for inappropriate distribution of the software to other parties.
4. In the event that my organization completes or ends the funded program activity prior to the expiration of the license I assure my organization will promptly destroy or return all the licensed materials to CDC.
5. I understand that failure of my organization to abide by these requirements will obligate CDC to request the return of the SAS products to CDC and the termination of their use by my organization.
6. I agree to report to CDC any violations of these terms whether intentional or unintentional.
7. I understand that at the termination of the DHHS license for the SAS products, CDC may be required to request the return of some or all of the provided SAS products.
8. I acknowledge that no ownership rights to the provided SAS products accrue to my organization by virtue of the use of the provided products.

9. I agree to assure that all organization or location personnel will be informed of the obligations and responsibilities acknowledged by this agreement.
10. I understand that the license does not obligate SAS Institute to provide user support for any of the SAS products provided to my organization.

RECIPIENT SIGNATURE PAGE

Principal Contact Signature: _____ Date: _____

Special Note: Please print, sign, scan, and return this document to your assigned HICSB Program Consultant via e-mail.

Appendix E: SAS Licensing Request and Memoranda of Acceptance Instructions

Instructions: *For each workstation license* (WCF and DA) requested provide the name and email address of the user. This person/workstation must spend 50% of their time utilizing/analyzing HIV or HIV related data. If proposed positions are vacant, you must still list the workstation and supply the e-mail address after the position is filled. If you are to receive 21 workstation licenses, then you must provide information for 21 workstations on this list. If you need to add rows to accommodate the number of workstations for your program, you can easily do so by highlighting all four cells in row 15, clicking on layout and selecting "insert below."

Note: The information in 1-3 below is an example for instructional purposes. Please delete these examples and replace them with user information specific to your program.

Agency Name:		**Submitted By:**	
Project Area	**Last Name**	**First Name**	**E-Mail Address**
1. HIV Surveillance	Allen	Michael	michaealle@pa.us
2. HIV Surveillance	Godwin	Obiri	gobiri@pa.gov
3. HIV Surveillance	Ngokion	Martin	mngokion@pa.gov
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Tip #1: Please contact your Assigned Program Consultant with any questions

Tip #2: PS18-1802 recipients submit one joint request addressing total programmatic need.

Box Number:

1. Enter the date this form is completed.
2. Enter the jurisdiction's PS18-1802 Award number.
3. *Question 3 is a pre-populated field, no action required.*
4. *Question 4 is a pre-populated field, no action required.*

5. Enter the legal name of Recipient Institution.
6. Enter your jurisdiction name (i.e. San Francisco, Maine, Puerto Rico).
7. Enter the name of the Principal Contact who will be notified when general communications regarding collective licenses are required.
8. Enter the email address and telephone number of the Principal Contact.
9. Enter the mailing address of the Principal Contact.
10. Select the appropriate box - First Year Award or Continuation Award (Years 2-5).
11. Media Type – Enter the media required by selecting the appropriate box.

12. Working Capital Fund (WCF) Workstation License – Enter the information in the appropriate columns:
    a. The number of SAS workstation licenses requested. This number is limited to the number of WCF workstation licenses received (at no cost to your program) in 2020.
    b. Enter the type workstation licenses required 32-bit or 64-bit. If you require a combination of these two license types, please identify the number and type requested.
    c. Product Version - *Pre-populated field. No action required*.
13. Direct Assistance (DA) Workstation License – If you are requesting to purchase additional SAS workstation licenses (above the capped WCF licenses noted in line 12); you are agreeing to reimburse CDC's Working Capital Fund for acquiring the licenses on your behalf at an approximated per unit cost of $1,396.90. This acquisition mechanism is called Direct Assistance (DA). This mechanism requires that you annually submit a budget request seeking to convert the appropriate amount (for example, 5 additional licenses would cost $6,984.50) from your PS18-1802 Cooperative Agreement's Financial Assistance (FA) to Direct Assistance (DA). This action to convert is described in your Notice of Award as a "Prior Approval Request" This action can be submitted for approval by two methods:
    a. As part of your proposed annual Continuation Budget Request. This requires your program submit a cover (on letterhead) with the signatures of two officials requesting to convert the appropriate amount from FA to DA. Additionally, a special note must be placed in the budget narrative's "Other" line item reducing the award by the appropriate amount. Finally, a separate 424-A form for the DA must be submitted. Remember this action must be executed each budget year with your continuation submission (for PS18-1802 this usually occurs in the fourth quarter).
    b. As a budget revision/redirection request that must be submitted via GMM (Grant Solutions) as an amendment. This method requires the same actions as in section "a" above and should be submitted by the recipient by December 31 of the current budget year. After the initial request using this method, the requests must be executed each budget year with the APR continuation submission.
14. Working Capital Fund Server License (WCF) – Enter the following information in the appropriate columns:

