



**Ending
the
HIV
Epidemic**

**Notice of Funding Opportunity (NOFO) PS19-1906:
Strategic Partnerships and Planning to Support Ending
the HIV Epidemic in the United States
Component B: Accelerating State and Local HIV
Planning to End the HIV Epidemic**



PROGRAM GUIDANCE

Executive Summary

This program, PS19-1906: Component B: Accelerating State and Local HIV Planning to End the HIV Epidemic, will support jurisdictional planning efforts to end the HIV epidemic in the U.S. These efforts will address emerging and existing needs of targeted jurisdictions through support of planning activities by CDC-funded state and local health departments and their partner organizations and communities. Despite many treatment and prevention advances, reducing HIV infections and improving health outcomes for people with HIV in the U.S. remain challenging. In February 2019, the President announced the Ending the HIV Epidemic in America initiative. The initiative will leverage powerful data, tools, and resources to reduce new HIV infections by 90% over the next 10 years.



Figure 1. Geographic focus of Phase I of the Ending the HIV Epidemic Initiative focuses on 48 counties, Washington, DC, and San Juan Puerto Rico as well as seven states with a high proportion of HIV diagnoses in rural areas. (Source: <https://www.cdc.gov/endhiv/priorities.html>)

Introduction

This NOFO supports planning for those jurisdictions identified as part of Phase 1 (Figure 1) in the Ending the HIV Epidemic (EHE) initiative. This planning guidance clarifies requirements for the PS19-1906-B EHE planning NOFO. Specifically, it emphasizes the need for ongoing community engagement within the jurisdictions. Reaching the ambitious goals of the initiative will require direct engagement of communities in the identified counties and jurisdictions. For states with identified Phase 1 counties, those counties will be the focus of the final plan, and community engagement in these counties will be a key element to the planning efforts. This planning will emphasize the development of a streamlined and concisely written plan to minimize burden on both the planning and the review processes. The resulting focused EHE plans will guide the development and implementation of future EHE activities.

The written plan created by PS19-1906-B recipients will serve as a blueprint for the development of more detailed applications and workplans to be submitted to each federal agency following their specific guidance. These federal funding mechanisms that support the implementation of activities will require specific goal setting and monitoring. The written plan being developed will describe the key strategies and activities that each participating health department plans to operationalize and monitor with future implementation funds. Recipients are strongly encouraged to propose other novel and disruptively innovative activities that are unique to their jurisdiction's local context.

The new written plan should not redevelop existing products such as epidemiologic profiles, and situational analyses (among others) if those products are current and up-to-date. The new plan should focus on those Phase I jurisdictions identified in the EHE initiative. Existing versions of these documents may be updated or modified if needed for the current planning effort using resources from this NOFO.

Planning Highlights

- Increased and ongoing community engagement
- Concise and expedited planning documentation
- EHE planning will add to or enhance - not replace - previous planning efforts

Background: HIV Planning Group Process

Since 1993, health departments funded by CDC, through their federally funded state and local level HIV prevention programs, are required to have an HIV prevention planning process that includes the establishment of an HIV prevention planning group (HPG) and the development of a jurisdictional HIV prevention plan. HIV planning is a process through which people from different walks of life, interests, responsibilities, and involvement with HIV come together as a group to inform and support the development and implementation of a Jurisdictional HIV Prevention Plan. HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention needs and priorities. In 2012, CDC issued an updated HIV Planning Guidance (current version). This guidance for HIV planning defines CDC's expectations of health departments and HIV planning groups (HPGs) in implementing HIV prevention planning. (Source: <https://www.cdc.gov/hiv/pdf/p/cdc-hiv-planning-guidance.pdf>.)

In 2015, CDC and HRSA jointly issued Integrated HIV Prevention and Care Guidance that allowed one plan to satisfy both CDC's and HRSA's requirements. All jurisdictions funded by CDC/DHAP and HRSA/HAB are required to have a planning process and the establishment of either an HIV Planning Group, Planning Council, or Advisory Group, referred to as "planning body." Currently, local HIV prevention and care planning is integrated between activities funded by CDC and activities supported by HRSA's Ryan White HIV/AIDS Program for Part A and B (see: <https://hab.hrsa.gov/sites/default/files/hab/Global/hivpreventionplan062015.pdf>). These HIV planning bodies are therefore central to local planning activities.

