HIV Health Improvement Affinity Group

State Health Department HIV Programs: An In-Depth Look

February 23, 3:00pm-4:30pm ET
Logistics for the Webinar

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  Dial in: (844)-404-0018 Access Code: 58413777

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• Comments are encouraged. Please use that chat box on the lower left corner of your screen.

• The chat feature is available, but will not be visible in full screen mode
Welcome HIV Affinity Group Teams!
Presenters

• Azfar Siddiqi, Associate Chief of Science, HIV Incidence and Case Surveillance Branch, Centers for Disease Control and Prevention (CDC)

• Erica Dunbar, Program Lead, Health Department Initiatives, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention (CDC)

• Heather Hauck, Deputy Associate Administrator, HIV/AIDS Bureau, Health Resources and Services Administration (HRSA)
HIV Surveillance

Azfar Siddiqi, PhD
Associate Chief of Science
HIV Incidence and Case Surveillance Branch

February 24, 2017
Overview of National HIV Surveillance System (NHSS) and activities

- How is the data collected
- What data is collected
- Data use
  - Surveillance products
National HIV/AIDS Strategy
Updated to 2020

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related health disparities

HIV Case Surveillance

How do we collect data
National HIV Surveillance System (NHSS)

- The NHSS is an organized infrastructure that enables the ongoing, systematic collection, management, analysis, interpretation, and dissemination of HIV-related health data.
- Began collecting data in 1980
National HIV Surveillance System (NHSS)

- Primary source for monitoring trends in HIV infection in the United States
- 50 states, the District of Columbia, and 6 U.S. dependent areas* have regulatory authority and confidentiality protections to collect information on persons with diagnosed HIV infection
  - Surveillance data used by public health partners to
    - monitor trends
    - focus prevention efforts
    - plan services
    - allocate resources
    - develop policy

*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the U.S. Virgin Islands
National HIV Surveillance System: Components

- All programs use same surveillance case definition
- Data are collected in standard manner
- Enhanced HIV/AIDS Reporting system (eHARS) is a browser-based, CDC-developed application
- Outcome and process standards used to monitor local program activities
Document-Based Surveillance System

- Preserves the relationship between the information and the source of the information

- Allows the collection of multiple values for a given piece of data
Spectrum of Events in HIV Surveillance

Measures of HIV morbidity and mortality

HIV Infection

HIV diagnosis
(1st positive confidential test)

1st CD4 Count
1st Viral Load Test
1st Drug Resistance test

1st CD4 Count <200

AIDS-OI

All subsequent laboratory tests

Death

Entry to care
Retention in care and viral suppression
HIV Case Surveillance Information Flow

Sources of Reports
- Hospital Practitioners
- Private Practitioners
- Public Clinics
- Laboratories

Active Case Finding
- Local Health Dept.
- HIV Report
  - 2013 Region X

State Health Dept.
- 7,738 People with HIV

Dissemination
- Local Bulletins
- CDC Annual Report
- HIV Web Sites
- Public Information Data Set
- Surveillance Slide Set

CDC
- 74,353
HIV Case Surveillance

What data is collected
Data Collected by HIV Surveillance Programs

- The following data on persons with diagnosed HIV infection are collected by local, state, and territorial HIV surveillance programs and maintained in the local-level eHARS:
  - Personally identifiable information (PII)
  - Demographic characteristics
  - Geographic locations
  - Transmission category
  - Facilities and providers (diagnosing and care)
  - HIV-related laboratory test results
  - Clinical events
  - HIV testing, prophylaxis and treatment history
  - Birth history
  - Death and causes of death
  - Case duplication status (intra- and inter-state)
Data Sources

- Laboratories
- Health care providers
- Medical chart abstractions
- Patient interviews
- Vital statistics registries
- Public health clinics and registries
- Service providers of HIV prevention, care and case management programs
- Public health databases
- HIV surveillance programs in other reporting jurisdictions
- Databases from other local/state agencies
Data Reported to CDC

- At the end of every month, sites transmit HIV surveillance data to the Division of HIV/AIDS Prevention (DHAP) using eHARS via the Secure Access Management Services (SAMS)

- The following data are not transmitted to DHAP:
  - PII (e.g., name, SSN, medical record number)
  - Residence street address, zip code
  - Telephone number

- The following data are transmitted to DHAP to facilitate the creation of the quarterly de-duplicated national datasets, the semi-annual Routine Interstate Duplicate Review (RIDR), and for reporting, analyses and evaluation purposes:
  - eHARS unique identifier (system-generated)
  - STATENO, CITYNO (jurisdiction-assigned, unique within a jurisdiction)
  - Last name soundex, date of birth, sex at birth, current gender identity, race, ethnicity, and country of birth
  - Residence city, county, state, and country
Data Uses

