

2011

New AIDS Director Orientation Guide

Guide for new directors of HIV/AIDS and adult viral hepatitis programs, including key elements of managing a state HIV/AIDS and viral hepatitis program. Part of NASTAD's Leadership Development Resource Modules



INTRODUCTION:
ABOUT THIS GUIDE

• Page 3

NEW AIDS
DIRECTOR ADVICE
& VISIONING
RESOURCES

• Page 4

PUBLIC HEALTH
ORGANIZATION

• Page 15

MAJOR PROGRAM
COMPONENTS

• Page 19

TA AND
RESOURCES

• Page 37

GLOSSARY

• Page 40

1. INTRODUCTION: ABOUT THIS GUIDE

Welcome to your new role as an HIV/AIDS Director. You also may be responsible for other STDs, viral hepatitis, tuberculosis, refugee health, or some other combination of programs in your health department structure.

Whether you have come to this position from years of experience managing HIV/AIDS programs at the state or local levels, or have moved into the field of HIV/AIDS from other fields of public health or public administration, learning that no two states organize their HIV/AIDS programs in the same way is your first lesson.

Yet you also instinctively know that connecting with and learning from

your colleagues in other states is a critical lifeline for understanding your new role and the challenges you will face.

Key lessons and recommendations from your colleagues are featured throughout to help you in interactions with your staff, the HIV/AIDS community, funders and colleagues from around the country.

We recommend you skim through this guide in your first few months in your job, then keep it handy as a resource when you need to deal with an issue.

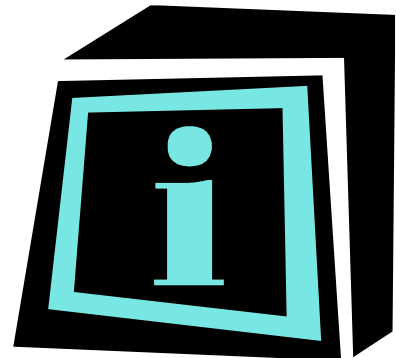
Core competences: a short text box of competencies drawn from the "Core Competencies for Public Health Professionals"

Information: key aspects an AIDS director may be responsible for or need to know about

Resources

Advice & Words of Wisdom

This Guide is a quick reference guide for more information on critical aspects of your job.



2. ADVICE TO A NEW AIDS DIRECTOR

AIDS directors are required to manage large and complex programs, connect with many

different constituencies and stakeholders, and respond to multiple funders, as well as their own hierarchies within their public health systems.

AIDS directors often must “manage chaos.”

You are often responding to issues on a continual

basis. Often, this creates challenges for planning and managing your program, particularly when you receive an emergency call from the Governor’s office to answer a question about your program or the clients you serve.

Four Key Challenges You Will Face:

1. Knowing the major funding sources for your programs.

- Learn acronyms
- Understand the roles of Project Officers, Grants Management Specialists and other funding agency personnel
- Know differences between Federal and state funding, matching requirements and reporting requirements.

2. Understanding your bureaucracy – the internal and external influences and inputs and the political power structure.

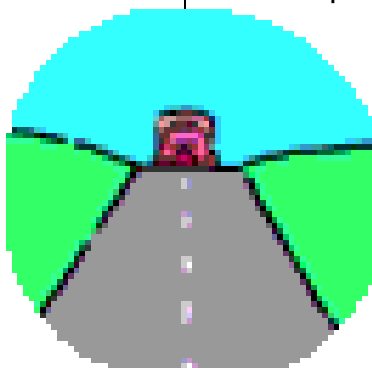
- Understand the federal, state and local structures and statutes
- Learn the political landscape
- Ensure appropriate collaboration with other state agencies
- Build relationships with communities and funded agencies.

3. Identifying local, state, and national reliable data information and resources.

- Keep abreast of funding opportunities
- Maximize access to data and epidemiologic information

4. Understanding the scope of the work and the resources necessary to get the job done.

- Know external and internal expectations
- Understand program integration (HIV, STDs and viral hepatitis) opportunities
- Continually assess and develop staff skills, abilities and capabilities



Top Questions AIDS Directors Want Answered

1. WHO DOES THE EPIDEMIC IMPACT IN MY STATE?

You will need to know what HIV/AIDS surveillance and data systems are available to you, as well as care and prevention evaluation systems.