a. The number of SAS server licenses requested. This number is limited to two WCF server licenses per recipient (These are the server licenses you received at no cost to your program in 2020).
b. Enter the type server licenses you require 32-bit or 64-bit. If you require a combination these two license types, please specify how many of each type you are requesting.
c. Product Version - *Pre-populated field. No action required*.

15. Direct Assistance Server License - same as #13 above
16. Describe the "Bona Fide" need for SAS Licenses – *Pre-populated field. No action required*.
17. CDC Program Official Responsible for Processing this Request – Enter the name of your assigned CDC Program Consultant. If you unsure who this is, please contact a member of your PS18-1802 Joint Monitoring Team.
18. *Memoranda of Acceptance for the Use of SAS Institute's Products Provided by CDC* – On the appropriate lines enter:
    a. **Name** - Enter the Name of the Principal Contact on Line #7.
    b. **Organization** - Enter the Recipient Institution's Legal Name on #5.
    c. **Recipient Award Number** - Enter the Award Number on Line #3.
    d. **My Role within the Grant or Cooperative Agreement is** – List the position or role of the Principal Contact.
19. Recipient's Signature – Have the Principal Contact sign and date in the appropriate space.
20. Listing of Assigned SAS Users - *For each workstation license* (WCF and DA) requested provide the name and email address of the user. This person/workstation must spend 50% of their time utilizing/analyzing HIV or HIV related data. If proposed positions are vacant, you must still list the workstation and supply the e-mail address after the position is filled. You are to provide information for workstations for which you receive licenses. If you need to add rows to accommodate the number of workstations for your program, you can easily do so by highlighting all four cells in row 15, clicking on layout and selecting "insert below".

    Final Reminder: *Although the FY 2020 SAS licenses expire on December 31, 2020, an automatic 60- day grace period (February 28, 2021) exists to allow for final distribution of licenses. So, we are asking your patience with the process. However, it is imperative you reach out to your assigned Program Consultant if your licenses are not received by February 20th to avoid a potential interruption in service.*

Appendix F: Certification of Compliance for Data Security and Confidentiality

Attached as a separate document.

Appendix G: COVID-19 HIV Surveillance and Prevention Activities Check-In			
COVID-19 was declared a national emergency and many state and local health departments also declared emergencies. As a result, HIV surveillance and prevention services and activities funded under PS18-1802 may have been impacted in some way. This section provides the opportunity to expand upon the impact of the COVID-19 pandemic on the continuity of PS18-1802 services and activities during the period of January 1, 2020 – June 30, 2020. Please check the box that represents the current status of your program activities. This information will help us better respond to the needs of jurisdictions in the future.			
Jurisdiction:	**Date:**		
Strategy 1: HIV data	**Status of Activity**		
Identify and report all persons with diagnosed HIV infection	☒On-track	☐Scaled Back	☐Interrupted
Collect and report to CDC all HIV-related laboratory results	☒On-track	☐Scaled Back	☐Interrupted
Conduct monthly eHARS data transfers	☒On-track	☐Scaled Back	☐Interrupted
Investigate cases of public health importance (COPHI)	☒On-track	☐Scaled Back	☐Interrupted
Conduct death ascertainment activities	☒On-track	☐Scaled Back	☐Interrupted
Conduct intrastate de-duplication of HIV cases	☒On-track	☐Scaled Back	☐Interrupted
Conduct cumulative interstate duplicate review (CIDR)	☒On-track	☐Scaled Back	☐Interrupted
Complete routine interstate duplicate review (RIDR)	☒On-track	☐Scaled Back	☐Interrupted
Conduct risk factor ascertainment	☒On-track	☐Scaled Back	☐Interrupted
Analyze HIV surveillance data and disseminate findings	☒On-track	☐Scaled Back	☐Interrupted
Assess data quality and evaluate surveillance system	☒On-track	☐Scaled Back	☐Interrupted
Implement and maintain activities to support complete laboratory reporting	☐On-track	☒Scaled Back	☐Interrupted
Identify early HIV infection	☒On-track	☐Scaled Back	☐Interrupted
Collect treatment information/HIV antiretroviral use history information	☒On-track	☐Scaled Back	☐Interrupted
Monitor HIV drug resistance and HIV genetic diversity	☒On-track	☐Scaled Back	☐Interrupted