*Surveillance products*
HIV Surveillance Report

Data Dissemination

https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html
Data Dissemination

- Surveillance reports
- Supplemental surveillance reports
- Slide sets
- Informational posters
- Conference presentations and posters
- Manuscripts in peer-reviewed journals
Surveillance reports in 2017

- Diagnoses of HIV Infection in the United States and Dependent Areas, 2016 — *Annual surveillance report*

- Supplemental reports
  - Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data United States and 6 Dependent Areas, 2015
  - Diagnosed HIV Infection among Adults and Adolescents in Metropolitan Statistical Areas United States and Puerto Rico
  - Social Determinants of Health among Adults with Diagnosed HIV Infection in 11 States, the District of Columbia, and Puerto Rico
  - HIV/AIDS Data through December 2015 Provided for the Ryan White HIV/AIDS Program, for Fiscal Year 2017
  - Social Determinants of Health and Selected HIV Care Outcomes among Adults with Diagnosed HIV Infection in 32 States and the District of Columbia
HIV Surveillance Reports

HIV surveillance reports disseminate data about HIV and AIDS—for example, the number and population rates of HIV diagnosis, the number of people living with HIV, and the number of people who are receiving HIV medical care.

- HIV Surveillance Reports
- HIV Surveillance Supplemental Reports
- HIV Surveillance Special Reports
- HIV Surveillance Technical Reports
- HIV Surveillance Other Reports

https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html
http://www.cdc.gov/nchhstp/atlas/
Data Uses

*Data to Care (D2C)*
Goals of the *Data to Care* Strategy

- Increase the number of HIV-diagnosed individuals who are engaged in HIV care

- Increase the number of HIV-diagnosed persons with an undetectable viral load
Data to Care Strategy

- Basic concept is using surveillance data to identify people who are not engaged in care
  - Never linked to care
  - Dropped out of care
- Uses surveillance data to determine care status
  - CD4 or viral load test result as proxy for care visit
- Data are used for public health follow up
  - Individual level; Link or re-link to care
  - Aggregate data; Monitor continuum of care
D2C Requirements

- **Complete reporting of CD4/VL test results**
  - Laws and regulations for reporting all values to health department
  - All laboratories report test results
  - All tests are entered into reporting system

- **Computer programs and data to generate a NIC list**

- **Data sharing from surveillance to program**

- **Field staff to find and link people to care**

- **Tracking of outcomes**

- **Security and confidentiality procedures and training**
HIV Case Surveillance
Data for Public Health Action

Sources of Reports
- Hospitals
- Private Practitioners
- Public Clinics
- Laboratories

Active Case Finding

Local Health Dept.
- HIV Report
  - 2013 Region X

CDC

Individual data reports
- Partner services
- Case management
- Diagnosis facilities
- Care providers

Aggregate data reports
- Prevention planning
- Resource allocation
- Outcome evaluation

People with HIV

Not in care
List of acronyms and abbreviations

- D2C: Data to Care
- DHAP: Division of HIV/AIDS Prevention
- eHARS: Enhanced HIV/AIDS Reporting System
- NCHHSTP: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- NHSS: National HIV Surveillance System
- NIC: Not in care
- OI: Opportunistic infections
- PII: Personally Identifiable Information
- RIDR: Routine Interstate Duplicate Review
- SAMS: Secure Access Management Service
Thank you!

For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Comprehensive HIV Prevention Programs for Health Departments

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Program Lead, Health Department Initiatives
Program Lead, Community-based Organization Initiatives (acting)
Division of HIV/AIDS Prevention, Prevention Program Branch (PPB)
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

HIV Affinity Group Presentation
February 23, 2017
Outline

- Overview of the Health Department HIV Prevention Program (PS12-1201)
  - Background and Goals
  - Funding Categories
  - Required and Recommended Components
  - Performance Standards
- Monitoring and Evaluation
- HIV Programs Moving Forward
HEALTH DEPARTMENT HIV PREVENTION FUNDING OPPORTUNITY ANNOUNCEMENT (FOA) PS12-1201
Background

With the Launch of National HIV/AIDS Strategy (2010), under PS12-1201, CDC was provided an opportunity to:

- **Address misalignment of HIV prevention resource allocation (funding realignment)**
  - CDC created a funding algorithm based on the number of adults and adolescents living with a diagnosis of HIV through 2008
  - Application of this new funding formula resulted in funding realignment that is based on the magnitude of the HIV epidemic within each jurisdiction

- **Realign CDC funded prevention activities (programmatic realignment)**
  - Focus on high impact prevention

- **Decrease the number of FOAs to reduce administrative burden**
Matching Prevention Funds to the Epidemic

When CDC’s new approach is fully implemented, HIV prevention resources will closely match the geographic burden of HIV.