Moving Forward: EHE Planning Guidance

A similar collaborative planning process can be used for these jurisdictional EHE plans as well, ensuring health departments address local needs and provide flexibility to address local challenges that vary from one community to another, consistent with the HIV integrated planning process. Recipients will be expected to engage in the following activities to support the purpose and outcomes of the NOFO.

Section I: Engagement Process [NOFO Activity 1, 4, 5]

The engagement process involves the collaboration of key stakeholders and broad-based communities who work together to identify strategies to increase coordination of HIV programs throughout the state, local health jurisdictions, or tribal areas (for a list of potential key stakeholders for community engagement and HPG membership, see Appendix A). The collaboration should result in a collective vision that assists the jurisdiction in achieving the goals of the EHE Initiative. The strategies should be flexible to ensure that the voices of the community and key stakeholders who may not be members of the existing HIV Planning Bodies are also heard. It is important that all voices are considered in the engagement process and reflected in the Ending the HIV Epidemic Plan. Additional information on "how to conduct the engagement process" can be found within the HIV Planning Guidance at: <https://www.cdc.gov/hiv/pdf/p/cdc-hiv-planning-guidance.pdf>.

Documentation of Engagement. For engagement activities supported by this NOFO, recipients will need to document each of the three types of engagement described below (planning bodies, community partners, and service providers). Recipients will need to submit documentation that includes the frequency, locations, anticipated number of attendees, profile of participants, etc. by providing a description of who was engaged, the time and location of the meeting, and a brief summary of what was discussed. Recipients should highlight any “new partners or voices” participating in this process (See Appendix A for examples). Comments or suggestions from these engagement sessions that are intended to be incorporated into the plan should be explicitly documented. To meet this documentation of engagement requirement, recipients will be required to submit *meeting agendas, description of attendees, description of outreach activities, and brief summaries of the discussion.*

Existing local prevention and care integrated planning bodies. Recipients should engage with existing local prevention and care HIV planning bodies that represent the identified Phase I jurisdictions. These local planning bodies should include “new voices” that represent communities identified in Phase I jurisdictions who have not previously participated in the planning process. This representation must include persons with HIV and persons who are at risk for acquiring HIV. These efforts should also include working with the relevant HRSA-funded Ryan White Part A and B recipients.

These planning bodies have experience representing key local populations and stakeholders in the discussion about local HIV prevention and care strategies. These groups also have existing and ongoing relationships with multiple community and service provider partners in the jurisdiction and are the groups that will provide concurrence to any new or realigned local HIV prevention and care integrated plan.

Local community partners. In cases in which a state health department is the recipient, they must work to engage communities in identified Phase I counties or, in the directly-funded 7 states with disproportionate rural epidemics, to engage communities with higher numbers or rates of new HIV diagnoses in the state. Local communities disproportionately affected by HIV are crucial partners in development and refinement of any HIV prevention and care plan. Their participation in the planning process and input to the final plan ensures the proposed programmatic activities are conducted in ways that are acceptable to the local population. This aspect of the planning process is critical for successfully increasing reach to people in communities experiencing health disparities and that have either not had access to prevention and care programs or who have not felt included as part of the intended audience for such programs.

A key purpose of the local community engagement activity is to increase the reach of the local HIV prevention and care efforts. Specifically, recipients should think about how this process can add to and inform the work of the existing local integrated HIV prevention and care planning bodies. Recipients must make and document their efforts to include broad voices of community members affected by or living with HIV.

Local service provider partners. Recipients should engage with partners who provide prevention, care and other essential services for people with HIV and at high risk for HIV in identified Phase I jurisdictions. Some jurisdictions may have an existing network of providers to engage and others may need to develop or expand such a network. Local HIV service providers are another set of key partners in planning for local HIV prevention and care programs. This also includes health and social service providers that engage with the communities we wish to reach (e.g., criminal justice system, youth services, addiction treatment centers, etc.). As a group that interacts with and provides so many services to key local populations with HIV, these partners’ input on planning is critical in the development of a feasible and sustainable plan.