2. WHERE DOES THE FUNDING FOR OUR PROGRAMS COME FROM? WHAT ARE THE SERVICES ELIGIBLE FOR FUNDING? WHAT ARE THE MAJOR COMPONENTS OF THE PROGRAMMATIC AND FISCAL MONITORING OF GRANT FUNDS?

You should ensure that you can quickly access comprehensive information on where funding goes, including how much is kept within health department and how much is granted out to who and for what populations/risks. Know the status of prevention, surveillance and care and treatment (Ryan White Part B/ADAP, other Parts) cooperative agreements or funding, including the history of these funding sources. Be aware of political decisions affecting these funds.

3. WHERE ARE THE GAPS IN SERVICES TO PEOPLE LIVING WITH HIV/AIDS AND HOW CAN THEY BE FILLED EFFECTIVELY WITHIN EXISTING RESOURCES?

Make sure you have access to all available information about what programs you are funding and the latest comprehensive plans developed by your program. Engage local planning, understand their recommendations and access gap analyses and resource inventories produced for their use. Talk with

colleagues and get TA to help address deficiencies.

4. WHAT ARE THE RELEVANT PUBLIC HEALTH CODES AND STATE STATUTES THAT IMPACT/AFFECT THE HIV/AIDS PROGRAM, WHETHER DIRECTLY OR INDIRECTLY?

Make sure that you familiarize yourself with the public health codes and statutes for your state....review what your predecessors had to work on relative to proposed changes in code and statute.

5. WHO ARE THE KEY STAKEHOLDERS? WHO ARE MY MAJOR LOCAL, STATE, AND NATIONAL PARTNERS IN THESE EFFORTS?

Make sure you capitalize on local planning groups as a key set of stakeholders, but also use the contacts, connections and relationships that have been built by your staff. Obtain TA/CBA to make inroads with communities you need to build relationships with. Ask NASTAD for help learning about national partners.

6. WHAT ARE EFFECTIVE METHODS OF DISSEMINATING INFORMATION TO THE COMMUNITY THAT HELPS THEM TO UNDERSTAND THE HIV/AIDS PROGRAM?

Use your media/communications department, but also use your planning group and key community stakeholders. Widely disseminate epidemiologic profiles and surveillance reports, use your website and other online media to get out your message as appropriate and allowable.

7. WHAT ARE THE BEST WAYS TO ENSURE HIV/AIDS IMPACTED POPULATION VOICE AND REPRESENTATION?

Ensure that you are regularly communicating (see above) with your communities, not only about the epidemiology, but also the steps the health department is taking to address the epidemic(s). Create a transparent participatory input process with multiple access mechanisms. Work with NAPWA and other TA providers to help give PLWHAs voice. Ensure inclusion of their “voice” in products and services distributed by the health department.

8. WHAT ARE THE MAJOR COMPONENTS OF COMMUNITY/PARTICIPATORY PLANNING (FOR CARE AND/OR PREVENTION) AND HOW DO THESE PROCESSES IMPACT THE HIV/AIDS PROGRAM?

The key role for participatory planning is help in identifying the issues, needs and gaps that exist in programming and messaging priority populations. For HIV, both CDC and HRSA have guidance that outlines their expectations for their planning processes. They fund numerous agencies to provide TA/capacity building on planning, and NASTAD can connect you with colleagues experienced in managing planning process and/or changes in input and planning processes.

9. HOW DO WE IMPRESS ON POLICYMAKERS THE ONGOING, IF NOT INCREASING NEED FOR RESOURCES FOR HIV/AIDS AMIDST THE CURRENT FISCAL CRISIS AND COMPETING PRIORITIES?

Access and use NASTAD’s policy and government relations fact sheets and other documents as well as your own state’s information to make your case. Point out the cost effectiveness of preventing infection and preventing illness.

10. WHO HAS ANSWERS TO MY QUESTIONS AND WHAT ARE MY BEST RESOURCES?

NASTAD staff can answer a lot of your questions. Your peers are an excellent resource for questions and problem solving. Make sure you learn from your veteran staff so you can both learn about your program’s history and get to know them. Access and utilize your federal project officers and TA/CBA providers.