Proportion of Americans Living with an HIV Diagnosis (2008)

Proportion of CDC Core HIV Prevention Funding—FY2016

1Maps do not include U.S. territories receiving CDC HIV prevention funding.

2New funding allocation methodology will be fully implemented by FY2016; this breakdown assumes level overall funding.
CDC’s HIV Prevention Funding Opportunity Announcement for Health Departments

- **Goals of PS12-1201:**
  - Focus HIV prevention efforts in communities and local areas where HIV is most heavily concentrated to achieve the greatest impact in decreasing the risks of acquiring HIV;
  - Increase HIV testing;
  - Increase access to care and improve health outcomes for people living with HIV;
  - Increase awareness and educate communities about the threat of HIV and how to prevent it;
  - Expand targeted efforts to prevent HIV infection using a combination approach; and
  - Reduce HIV-related disparities and promote health equity.

- **Project Period:**
  - One year extension through December 31, 2017.
FOA CATEGORIES OVERVIEW
# Health Department FOA Categories

The following categories are included in the Health Department FOA:

## Category A: HIV Prevention Programs for Health Departments *(core funding)*

**Required Core Program Components:** HIV Testing, Comprehensive Prevention with Positives, Condom Distribution, and Policy Initiatives

**Required Programmatic Activities:** Jurisdictional HIV Prevention Planning, Capacity Building and Technical Assistance, and Program Planning, Monitoring and Evaluation, and Quality Assurance

**Recommended Program Components:** Evidence-based HIV Prevention Interventions, Social Marketing, Media, and Mobilization, and PrEP and nPEP

## Category B: Expanded HIV Testing for Disproportionately Affected Populations *(limited eligibility)*

**Required:** HIV Testing in Healthcare Settings

**Optional:** HIV Testing in Non-healthcare Settings

**Optional:** Service Integration

## Category C: Demonstration Projects to implement and evaluate innovative, high impact HIV prevention activities *(competitive and optional)*

**Focus areas** include 1) structural, biomedical, and behavioral interventions (or any combination thereof), 2) innovative testing activities, 3) enhanced linkages to and retention in care, 4) advanced use of technology, and 5) use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk.
### PS12-1201 Funding Portfolio

<table>
<thead>
<tr>
<th>Funding Opportunity Announcement</th>
<th>Strategy</th>
<th>Target</th>
<th>Number of awards</th>
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</thead>
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<td>PS12-1201 Category A</td>
<td>HIV Prevention Programs for Health Departments</td>
<td>High Risk Populations</td>
<td>61</td>
</tr>
<tr>
<td>PS12-1201 Category B</td>
<td>Expanded HIV Testing Programs for Health Departments</td>
<td>Populations disproportionately affected by HIV</td>
<td>34</td>
</tr>
<tr>
<td>PS12-1201 Category C</td>
<td>Demonstration Projects for Health Departments</td>
<td>Not Targeted</td>
<td>30</td>
</tr>
</tbody>
</table>

**PS12-1201 Project Period:** January 1, 2012 – December 31, 2017
CATEGORY A: CORE HIV PREVENTION PROGRAM
Category A: Core Program Components and Activities

Four Required Core Program Components
- HIV Testing
- Comprehensive Prevention with Positives
- Condom Distribution
- Policy Initiatives

Three Required Program Activities
- Jurisdictional HIV Prevention Planning
- Capacity Building and Technical Assistance
- Program Planning, Monitoring and Evaluation, and Quality Assurance

Three Recommended Components
- Evidenced-Based HIV Prevention Interventions
- Social Marketing, Media, and Mobilization
- PrEP and nPEP Services

75% of Funding
Up to 25% of Funding
Examples of Required HIV Prevention Activities

Four Required Core Program Components

- HIV Testing
- Comprehensive Prevention with Positives
- Condom Distribution
- Policy Initiatives

HIV Testing
- Implement and/or coordinate opt-out HIV testing in healthcare settings
- Implement and/or coordinate HIV testing in non-healthcare settings
- Promote routine, early HIV screening for all pregnant women
- Facilitate voluntary testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), viral hepatitis, and TB, in conjunction with HIV testing
- Incorporate new testing technology
Examples of Required HIV Prevention Activities

Four Required Core Program Components

- HIV Testing
- Comprehensive Prevention with Positives
- Condom Distribution
- Policy Initiatives