A note about community engagement. Recipients should consider ways that have been most productive for reaching out and engaging with community and provider partners. New approaches may be necessary to reach new partners needed to improve the HIV prevention and care activities in the jurisdiction. In many cases, community engagement will need to include “new voices” that represent communities impacted by HIV in the identified in Phase I jurisdictions.

Section II: Epidemiologic Profile [NOFO Activity 2]

Recipients should submit a *snapshot summary* of a current epidemiologic profile (most current data available) for their jurisdiction. This snapshot should be *no more than 5 pages* and should highlight key aspects of the HIV burden in the identified Phase I jurisdiction(s) as they relate to the EHE initiative. A traditional epidemiologic profile provides a description of the burden of HIV in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, people with HIV (PWH) and persons at higher risk for infection. Understanding the populations affected by HIV provides the basis for setting priorities, identifying appropriate interventions and services, allocating HIV prevention and care resources, planning programs, and evaluating programs and policies. The snapshot should serve the same purpose as the full epidemiologic profile, yet constitutes a much less burdensome document for a jurisdiction to generate.

For the snapshot, recipients should use the most currently available local data to synthesize a comprehensive overview of the local HIV epidemic. Recipients should also include descriptions of key characteristics relevant to planning from any recent or active cluster investigations (note that confidentiality is of critical importance and *should not be violated* when describing these characteristics.). This tool will be critical to local planning activities and it should be shared with local planning bodies and partners. A copy of the full current epidemiologic profile may be requested by CDC at a later point in time.

For additional information on developing an epidemiologic profile, recipients may refer to the “Integrated Guidance for Developing Epidemiologic Profiles: HIV Prevention and RWHAP Planning” issued by CDC and HRSA in August 2014. (https://www.cdc.gov/hiv/pdf/guidelines_developing_epidemiologic_profiles.pdf)

Section III: Situational Analysis (including Needs, Gaps, and Barriers) [NOFO Activity 3]

Recipients will also submit a *snapshot summary* of a current situational analysis that provides an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. The format of this document will facilitate the expedited planning process and should be *no more than 10 pages*. Similar to the integrated prevention and care planning, this snapshot should synthesize information from the local epidemiologic data, from the engagement with local planning bodies, and from other local partners and local community engagement efforts.

The analysis should be informed by and include consultation of other federally and state/locally funded implementation partners (e.g., Community-based Organizations, HRSA-funded Ryan White HIV/AIDS Program Clinics and Community Health Centers, SAMHSA, HUD, IHS, or HHS recipients, CMS, Local Education Agencies supported under PS18-1807, etc.). Previously developed Integrated HIV Prevention and Care plans, as well as any locally-relevant “Getting to Zero”, “Ending the Epidemic” plans, or “Fast Track City” commitments should also be considered.

The content of the situational analysis should clearly lay the groundwork for proposed strategies in the workplan. The submitted snapshot should be *organized by Pillars* to facilitate articulating the link between needs and proposed activities (See Appendix B). A copy of the full situational analysis may be requested by CDC at a later point in time.

Needs Assessment. As part of the situational analysis, recipients should conduct a needs assessment (e.g., resources, infrastructure, and service delivery). A needs assessment is the process of collecting information about the needs of persons at risk for HIV and people with HIV (those receiving care and those not receiving care); identifying current resources available to meet those needs; and determining what gaps in HIV prevention and care services exist.

The needs assessment for this NOFO should be consistent with the current or updated epidemiologic profile and incorporate input from the engagement activities. It should include a description of identified gaps in local HIV prevention and care activities as well as unmet needs. Any relevant barriers identified should also be described. Capacity-building needs assessment of the health department, HIV prevention service providers, and other prevention agencies/partners, including CBOs' capacity to provide HIV prevention services (e.g., testing, navigation, and linkage to care), should also be described. Needs may also be identified through the engagement sessions.

A note about the situational analysis. If a recipient has a current situational analysis, but not a current EHE plan, additional engagement will need to occur – resulting in an updated situational analysis. It is important to engage and identify existing needs from partners, including partners that are not traditionally at the table.