Top Ten Suggestions of AIDS Directors Who Have Been There

1. Read, read, read
2. Establish relationships – Ask other states. Utilize NASTAD. Network (internal and external), establish relationships with project officers (CDC and HRSA) staff, ensure internal cross program training/TA and cultivate external partners.
3. Pay a lot of attention to detail and be ready to roll (and roll and roll) with punches because there will be a lot of them on all levels as you work through a multitude of systems and processes.
4. Keep your eye on the prize (effective prevention and reduced transmission) because sometimes the processes seem counterproductive and counter intuitive.
5. Find and utilize strong outside (and inside) resources.
6. Learn the program’s history – its past successes and failures. <ul style="list-style-type: none"> • Develop (or build upon) an action plan • Establish a forward vision/conduct strategic planning
7. Discover the context – local and national political contexts, law and policy (statutes, laws, regulations, mandates, etc.), and agency decision-making processes.
8. Become well versed in how to deal with the media
9. Ensure that your program has developed an emergency preparedness plan. Also ensure there is a business continuity plan.
10. Make sure you learn and understand your health department’s structure. Make sure you know how it operates, what the alignment of programs is, what populations cross programs, etc. Work within your agencies procedures and policies.

Linking with NASTAD and Other AIDS Directors

NASTAD is a membership organization for the state and territorial health agency staff with administrative responsibility for AIDS health care, prevention, education and supportive service programs funded by states and the federal government.

Many NASTAD members also have adult viral hepatitis under their purview, and some combination of STD, TB, refugee health and surveillance programs as part of their management portfolio as well.

NASTAD members receive many benefits, including regular policy updates and electronic newsletters and communications, many of which are also sent to their key program staff.

[NASTAD's elected Executive Committee](#) is comprised of 20 state AIDS directors and is charged with making policy and programmatic recommendations to the full membership.



Standing and ad-hoc work groups and committees discuss specific programmatic and management issues in state health department HIV/AIDS and viral hepatitis programs.

NASTAD's work groups and advisory committees are comprised of AIDS directors or designated senior program staff members interested in working on a particular issue or concern. All members are encouraged to participate in NASTAD via becoming a member of the Executive Committee or participating in a work group or committee!

Here's what NASTAD can help you with:

Accessing Your Colleagues

Linking to your colleagues is very important. A directory of NASTAD members is accessible online – you can pick up the phone or email your colleagues anytime! And, you have a chance each year to meet your colleagues at our Annual Meeting. Also, as part of our approach to technical assistance (TA), NASTAD offers peer-based mentoring to new AIDS directors – an opportunity to regularly check in with a colleague in another health department to answer questions and be a sounding board.

Understand Bureaucratic Structures

Each state health department bureaucracy is uniquely organized, depending on the structure of that state's government. Some AIDS directors are appointed and some are not. HIV prevention and care and treatment are organized under one department in some health departments, but in others, they are administratively separated. The same is true for HIV/AIDS surveillance. In approximately half of state health departments, HIV/AIDS and other STDs are administered in one department and the NASTAD member also is responsible for STD programs. Increasingly, viral hepatitis is also in the "AIDS director's" purview.



Resources

For State AIDS Programs: Go to www.NASTAD.org, click on the State HIV/AIDS Directory in *Featured Resources*

Resources on the NASTAD site:

- Member Services: Information about membership, ways to participate in NASTAD
- NASTAD Member Handbook: Available online and provided in hard copy to all members.
- NASTAD Annual Meeting: held each spring in Washington, D.C.
- Policy and Advocacy: the latest information about policy issues impacting state AIDS and viral hepatitis
- Program Support: the latest information on program requirements, practices and trends.

Creating Vision and Leadership

excerpted from the 2009 NASTAD Leadership Institute

Leaders have a responsibility to staff to lead, inspire, empower, impart knowledge and experience, etc.

– AIDS Director, J/J study

Vision Defined

- The act or power of imagination
- Mode of seeing or conceiving
- Unusual discernment or foresight



Building Success, Policy and Public Health

Leadership Styles – Turning Point

- Directing
- Coaching
- Supporting
- Delegating

• What is your style?
• What do you want your style to be?