Comprehensive Prevention with Positives

- Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV positive or currently living with HIV
- Promote retention or re-engagement in care for HIV-positive persons
- Offer referral and linkage to other medical and social services
- Provide ongoing Partner Services (PS)
- Support implementation of behavioral, structural, and/or biomedical interventions for persons living with HIV (PLWH)
- Support reporting of CD4 and viral load results to health departments
Examples of Required HIV Prevention Activities

Condom Distribution
- Conduct condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection
Examples of Required HIV Prevention Activities

### Four Required Core Program Components

- HIV Testing
- Comprehensive Prevention with Positives
- Condom Distribution
- Policy Initiatives

### Policy Initiatives

- Support efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts.
- Policy initiatives may include reporting of CD4 and viral load; routine, opt-out HIV testing policies; other internal protocols and policies.
Examples of Recommended HIV Prevention Activities

Three Recommended Components

- Evidenced-Based HIV Prevention Interventions
  - Implement individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV
  - Implement community level evidence-based interventions that reduce HIV risk
  - Support syringe services programs (SSPs), where allowable

- Social Marketing, Media, and Mobilization

- PrEP and nPEP Service
Examples of Recommended HIV Prevention Activities

Three Recommended Components

- Evidenced-Based HIV Prevention Interventions
- Social Marketing, Media, and Mobilization
- PrEP and nPEP Service

Social Marketing, Media, and Mobilization

- Support and promote social marketing campaigns targeted to relevant audiences
- Support and promote educational and informational programs for the general population based on local needs
- Support and promote the use of media technology
- Encourage community mobilization
Examples of Recommended HIV Prevention Activities

**PrEP and nPEP**
- Support Pre-Exposure Prophylaxis (PrEP) services for persons at high risk for HIV consistent with CDC guidelines
- Offer Non-Occupational Post-Exposure Prophylaxis (nPEP) to populations at greatest risk
Examples of Required Supporting HIV Prevention Activities

Three Required Program Activities

- Jurisdictional HIV Prevention Planning
- Capacity Building and Technical Assistance
- Program Planning, Monitoring and Evaluation, and Quality Assurance

Required Program Activities

- HIV Planning Group (HPG) process and plan development
- Building capacity of the health department and their community
- Monitor the burden of HIV disease within the jurisdiction for program planning, resource allocation and monitoring and evaluation purposes
Category A: National Goal and Performance Standards

National Goal: CDC expects approximately two million HIV tests will be provided annually, among all funded jurisdictions, when the program is fully implemented.

Performance Standards: CDC expects each funded jurisdiction to achieve the following performance standards, when the program is fully implemented:

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1.0% rate of newly identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment.
- At least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services.
CATEGORY B: EXPANDED HIV TESTING PROGRAM (ETP)
Category B: Expanded Testing for Disproportionately Affected Populations

Required Core Program Component

Expanded HIV Testing in Healthcare Settings

Optional Component

Targeted HIV Testing in Non-Healthcare Settings

Optional

Service Integration

70% of Funding

Linkage to Care, Referral to Partner Services, and Sustainability of Programs (encourage reimbursement for HIV testing)

Up to 30% of Funding
Category B Billing Redirection

Through a redirection in funds, jurisdictions were expected to:

- Develop the infrastructure to establish or improve systems that allow for third party reimbursement for HIV testing and other related co-infections (e.g., sexually transmitted infections, hepatitis C, tuberculosis)
- Provide and/or facilitate needed technical assistance

Grantees were expected to focus efforts based on:

- Amount of resources provided for testing
- Feasibility of changing systems
- An understanding that HIV prevention programs often support testing in settings that are not under the control of the HIV prevention program
CDC expects that approximately 1.3 million HIV tests are provided and approximately 6,500 HIV-infected persons who were previously unaware of their infection are identified annually.

Performance Standards: CDC expects each funded jurisdiction to achieve the following performance standards, when the program is fully implemented:

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 2.0% rate of newly identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV-positive test results are linked to medical care and attend their first appointment.
- At least 80% of persons who receive their HIV-positive test results are referred and linked to Partner Services.
- At least 80% of persons who receive their HIV-positive test results receive prevention counseling or are referred to prevention services.
CATEGORY C: DEMONSTRATION PROJECTS
Category C: Demonstration Projects

- 30 jurisdictions funded to implement High Impact Prevention demonstration projects.
- This funding was designed to evaluate innovative approaches to HIV prevention.
  - Included five focus areas.
  - Projects addressed single or multiple focus areas.
- Project period:
Distribution of Category C Work, by Focus Area

