

# Syringe Services Program Work Plan

**Year this work plan is for:**

**Agency name:**

**Program name (if applicable):**

## Program Overview and Goals

If your agency is unable to track any of these variables, please explain why.

**Number of unique\* participants you plan to serve (Jan-Dec):**

\*Unique participants are individual participants utilizing the SSP who may visit the SSP multiple times during the time frame but should only be counted once for this category.

**Number of new\*\* participants you plan to serve (Jan-Dec):**

\*\*New participants are participants who are enrolled into the SSP for the first time at the agency ever.

**Number of sterile syringes to be distributed (Jan-Dec):**

**Number of used syringes to be collected (Jan-Dec):**

**Number of exchanges to be conducted (Jan-Dec):**

**Number of (naloxone) doses to be distributed (Jan-Dec):**(Naloxone is not funded by this particular grant so this is not a required goal but if this is something you already track and are able to estimate, we find this measure useful to track the work of the SSPs we fund)

**Number of HIV tests to be done (Jan-Dec):**

**Number of HCV tests to be done (Jan-Dec):**

## Engagement and Recruitment

Complete the table to describe a typical weekly SSP plan/schedule.

| Syringe services locations | Days of the week | Time of day  (start to finish) |
| --- | --- | --- |
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Describe activities you will undertake to recruit individuals to access your syringe services program; include how you will address barriers to participation identified by clients:

### Media

List any apps, websites, and other social media you will use to promote your program:

## Syringe Services and Activities

**Describe how you will implement required syringe services activities. Include action steps, resources needed, and where activities will take place.**

Syringe distribution:

Syringe returns/collection (include any anticipated syringe clean-up activities, if applicable):

HIV/HCV prevention education (including hormone use and sex work):

HIV testing (including type of test(s) and where/how will be conducted):

HCV testing (including type of test(s) and where/how will be conducted):

Overdose prevention (including distribution of naloxone or referral for) including materials/protocols:

Describe how your program might engage with law enforcement to assure them that your program both intends to be a good neighbor AND that your program will work to assure your participants that they will be free from police harassment when accessing your syringe services program:

Describe how your program provides other harm reduction services, including education and tools related to wound care, safer injection/smoking/snorting practices, resources/safety tips for sex workers, resources/tools related to injectable medications such as insulin and/or hormones, sexual assault and intimate partner violence referrals, referrals to treatment for substance use disorder, and others:

Describe how you will educate clients about the MN Pharmacy Syringe Access Law and participating pharmacies in your area. Please describe potential plans to work with participating pharmacies:

Describe how you will assure culturally appropriate services for men who have sex with men (MSM) and people who inject drugs (PWID) whether on site or via referral:

## Connection to Care and Referrals

How will persons testing positive (reactive) be rapidly linked to confirmatory testing for HIV:

For HCV:

List clinics or providers you currently have a relationship with where clients will be connected to care or confirmatory testing for HIV or HCV:

How will you actively refer or link clients to appropriate prevention and/or support services (other than HIV or HCV care)? What agencies/providers are you connecting clients to (e.g. STD testing, housing, mental health, chemical dependency treatment, etc.):

## Condom Distribution

Describe how targeted condom distribution will be implemented in your Syringe Services Program:

## PrEP

Describe how PrEP education and active referrals will be integrated into your work:

## Monitoring and Evaluation

List one specific program activity that will be evaluated this year. Include the type of data that will be collected to evaluate the activity:

## Incentives

Will incentives be utilized? Please describe how, if so:

Has your incentive policy been submitted and approved?

## Volunteers

Number of volunteers in your program:

Describe the roles and responsibilities of volunteers in your program:

## Staffing

Complete the table to list any staff paid through this project’s budget.

| Name (first and last)  (If position is unfilled, use “vacant.”) | Title | FTE on program  (Must match FTE in Budget Plan and Narrative) | Authorized to use EvalWeb  (Yes or No) |
| --- | --- | --- | --- |
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If no staff is currently in place, describe how staff will be recruited:

## Additional Comments

Describe any additional information that you think is important for MDH to know:

Minnesota Department of Health  
651-201-5414 | 1-877-676-5414  
[www.health.state.mn.us](http://www.health.state.mn.us/)/hiv

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