Ensure that all CDC provided software releases and upgrades are installed within required time frames (e.g., eHARS)	☒On-track	☐Scaled Back	☐Interrupted
Conduct geocoding and data linkage activities	☒On-track	☐Scaled Back	☐Interrupted
NHM&E data collection and reporting	☒On-track	☐Scaled Back	☐Interrupted
EPMP monitoring and completion	☒On-track	☐Scaled Back	☐Interrupted
Strategy 2: Identify persons with HIV infection and persons at risk for HIV infection	**Status of Activity**		
Conduct HIV testing (healthcare and non-healthcare settings)	☐On-track	☒Scaled Back	☒Interrupted
Implement HIV self-testing, if applicable	☒On-track	☐Scaled Back	☐Interrupted
Provide Partner Services	☐On-track	☒Scaled Back	☐Interrupted
Conduct Data to Care (D2C) activities	☐On-track	☐Scaled Back	☒Interrupted
Strategy 3: Cluster detection and outbreaks	**Status of Activity**		
Analyze data to identify HIV transmission clusters and outbreaks	☒On-track	☐Scaled Back	☐Interrupted
Analyze data to identify HIV transmission clusters and outbreaks	☒On-track	☐Scaled Back	☐Interrupted
Rapidly respond to and intervene in HIV transmission clusters and outbreaks	☒On-track	☐Scaled Back	☐Interrupted
Communicate with CDC and other partners during investigation of and intervention in transmission clusters and outbreaks	☐On-track	☒Scaled Back	☐Interrupted
Strategy 4: Linkage to medical care, treatment, and prevention services for PLWH	**Status of Activity**		
Linkage to care for PLWH	☒On-track	☐Scaled Back	☐Interrupted
Strategy 5: Prevention services for HIV-negative persons at risk for HIV (e.g., PrEP)	**Status of Activity**		
PrEP screening and referrals	☐On-track	☒Scaled Back	☐Interrupted

Linkage to and support for PrEP (e.g., Navigation Services, Enrollment, Maintenance and Retention)	☐On-track	☐Scaled Back	☒Interrupted
Strategy 6: Perinatal HIV prevention and surveillance	**Status of Activity**		
Promote prenatal HIV testing according to CDC recommendations	☐On-track	☒Scaled Back	☐Interrupted
Case surveillance activities for women and children < 13 years of age	☒On-track	☐Scaled Back	☐Interrupted
Annual matching of HIV-infected women reported to surveillance to the state birth registry	☒On-track	☐Scaled Back	☐Interrupted
Analysis and dissemination of data on HIV-infected women of childbearing age, perinatal HIV exposures, and infected infants	☐On-track	☒Scaled Back	☐Interrupted
Activities required for the following 16 jurisdictions: California (excluding Los Angeles County and San Francisco), Delaware, The District of Columbia, Florida, Georgia, Houston, Louisiana, Maryland, Mississippi, New Jersey, New York City, North Carolina, Philadelphia, Puerto Rico, South Carolina, and Texas (excluding Houston).			
Perinatal HIV Exposure Reporting (PHER)	☒On-track	☐Scaled Back	☐Interrupted
Perinatal HIV Services Coordination (PHSC)	☒On-track	☐Scaled Back	☐Interrupted
Case review and community action of perinatal HIV transmission and exposure using the FIMR/HIV methodology	☐On-track	☐Scaled Back	☐Interrupted
Strategy 7: Community-level prevention activities	**Status of Activity**		
Social marketing campaigns	☒On-track	☐Scaled Back	☐Interrupted
Community outreach activities	☐On-track	☒Scaled Back	☐Interrupted
Condom distribution	☒On-track	☐Scaled Back	☐Interrupted
Syringe services programs	☐On-track	☐Scaled Back	☐Interrupted
Evidence-based interventions (individual-level, group-level, and community-level)	☐On-track	☒Scaled Back	☐Interrupted
Strategy 8: Integrated HIV prevention and care planning	**Status of Activity**		