- Advanced Technology: n=8, 9%
- Interventions: n=10, 12%
- HIV Testing: n=19, 22%
- HIV Surveillance Data Use: n=24, 28%
- Linkage to Care: n=25, 29%

Note: N=86 total Focus Areas
Health Departments Funded for PS 12-1201 Category C Projects

Funded under Category C: San Francisco, Los Angeles County, Chicago, Fulton County, Baltimore

MONITORING & EVALUATION

PROVIDING FEEDBACK USING PROGRAM DATA
<table>
<thead>
<tr>
<th>DATA</th>
<th>DATA SYSTEM OR REPORTING SOURCE</th>
<th>LEVEL OF PROGRAM MONITORING, EVALUATION, AND IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV SURVEILLANCE</td>
<td></td>
<td></td>
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<tr>
<td>HIV cases</td>
<td>National HIV Surveillance System</td>
<td>National level Jurisdictional level</td>
</tr>
<tr>
<td>Behavioral</td>
<td>National HIV Behavioral Surveillance (NHBS)</td>
<td>National sample Jurisdictional level</td>
</tr>
<tr>
<td>Behavioral and Clinical</td>
<td>Medical Monitoring Project (MMP)</td>
<td>National sample Jurisdictional level</td>
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<tr>
<td>NATIONAL HIV MONITORING AND EVALUATION</td>
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<td></td>
</tr>
<tr>
<td>HIV Testing</td>
<td>EvaluationWeb® Progress Reports</td>
<td>Jurisdictional level FOA-specific level</td>
</tr>
<tr>
<td>Partner Services</td>
<td>EvaluationWeb® Progress Reports</td>
<td>Jurisdictional level FOA-specific level</td>
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<tr>
<td>Linkage to Care</td>
<td>National HIV Surveillance System EvaluationWeb® Progress Reports</td>
<td>National level Jurisdictional level FOA-specific level</td>
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<tr>
<td>Community and Behavioral Interventions</td>
<td>EvaluationWeb® Progress Reports</td>
<td>FOA-specific Individual grantee level</td>
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<tr>
<td>QUALITATIVE PROGRAM DATA</td>
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<td></td>
</tr>
<tr>
<td>Other Jurisdictional/FOA specific activities</td>
<td>Applications Progress Reports Work Plans</td>
<td>FOA-specific Individual grantee level</td>
</tr>
<tr>
<td>Capacity Building Assistance</td>
<td>Capacity Building Request Information System (CRIS) Progress Reports</td>
<td>FOA-specific Individual grantee level</td>
</tr>
</tbody>
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National HIV Prevention Program Monitoring and Evaluation (NHM&E)

- **Purpose:**
  - CDC’s data system utilizing standardized variables for data collection of programmatic activities
  - Assist health departments (HDs) and community-based organizations (CBOs) with monitoring and evaluating their local programs
  - Assist CDC in monitoring and evaluating program performance at the national- and jurisdictional-level

- **Types of Data:**
  - HIV Testing
  - Partner Services
  - Linkage to Care
  - Community & Behavioral Interventions (risk reduction activities)
  - Funding Allocation
Feedback to Grantee on FOA-specific Performance

Rapid Feedback Reports (RFRs) and Individual Grantee Reports (IGRs)

- Describe program achievements and progress toward meeting FOA-specific performance targets
- Directly compares grantee performance
- Intended to be provided to grantees no later than 3 months following data submission

Data Source
- NHM&E
- Performance Reports
MOVING FORWARD
Ongoing Health Department Coordination

- HIV Testing
- Linkage to Care Coordination
- Service Agreements and MOAs/MOUs
- Navigation Services
- Referrals to PH Clinic Services
- Partner Services
- PrEP Referrals

Note: Not an exhaustive list
Integrating HIV Surveillance and Prevention Programs

- Integrating HIV case surveillance and HIV prevention program efforts
- Many HDs have successfully integrated programs, although there are barriers and challenges for others
- A joint approach would allow health departments to:
  - Align resources to better match the geographic burden of HIV infections within their jurisdictions
  - Foster better integration of HIV prevention and surveillance programs
  - Reduce administrative and reporting burden
- In 2018, CDC will release a new, integrated funding opportunity announcement (FOA) in 2018 that combines the National HIV Surveillance System and HIV Prevention Programs for Health Departments
Acknowledgements

- **DHAP Office of Director**
  - Dr. Eugene McCray, Janet C. Cleveland, Renata Ellington, June Mayfield, Dr. David Purcell