Vision is the art of seeing the invisible

– Jonathan Swift



Building Success, Policy and Public Health

Leadership Style: Directing

- Focuses communication on goal achievement
- Gives instructions – what goals to achieve and how
- Limited time on supportive behaviors



Building Success, Policy and Public Health

Leadership Style: Coaching

- Focuses communication on goal achievement AND peoples' needs
- Gives encouragement
- Asks for input
- Ultimately, leader still makes the final decision



Building Success, Policy and Public Health

Leadership Style: Supporting

- Does not focus just on goals
- Focuses on tasks to be accomplished
- Uses supportive behaviors to bring out others

Skills

- Listening
- Praising
- Asking for input
- Giving feedback



Building Success, Policy and Public Health

Leadership Style: Delegating

- Offers less input and social support
- Facilitates others' confidence and motivation to accomplish the tasks
- Leader is not as involved in planning, details or goals clarification



Building Success, Policy and Public Health

On Leadership Skills and Competencies...

Core Competencies for Public Health Professionals

- *from the Public Health Foundation's Council on Linkages Between Academia and Public Health Practice*
 1. Analytical/Assessment Skills
 2. Policy Development/Program Planning Skills
 3. Communication Skills
 4. Cultural Competency Skills
 5. Community Dimensions of Practice Skills
 6. Public Health Sciences Skills
 7. Financial Planning and Management Skills
 8. Leadership and Systems Thinking Skills

Skills that Strengthen AIDS Programs

- *from a NASTAD assessment funded by the Johnson & Johnson Foundation*
 1. Knowledge
 2. Analytical Skills
 3. Passion
 4. Dedication, Persistence and Resilience
 5. Flexibility
 6. Communication and Team Building
 7. Vision

Key Skills of an AIDS Director

- *from the NASTAD assessment referenced above*

Respondent #1

- *Be nosy, ask lots of questions*
- *Have good communication skills*
- *Be able to manage chaos*
- *Think outside the box*
- *Have management skills*

Respondent #2

- *Delegation*
- *Listen to and encourage different opinions*
- *Trusting people*
- *Creating open communication*
- *Creating a strong team*
- *Leading by example*
- *Managing conflicting interests*
- *Political savvy*
- *Effective community recruitment*

Respondent #3

- *Communication skills*
- *Agility/flexibility*
- *Patience*
- *Out of the box thinking (vision)*
- *When to get out of the way*
- *Show by example*
- *Demonstrate the value of the work*
- *Support cross training*

Respondent #4

- *Public health knowledge*
- *Community awareness*
- *Flexibility*
- *Hiring from the community*
- *Building relationships*
- *Collaboration*
- *Cultural competence*

Leadership and Systems Thinking Skills

From the Core Competencies for Public Health Practice

1. Incorporates ethical standards of practice as the bases of interactions with organizations and communities
2. Incorporates systems thinking into public health practice
3. Participates with stakeholders in identifying key values and a shared vision as guiding principles for community action
4. Rectifies internal and external problems that may affect the delivery of essential public health services
5. Sponsors team and organizational learning opportunities
6. Contributes to the measuring, reporting and improvement of organizational performance
7. Modifies public health practice in concordance with changes in the larger social/political environment
8. Establishes mentoring, peer advising, coaching or other personal development opportunities for newer public health workers



[Public Health Leadership Competency Framework](#)

Developed by the National Public Health Leadership Development Network

LEADERSHIP DEVELOPMENT RESOURCES

Standards:

[National Public Health Performance Standards](#)

[The American College of Healthcare Executives - Health Care Executives Competencies Self Assessment \(2008\)](#)

Leadership Development Programs:

[State Public Health Leadership Program](#)

[CDC/CCL/UNC National Public Health Leadership Institute \(PHLI\):](#)

A program offered by the CDC/Center for Creative Leadership/the University of North Carolina. Each year PHLI accepts some 15-20 teams totaling 50-60 public health system leaders.

[J&J UCLA Executive Health Care Management Institute:](#) A management development program for executive directors and leaders of community-based health care organizations.

Leadership Resources:

[The Turning Point Collaborative:](#) Was funded by [The Robert Wood Johnson Foundation](#) - Collaborative Leadership Model. See also: www.collaborativeleadership.org/.

[The Mentoring Group](#)

[Center for Creative Leadership:](#) training on [innovative programs](#), [coaching](#), [assessments](#) and [virtual learning](#)

[Johns Hopkins Maternal and Child Health Leadership Skills Development Series](#)

Other Public Health Leadership and Management Resources:

[Public Health Foundation Workforce Development and Performance Management and Quality Improvement Resources](#)

[National Association of City and County Health Officials Public Health Infrastructure and Systems](#)

[Association of Schools of Public Health](#): Link to schools of public health and competencies for MPH degree

Association of State and Territorial Health Officials (ASTHO) - [State Health Leadership Initiative: Leadership development resources for new state health officials](#). Also, [ASTHO State Health Officials' Guide](#)

[National Quality Center, Institute for Health Care Improvement](#): Quality improvement technical assistance for Ryan White Programs

LINK TO THE [CORE COMPETENCIES](#) FOR PUBLIC HEALTH PRACTICE.