Social Determinants of Health. Given the focus on Ending the HIV Epidemic, recipients, during their planning, must consider populations that are not optimally benefiting from current HIV prevention and care activities. Environmental, social and structural issues may limit the impact of HIV prevention tools that represent the current state of the science. Social determinants of health relevant to HIV prevention (e.g., housing instability, food insecurity, transportation, homophobia, transphobia, racism, etc.) should be considered in the planning activities. When engaging with partners and considering the local situational analysis, recipients should explore strategies that may be able to address or mitigate these factors as they relate to barriers to effective HIV prevention and care efforts. For more information on social determinants of health, see <https://www.cdc.gov/nchhstp/socialdeterminants/index.html>.

Section IV: EHE Planning [NOFO Activity 6, 7]

This cooperative agreement requires participating Phase I health departments to engage local partners in an accelerated and collaborative planning process to develop written EHE plans tailored for the local jurisdictions. This collaborative planning process will allow health departments to address local needs and provide flexibility to address local challenges that vary from one community to another, consistent with the HIV integrated planning process.

CDC emphasizes that proposed activities should show promise in their potential to drive down the number of new HIV infections, be legally permissible, be informed by local context, meet local needs, and be feasible and scalable. HRSA and CDC anticipate broad flexibility in funding to allow jurisdictions to customize and optimize their approach in order to achieve success. Jurisdictions are encouraged to propose “disruptively innovative” activities, which have a reasonable rationale that is ideally grounded in the available scientific evidence and experience.

EHE Planning by Pillars. The EHE plan should be organized by Pillars: Diagnose, Treat, Prevent, and Respond. Please see Appendix A for examples.

HIV Workforce. For each Pillar, anticipated HIV workforce needs should be described. These can include human resources (e.g., personnel, types of positions, or skill sets) and/or partnerships (e.g., faith community, civic organizations, local and federal government).

Reaching concurrence on the EHE Plan with local HIV planning groups. The same process that recipients typically use for reaching concurrence on their jurisdictional Integrated HIV Prevention and Care Plan (<https://www.cdc.gov/hiv/pdf/p/cdc-hiv-planning-guidance.pdf>) should be leveraged for the EHE planning process. This approach will allow for input and support to be gained from existing local planning groups and will avoid having to create a new planning body or system for approving the EHE plan. This approach should also support the accelerated timeline for the EHE planning effort. Additionally, recipients should ensure that the planning process at every step, including concurrence, is truly inclusive of communities in Phase I jurisdictions that are impacted by HIV and who are community stakeholders in the EHE activities and outcomes.

Documentation of Concurrence. To reach concurrence on the EHE Planning process, recipients will need to document their process for reaching concurrence, non-concurrence, or concurrence with reservations. Recipients will need to outline the segments of the Phase I community represented in the concurrence process (i.e., community members, PWH, providers, governmental) and approach to be used for concurrence should be outlined in the draft EHE Plan. Concurrence will need to be provided for the final submitted EHE plan.

Scenarios of EHE Planning.

Jurisdictions at various stages of EHE Plan development

- Recipient health departments that already have an EHE Plan or equivalent in place for the relevant Phase I jurisdiction(s) may only require some adjustments to these plans; although continual community engagement will be necessary. These health departments may have identified needs for additional community engagement and updates to their plan, based on what is gathered via the community engagement or from initial implementation efforts.
- Jurisdictions that have an EHE plan in development (not yet completed) may require additional community engagement and updating their epi profile to inform their EHE Plan.
- For jurisdictions that do not have an EHE plan, the requirements of the NOFO should directly support the development of one.