- **Prevention Program Branch (PPB)**
  - Dr. Stan Phillip, Dr. Kimberly Hearn Murray, Stacey Bourgeois, Reginald Carson, Odessa Dubose, Benny Ferro, Erica Dunbar, Dr. John Beltrami
  - PPB Project Officers and Branch staff

- **Collaborating Branches**
  - Program Evaluation Branch (PEB), Capacity Building Branch (CBB), HIV Incidence and Case Surveillance Branch (HICSB), Behavioral and Clinical Surveillance Branch (BCSB), Quantitative Sciences and Data Management Branch (QSDMB), Prevention Research Branch (PRB), Epidemiology Branch (EB)

This presentation could not be done without the contributions and support from staff across the Division of HIV/AIDS Prevention (DHAP), as well as our CDC-funded Health Department and CBO grantees.
Thank you!

For more information on PS12-1201, please visit: https://www.cdc.gov/hiv/funding/announcements/ps12-1201/attachments.html

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: http://www.cdc.gov

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The Ryan White HIV/AIDS Program and Global HIV Program: Overview

HIV/AIDS Bureau
December 2016
Program Legislation

• The Ryan White HIV/AIDS Treatment Extension Act is a legislative program:
  • Public Health Law 111-87 under Title XXVI
  • Enacted into law in 1990

• The authorization of appropriation for the Ryan White HIV/AIDS Program (RWHAP) expired on September 30, 2013. The Program will not sunset and can continue to operate through Congressional appropriations
Ryan White HIV/AIDS Program

• Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV
  • More than half of people living with diagnosed HIV in the United States – more than 500,000 people – receive care through the Ryan White HIV/AIDS Program

• Funds grants to states, cities/counties, and local community based organizations
  • Recipients determine service delivery and funding priorities based on local needs and planning process

• 83% of Ryan White HIV/AIDS Program clients are virally suppressed, exceeding national average of 55%
Ryan White HIV/AIDS Program

• Parts A (Cities), B (States), C (Community based organizations), and D (Community based organizations for women, infants, children, and youth) Services
  • Medical care, medications, and laboratory services
  • Clinical quality management and improvement
  • Support services including case management, medical transportation, and food bank

• Part F Services
  • Clinician training, dental services, and dental provider training
  • Development of innovative models of care to improve health outcomes and reduce HIV transmission among hard to reach populations

• Payer of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
Clients Served by the Ryan White HIV/AIDS Program, 2015
Clients Served by the Ryan White HIV/AIDS Program* by Gender, 2015—United States and 3 Territories**

- Male: 71.3%
- Female: 27.6%
- Transgender: 1.1%

N=531,816

*Does not include clients receiving only AIDS Drug Assistance Program services.

**Puerto Rico, Guam, U.S. Virgin Islands
Clients Served by the Ryan White HIV/AIDS Program* by Age Group, 2011 to 2015—United States and 3 Territories**

2015  
N=532,949

<table>
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<th>Age (years)</th>
<th>%</th>
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<tr>
<td>&lt;13</td>
<td>1.1%</td>
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<tr>
<td>13–24</td>
<td>5.1%</td>
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<tr>
<td>25–34</td>
<td>16.6%</td>
</tr>
<tr>
<td>35–44</td>
<td>20.0%</td>
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<tr>
<td>45–54</td>
<td>31.6%</td>
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<td>55–64</td>
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<td>≥65</td>
<td>5.3%</td>
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</table>

*Does not include clients receiving only AIDS Drug Assistance Program services.  
**Puerto Rico, Guam, U.S. Virgin Islands
Clients Served by the Ryan White HIV/AIDS Program* by Race/Ethnicity, 2015—United States and 3 Territories**

N=528,847

- Black/African American: 22.7%
- White: 47.1%
- Hispanic/Latino***: 1.3%
- Multiple races: 0.5%
- Asian: 0.2%
- American Indian/Alaska Native: 0.1%
- Native Hawaiian/Pacific Islander: 1.4%

*Does not include clients receiving only AIDS Drug Assistance Program services.
**Puerto Rico, Guam, U.S. Virgin Islands
***Hispanics/Latinos can be of any race
Clients Served by the Ryan White HIV/AIDS Program* by Poverty Level, 2015—United States and 3 Territories**

N=510,218

Federal Poverty Level (% FPL)

- ≤100% FPL: 65.4%
- 101–138% FPL: 11.9%
- 139–250% FPL: 15.0%
- 251–400% FPL: 5.7%
- >400% FPL: 2.0%

*Does not include clients receiving only AIDS Drug Assistance Program services.
**Puerto Rico, Guam, U.S. Virgin Islands
Health Outcomes of People served by the Ryan White HIV/AIDS Program
Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program*, 2010–2015—United States and 3 Territories**

- The percent of RWHAP clients virally suppressed has increased steadily from 69.5% in 2010 to 83.4% in 2015.
  - The Centers for Disease Control and Prevention estimates that in the U.S., 54.7% of people diagnosed with HIV are virally suppressed.