Collaborative activities for HIV prevention and care planning	☒On-track	☐Scaled Back	☐Interrupted
HIV Planning Group (HPG) processes and activities	☐On-track	☐Scaled Back	☒Interrupted
Other jurisdictional planning activities	☒On-track	☐Scaled Back	☐Interrupted
Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention	**Status of Activity**		
Procedures to ensure data security and confidentiality	☒On-track	☐Scaled Back	☐Interrupted
Sharing of stateno/cityno data	☒On-track	☐Scaled Back	☐Interrupted
Data sharing agreements	☒On-track	☐Scaled Back	☐Interrupted
Strategy 10: Data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities	**Status of Activity**		
Data-driven planning, monitoring, and evaluation activities	☐On-track	☒Scaled Back	☐Interrupted
Dissemination of data reports	☒On-track	☐Scaled Back	☐Interrupted
Allocation of resources	☒On-track	☐Scaled Back	☐Interrupted
Execution of contracts	☒On-track	☐Scaled Back	☐Interrupted
Strategy 11: Capacity building	**Status of Activity**		
Capacity building activities	☒On-track	☐Scaled Back	☐Interrupted
Execution of planned technical assistance and training events	☐On-track	☐Scaled Back	☒Interrupted

Appendix H: Component B Focus Area Questions

Please complete the information below based upon your Component B Focus Area:

a) If you conducted PrEP activities:

i. Provide any quantitative data or contextual information you collected on reasons why clients fall out of the PrEP cascade (e.g., number of HIV seroconversions, persons who no longer need PrEP due to decreased risk, etc.).

Not applicable as the demonstration project is not being implemented at this time.

ii. Indicate which PrEP cascade steps you are conducting and provide any quantitative data that are collected for each step, including age, sex, race/ethnicity, and risk of clients:

Not applicable as the demonstration project is not being implemented at this time.

b) If you conducted HIV testing, linkage to care, and/or partner services during the reporting period, please provide the following:

Step 1 →	**Step 2 →**	**Step 3 →**	**Step 4 →**	**Step 5 →**	**Step 6 →**	**Step 7**
# of persons eligible for referral	**# referred to PrEP provider**	**# linked to PrEP provider**	**# PrEP prescribed**	**# PrEP initiated**	**# in PrEP care for ≥ 3 months**	**# adherent to PrEP medication**

HIV Testing ☒ Not applicable

Specify if testing is in health care settings ☐ , non-health care settings ☐ , or both ☐ , and if possible, provide the information below separately if conducting testing in both settings.

Total number of HIV tests: _____

Total number of persons newly diagnosed with HIV[1]: _____

Total number of persons previously diagnosed with HIV[1]: _____

[1]Includes unconfirmed preliminary positive tests plus confirmed positive tests.

Linkage to Care ☒ Not applicable

Total number of persons newly diagnosed with HIV*: _____

Number of persons newly diagnosed with HIV who were linked to HIV medical care within 30 days of the diagnosis, i.e., attended an appointment with an HIV medical provider within 30 days of the diagnosis: _____

*Includes unconfirmed preliminary HIV positive persons plus confirmed HIV positive persons

Total number of persons previously diagnosed with HIV who were not in care **: _____

Number of persons previously diagnosed with HIV who were not in HIV medical care but then were re-engaged in care: _____

**Only includes confirmed previously diagnosed HIV positive persons

Partner Services ☒ Not applicable

Total number of persons diagnosed with HIV* who were interviewed for partner services: _____

Number of partners elicited from these persons diagnosed with HIV: _____

Number of partners elicited that were tested for HIV: _____

Number of these elicited partners who had a confirmed new diagnosis of HIV: _____

*Includes confirmed newly diagnosed and previously diagnosed HIV positive persons

c) Data to Care ☒ Not applicable

Please specify what data were used (e.g., surveillance, clinical, prevention) and provide any quantitative outcomes (e.g., linked or re-engaged to care, viral load suppression) and contextual information.

d) Data use or sharing ☒ Not applicable

Please specify what data were used or shared for which activities and provide any quantitative outcomes and contextual information.

e) Structural Interventions ☒ Not applicable

Please provide any quantitative outcomes and contextual information for the intervention(s) conducted.

f) Outbreak Planning ☒ Not applicable

Please provide any quantitative outcomes and contextual information for the outbreak planning.

g) Other Main Activities ☒ Not applicable

If conducting other main activities, provide a summary of the work and include any quantitative outcomes and contextual information.