Multiple or no named counties within jurisdiction

- State Health Departments with multiple contiguous EHE counties should have one plan for the jurisdiction that covers the specific named EHE counties. In these instances (e.g., Georgia Health Department with Cobb, DeKalb, Fulton and Gwinnett Counties), one plan that is inclusive of all named counties should be provided.
- Health departments with multiple Phase I counties that are spread throughout the state jurisdiction (e.g., Louisiana Health Department with East Baton Rouge Parish and Orleans Parish), should include sub-sections for each county within the overall written plan. Note that submitted snapshots as well as explicit plans for engagement and planned activities should be described for each named county.
- For states without identified Phase I EHE counties, plans should focus efforts on addressing HIV throughout the state, including rural areas with increased HIV burden. These recipients may wish to work with local and state data and should use their current and up-to-date state epidemiological profile to determine which rural areas are most affected. In most cases, efforts may also need to focus on certain urban activities that support rural service provision. Recipients should present a clear strategy for engaging and focusing on the rural aspects of their epidemic.

Section V: Submission and Review

Submission. Funded entities are expected to submit their DRAFT EHE Plan to CDC by December 30, 2019. Draft plans should be submitted to PS19-1906@cdc.gov and a courtesy copy to your project officer. Note

that these are referred to as ‘Draft’ EHE plans as the process for moving from planning to implementation is expected to be iterative, and these plans will be “*living*” documents as implementation begins.

Please submit only one submission per recipient. For those with multiple counties, separate plans are not required for submission. Identified EHE counties should be included in the overall plan.

Final EHE plans will be due by the end of the project period, September 2020. However, implementation will overlap with this time period, so final plans should reflect these implementation activities. Details on the submission of the final plan will be provided.

Plan structure and content. There is no single template for the plan submission. Submitted documents should outline the engagement process, epi overview, plan contents, and monitoring and oversight. The written plan should be organized by pillar activity and consistent with implementation NOFO requirements and include specific goals, key activities and strategies, key partners, potential funding resources (including leveraged and other resources), estimated funding allocation and outcomes with identified data sources as applicable for each of the four Pillars.

Review Process. Federal partners, ODP, CDC, HRSA, and SAMSHA, will participate in the review of the draft EHE plans and will provide joint feedback to the funded programs, as appropriate. Any comments that require changes to the plan will be documented in the feedback shared with the funded health department. Recipients should incorporate feedback received from federal and local partners. Recipients should also continue with local community engagement and identifying gaps, needs, etc. for informing the final EHE plan.

Main elements to be submitted to CDC

1. Documentation of Community Engagement
2. Current Snapshot Summary of an Epidemiologic Profile (maximum 5 pages)
3. Current Snapshot Summary of a Situational Analysis (maximum 10 pages)
4. Draft EHE Plan
5. Concurrence on final, submitted EHE Plan

Note: Elements 2, 3, and 4 should be organized by Pillar

Examples of Key Stakeholders to Consider for Community Engagement

- City, county, tribal, and other state public health department partners
- Existing community advisory boards
- Community members resulting from new outreach efforts
- Community members that represent the demographics of the local epidemic
- Local and regional clinics, healthcare facilities, clinicians, and other medical providers
- Medicaid/Medicare partners
- Correctional facilities, local law enforcement and related service providers
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions
- Other key informants

Key Stakeholders to Consider for Planning Group Membership

- Health department staff
- Social service providers
- People with HIV
- Behavioral or social scientists
- Epidemiologists
- HIV clinical care providers
- Faith community members
- Business/labor representatives
- Community health care center representatives
- Substance use treatment providers
- Intervention specialists
- Local education agencies/academic institutions
- Mental health providers
- Homeless services representatives
- Corrections
- Housing service providers (e.g., HOPWA)
- Diverse geographic distribution (urban, metropolitan, rural)
- Risk populations (e.g., MSM, PWID, Transgender, Heterosexual)
- Diversity of race and ethnicity, age and gender

Example of EHE Plan Structure

Note. Jurisdictional targets will be refined over time as the national targets become final and available, and as lessons learned are identified from implementation. Due to the overlap in planning and implementation, this planning process will be iterative to allow for adjustments, accordingly.

Pillar One: Diagnose (EXAMPLE)

Goal: To diagnose XX # of PWH in 5 years.

Key Activities and Strategies:

- 1) Increase routine testing in XX ERs, acute care settings, etc.
- 2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venue to reach demographic XX

Key Partners: Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, sexual health clinics, women's health services/prenatal services providers, hospitals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Ryan White HIV/AIDS Program (RWHAP), State and/or Local Funding, Medicaid, etc.