- Viral suppression outcomes lower among:
  - Younger age groups (13–24 years)
  - Specific minority populations
  - Clients with unstable housing

*Does not include clients receiving only AIDS Drug Assistance Program services.
**Puerto Rico, Guam, U.S. Virgin Islands
Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program*, by State, 2010–2015—United States and 3 Territories**

Viral suppression: ≥1 OAMC visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL. Source: HRSA, HIV/AIDS Bureau, Annual Client-Level Data Report, Ryan White Services Report, 2014 & 2015

*Does not include clients receiving only AIDS Drug Assistance Program services.
**Puerto Rico, Guam, U.S. Virgin Islands
Ryan White HIV/AIDS Program System of Care and Services
Ryan White HIV/AIDS Program
Part Overview

• Part A (Cities/Counties)
• Part B (States and Territories)
  • ADAP – AIDS Drug Assistance Program
• Part C (Health Care Agencies)
  • Early Intervention Services and Capacity Development
• Part D (Women, Infants, Children and Youth)
• Part F (Other programs)
  • AIDS Education and Training Centers (AETCs)
  • Special Projects of National Significance (SPNS)
  • Dental Programs
  • Minority AIDS Initiative (MAI)
Emergency Relief Grants – Part A
FY 2016 Funding: $656 million

• Provides grants to 52 Eligible Metropolitan Areas and Transitional Grant Areas that are most severely impacted by the HIV/AIDS epidemic:
  • 73% of people with HIV live in these areas
  • Award made to Chief Elected Official
    • Local funding allocations determined by legislatively required Planning Council

• Part A funds distribution (annual application process):
  • 2/3 by formula – based on the number of living cases of HIV (non AIDS) and AIDS
  • 1/3 supplemental – competitive grant process
  • Includes statutorily defined Minority AIDS Initiative (MAI) funds, which support services targeting minority populations
Ryan White HIV/AIDS Program
Part A Recipients - 2016
HIV Care Grants to States – Part B
FY 2016 Funding: $1.3 billion

• Provides formula and competitive grants to all 50 States, the District Columbia, Puerto Rico, Guam, U.S. Virgin Islands, 5 Associated Pacific jurisdictions (annual application process)
  • Funds distributed annually by formula based on HIV/AIDS cases (Part B Base, AIDS Drug Assistance Program (ADAP), ADAP Supplemental, Emerging Communities, Minority AIDS Initiative)
  • Some funds distributed as competitive supplemental (Part B Supplemental)
  • Award made to Chief Elected Official to ensure statewide HIV care and treatment services based on locally assessed need

• AIDS Drug Assistance Program:
  • Purchases medications, insurance premiums, and assists with cost sharing for HIV medications
  • 268,636 ADAP clients in 2014, over 50% of people on HIV treatment nationally
  • Average annual medication costs per client were $8,591

• ADAP Emergency Relief Funds to qualifying States:
  • Funds ADAP to prevent, reduce or eliminate ADAP waiting lists or implement ADAP–related cost-containment measures (authorized through appropriation, annual competition)
Early Intervention Services – Part C
FY 2016 Funding: $205 million

• Currently provides grants to 346 recipients in 49 states, DC, Puerto Rico, and the Virgin Islands
  • Funds community health centers, health departments, hospital clinics, and other community based organizations
  • All funds are awarded competitively every three to five years
    • Statutory preference given to areas with high rates of sexually transmitted diseases, tuberculosis, drug abuse, and hepatitis B and/or C
    • Statutory preference given to entities that provide primary care services in rural areas or to underserved populations
Women, Infants, Children, and Youth – Part D

FY 2016 Funding: $75 million

• Currently provides grants to 115 recipients in 39 states and Puerto Rico
  • Focuses on HIV care and treatment services for Women, Infants, Children, and Youth populations
  • Funding may also be used to provide support services to PLWH and their affected family members
  • All funds are awarded competitively; the FY 2017 – FY 2020 funding opportunity was announced in December 2016
Part F Programs –
AIDS Education and Training Centers
FY 2016 Funding: $34 million

• Funds 8 Regional training programs for multidisciplinary health care providers
  • Provides clinical training in all States, DC, Puerto Rico, Virgin Islands and Associated Pacific Jurisdictions
  • From 2011 through 2014, conducted over 43,900 training events (approximately 14,500 per year) reaching 80,000–85,000 trainees each year to improve HIV testing and care and treatment
  • All funds are awarded competitively; the next competition will be in FY 2020