3. PUBLIC HEALTH ORGANIZATION

Core Competencies - Basic Public Health Sciences Skills

- Identifies the individual's and organization's responsibilities within the context of the Essential Public Health Services and core functions
- Defines, assesses, and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Understands the historical development, structure, and interaction of public health and health care systems
- Identifies and applies basic research methods used in public health
- Applies the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries
- Identifies and retrieves current relevant scientific evidence
- Identifies the limitations of research and the importance of observations and interrelationships

3A. Federal Agency Organizational Structure

HIV/AIDS and viral hepatitis services are primarily coordinated and funded through the Department of Health and Human Services. This includes the Centers for Disease Control and Prevention (CDC), based in Atlanta, GA, the Health Resources and Services Administration and the National Institutes of Health, in Maryland, and the D.C.-based Center for Medicaid and Medicare Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Housing and Urban Development (HUD), the Food and Drug Administration, and the Indian Health Service.

Administration

In the Executive Branch of Government, HIV/AIDS policy is driven by the White House Office of National AIDS Policy (ONAP), which is part of the Domestic Policy Council. The ONAP mission is to coordinate an integrated approach to domestic AIDS policy and in 2010, released the [National HIV/AIDS Strategy \(NHAS\)](#) and is working across agencies on implementation.

Department of Health and Human Services (HHS)

OHAP is the principle office advising the Assistant Secretary of Health on HIV/AIDS programs across HHS agencies.

The [President's Advisory Council on HIV/AIDS \(PACHA\)](#) is an independent body that provides recommendations to HHS Secretary on domestic and global HIV/AIDS programs.

[CDC/HRSA AIDS Advisory Committee on HIV and STD Prevention and Treatment \(CHAC\)](#) is convened to provide input and make recommendations to CDC and HRSA on their HIV and STD prevention and treatment activities and programs.

Centers for Disease Control and Prevention (CDC)

At the CDC, the [National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention \(NCHHSTP\)](#) is responsible for public health surveillance, prevention research, and programs to prevent and control human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS), other sexually transmitted diseases (STDs), viral hepatitis, and tuberculosis (TB).

Link to the following program areas:

- [Surveillance](#)
- [Prevention programs](#)
- [STDs](#)
- [Viral hepatitis](#)

- [Youth – Division of Adolescent and School Health](#)
- [Global](#)

Health Resources and Services Administration (HRSA)

The [HIV/AIDS Bureau \(HAB\)](#) administers the programs and resources of the Ryan White Program, which provides care and treatment services for people living with HIV/AIDS. The Division of Service Systems administers Part B (formerly Title II), including the AIDS Drug Assistance Programs, of the Ryan White Program.

The [Bureau of Primary Health Care \(BPHC\)](#) administers the **health center program that provides medical, oral and behavioral health services to uninsured and underinsured individuals** through a nationwide

network of community-based clinics and mobile medical vans. Community health centers predominantly serve Medicaid clients but some also receive Ryan White funds to serve people living with HIV/AIDS.

[Office of Minority Health \(OMH\)](#)

is housed in the office of the HHS Secretary and focuses on minority health. OMH has periodic grant opportunities and many resources,



including: capacity building, conferences, information and referrals, a knowledge center, OMH newsletters, regional offices of minority health and a network of resource persons.

The Center for Medicaid and Medicare Services (CMS)

administers the Medicare and Medicaid programs. The Medicaid program is a needs-based entitlement program jointly funded by the federal and state governments run by the states. Medicare is an entitlement insurance program for the elderly and disabled. Both Medicare and Medicaid provide prescription drug coverage. State AIDS programs often have to navigate a complex system to provide “wrap around services” for the shortfalls individuals on Medicaid/Medicare experience with these programs.

The Substance Abuse and Mental Health Services Administration (SAMHSA)

houses the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services. They provide grants and funding to states and include a strong focus on the co-occurring epidemics. Substance Abuse Prevention and Treatment Block Grant recipients with an AIDS case rate of 10 per 100,000 of population or greater are required to set aside 2–5 percent of their annual Block Grant funding for HIV

Early Intervention Services.