Estimated Funding Allocation: \$X

Outcomes (reported annually, locally monitored more frequently): # newly identified persons with HIV

Monitoring Data Source: EMR data, surveillance data

Pillar Two: Treat (EXAMPLE)

Goal: To engage XX # of PWH in ongoing HIV care and treatment in 5 years.

Key Activities and Strategies:

- 1) Increase linkage to care activities in XX populations
- 2) Increase public awareness campaigns focused on getting tested and treated in XX neighborhoods/venue to reach demographic XX

Key Partners: FQHCs, medical care providers, hospitals, community-based organizations, various professional health care associations, etc.

Potential Funding Resources: Ryan White HIV/AIDS Program (RWHAP), State Local Funding, SAMHSA, HUD/HOPWA, Medicaid expenditures, Bureau of Primary Health Care, Administration for Children and Families, and other public and private funding sources

Estimated Funding Allocation: \$X

Outcomes (reported annually, locally monitored more frequently): Linkage to care for # newly identified persons with HIV; Linkage to care for # persons with HIV identified as not in care

Monitoring Data Source: Surveillance, RWHAP, CDC testing linkage data

Pillar Three: Prevent (EXAMPLE)

Goal: To increase access to PrEP by X% for priority populations in 5 years.

Key Activities and Strategies:

- 1) Increase number of providers trained to prescribe PrEP
- 2) Increase PrEP prescriptions among priority populations

Key Partners: Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, Bureau of Primary Health Care, State and/or Local Funding, Minority AIDS Initiative (MAI), SAMHSA, HUD/HOPWA, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, and other public and private funding sources, etc.

Estimated Funding Allocation: \$X

Outcomes (reported annually, locally monitored more frequently): # providers trained; # prescriptions for PrEP
Monitoring Data Source: Local databases, medical records data, pharmacy records

Pillar Four: Respond (EXAMPLE)

Goal: To increase capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks in 1 year.

Key Activities and Strategies:

- 1) Increase capacity for rapid detection and response to active HIV transmission clusters
- 2) Increase community engagement and input in response activities

Key Partners: Local community members, PWH, health departments, public health professionals, etc.

Potential Funding Resources: CDC HIV Prevention and Surveillance Programs, STD Funding, Ryan White HIV/AIDS Program (RWHAP), State and/or Local Funding

Estimated Funding Allocation: \$X

Outcomes (reported annually, locally monitored more frequently): Establishment of protocols for cluster detection and response procedures.

Monitoring Data Source: Local protocols and reports

Additional Resources

Links to HIV Planning Resources

CDC HIV Planning Guidance (July 2012). <https://www.cdc.gov/hiv/pdf/p/cdc-hiv-planning-guidance.pdf>

CDC, HRSA (June 2015). Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017- 2021
<https://hab.hrsa.gov/sites/default/files/hab/Global/hivpreventionplan062015.pdf>

Published NOFOs

Notice of Funding Opportunity PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States
<https://www.cdc.gov/hiv/funding/announcements/ps19-1906/index.html>

Ending the HIV Epidemic: A Plan for America - Ryan White HIV/AIDS Program Parts A and B
<https://www.hrsa.gov/grants/fundingopportunities/default.aspx?id=9ba1c4a1-4d18-4782-8065-0be264564d64>

Ending the HIV Epidemic information on HIV.gov

What is 'Ending the HIV Epidemic: A Plan for America'?
<https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>

Other Federal Resources

IHIP: Integrating HIV Innovative Practices (HRSA): <https://targethiv.org/ihip>

Effective Interventions: HIV Prevention That Works (CDC): <https://effectiveinterventions.cdc.gov/>

HRSA Behavioral Health: <https://www.hrsa.gov/behavioral-health>

Strategies for Success in Integrating HIV Care into Behavioral Health Care (SAMHSA):
https://www.integration.samhsa.gov/about-us/Strategies_for_Success_in_Integrating_HIV_Care_into_Behavioral_Health__9_14_16.pdf

Syringe Services Programs (HHS):
<https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>

Recovery and Recovery Support (SAMHSA): <https://www.samhsa.gov/find-help/recovery>