• Funds National Centers for clinician consultation, dissemination of resources, and evaluation
  • Clinical consultation call volume has increased from 14,956 in FY 2011 to 77,343 in FY 2016 for general HIV disease management, perinatal HIV management, pre- and post-exposure prophylaxis management, hepatitis C management, and case consultations
Part F Programs –
Dental Reimbursement Program
FY 2016 Funding: $13 million

• Dental Reimbursement Program:
  • Currently funds 56 Dental Reimbursement Programs in 21 states and DC
    • Awarded annually
  • Expands access to oral health care for PLWH while training additional dental and
dental hygiene providers
  • Provides reimbursements (32% of uncompensated expenditures in FY 2016) to
dental schools, schools of dental hygiene, and post-doctoral dental education
programs
  • Between July 2014 – June 2015, 7,219 dental students, residents, and dental
hygiene students provided oral health services to 38,436 individuals living with HIV

• Community Based Dental Partnership Program:
  • Currently provides grants to 12 Community Based Dental Partnership Programs in
11 states; the next competition will be in FY 2019
  • Multi-partner collaborations between community-based dentists and dental clinics
and dental/dental hygiene education programs to train and expand provider
capacity
Part F Programs – Special Program of National Significance (SPNS)

FY 2016 Funding: $25 million

• Currently funds 64 ongoing programs for 7 innovative model initiatives which inform the evidence base for interventions with significantly difficult to engage and virally suppress populations
  - Serving over 8,700 HIV-positive clients during FY 2017
  - Competitive application process (4-5 years); new initiatives to be funded in FY 2018

• Evaluates the design, implementation, utilization, cost, and health related outcomes of innovative treatment models

• Disseminates successful models for replication and integration by Ryan White HIV/AIDS Program funded grantees in numerous peer review journals and national conferences
Ryan White HIV/AIDS Program Core Medical Service Requirement

• Under Title XXVI of the Public Health Service Act, recipients receiving Ryan White HIV/AIDS Program Part A, B, and/or C funds are required to spend at least 75% of grant funds on Core Medical Services:

<table>
<thead>
<tr>
<th>Outpatient ambulatory health services</th>
<th>AIDS pharmaceutical assistance</th>
<th>Medical case management, including treatment adherence services</th>
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<tbody>
<tr>
<td>AIDS Drug Assistance Program (ADAP) treatments</td>
<td>Health insurance premium and cost sharing assistance</td>
<td>Hospice services</td>
</tr>
<tr>
<td>Oral health care</td>
<td>Home health care</td>
<td>Home and community-based health services</td>
</tr>
<tr>
<td>Early intervention services</td>
<td>Substance abuse outpatient care</td>
<td>Mental health services</td>
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<tr>
<td>Medical nutrition therapy</td>
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• Support Services are defined as services that are needed for people living with HIV to achieve their medical outcomes.
The Ryan White HIV/AIDS Program Moving Forward
HIV/AIDS Bureau
Strategic Priorities

• **National Goals to End the HIV Epidemic/PEPFAR 3.0:** Maximize HRSA HAB expertise and resources to operationalize National Goals to End the HIV Epidemic and PEPFAR 3.0.

• **Leadership:** Enhance and lead national and international HIV care and treatment through evidence-informed innovations, policy development, health workforce development, and program implementation.

• **Partnerships:** Enhance and develop strategic domestic and international partnerships internally and externally.
HIV/AIDS Bureau
Strategic Priorities

• **Integration:** Integrate HIV prevention, care, and treatment in an evolving healthcare environment by maximizing opportunities provided by the healthcare system for preventing infections, increasing access to quality HIV care, and reducing HIV-related health disparities.

• **Data Utilization:** Use data from program reporting systems, surveillance, modeling, and other programs, as well as results from evaluation and special projects efforts to target, prioritize, and improve policies, programs, and service delivery.

• **Operations:** Strengthen HAB administrative and programmatic processes through Bureau-wide knowledge management, innovation, and collaboration.
Thank you

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Questions
# Upcoming Activities and Next Steps

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<tr>
<th>Activity</th>
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<tr>
<td>New Funding Opportunity through HRSA</td>
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<tr>
<td>Upcoming Webinar: Data Privacy &amp; Confidentiality</td>
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<tr>
<td>Technical Assistance - <a href="mailto:HIVtechnicalassistance@nashp.org">HIVtechnicalassistance@nashp.org</a></td>
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Thank you for participating in today’s webinar! Please complete the evaluation after exiting the webinar.