SAMHSA receives Minority AIDS Initiative funding. Most recently, SAMHSA has funded rapid HIV testing initiatives. They also offer TA and mental health grants.

The Department of Housing and Urban Development (HUD) administers the Housing Opportunities for Persons Living with HIV/AIDS (HOPWA)

program, which provides formula and competitive grants to states and localities to provide affordable housing to people living with HIV/AIDS.

The National Institutes of Health (NIH) is the federal agency that is responsible for medical research. Through 27 institutes and centers, NIH conducts or supports/funds research on the range of health issues that impact the nation’s health.

Of most relevance to HIV/AIDS and viral hepatitis, the National Institute of Allergies and Infectious Diseases conducts and supports basic and applied research on infectious diseases that has led to “therapies, vaccines, diagnostic tests and other technologies” that impact HIV/AIDS. It has a specific HIV/AIDS division. NIH also has an Office of AIDS Research that coordinates all HIV/AIDS research throughout NIH.

The Food and Drug Administration (FDA) regulates HIV/AIDS therapies and

medications, HIV diagnostic tests, and other HIV/AIDS related products.

The [Indian Health Service \(IHS\)](#) is responsible for providing health care services to American Indians and Alaska Natives in tribes and via urban Indian programs. The Consultant for the HIV/AIDS program primarily provides consultative services to IHS, tribal and urban Indian facilities on HIV/AIDS issues.

The Department of **Veterans Affairs (VA)** provides health care and benefits to the nation's military veterans and their families and/or survivors. In addition to providing

care services, there is an [HIV Program](#) that is focused on dissemination of information to patients and for clinicians on HIV/AIDS. They also provide [hepatitis C services](#).

The **State Department** is the lead agency for the implementation of the [U.S. President's Emergency Plan for AIDS Relief \(PEPFAR\)](#) through the Office of the Global AIDS Coordinator.

The [United States Agency for International Development \(USAID\)](#) supports the implementation of PEPFAR in nearly 100 countries.



4. MAJOR PROGRAM COMPONENTS

Depending on your jurisdiction, AIDS Directors are tasked with the overall management of HIV/AIDS care and treatment, prevention and integration with programs such as STD's, Adult Viral Hepatitis and Tuberculosis. The following are brief summaries of these and other, linked, programs.

SURVEILLANCE

HIV/AIDS programs conduct surveillance activities to track and monitor the epidemic in their jurisdictions. States have systems in place to conduct this work, and personnel who are responsible for the data, their confidentiality and the reporting and interpretation of these data. They work with local health departments, clinics and other funded agencies to collect this data.

Currently, nearly all states and dependant areas use confidential name-based reporting; however this has not always been the case. In the past, some jurisdictions utilized code or "unique identifier" HIV reporting which potentially posed a challenge when compiling national data. To address the problem, CDC advised in 1999 that all US states and dependent areas conduct confidential name-based HIV case surveillance as part of their AIDS case surveillance activities [1].

This advice was strengthened to a recommendation in 2005 [2]. Compared with HIV reporting systems based on other types of identifiers (such as those based on a code or name-to-code), confidential name-based HIV

reporting has proven to be more cost-effective, and it routinely achieves high levels of accuracy and reliability. Confidential name-based HIV infection reporting is consistent with reporting for other infectious diseases, including AIDS.

As of April 2008, all 50 states, the District of Columbia and 5 dependent areas (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands) use the same confidential name based reporting system for HIV and AIDS.

To ensure the validity of the data, CDC includes HIV infection data from states and dependent areas that have conducted confidential name-based HIV infection reporting for at least 5 years (i.e., since at least 2001), which allows time for stabilization of data collection and for adjustment of the data in order to monitor trends.

HIV/AIDS epidemiology, surveillance and seroprevalence activities provide data that are critical to targeting the delivery of HIV prevention, care and treatment services. State health agencies are uniquely positioned to conduct these activities because of the expertise,

statutory authority, and confidentiality protections of existing public health disease surveillance and reporting systems. States conduct a variety of surveillance activities to track the HIV/AIDS epidemic. The five main types of surveillance are discussed below.

Core Surveillance: Core surveillance is the primary source of population-based data on persons living with HIV and AIDS in the U.S. HIV and AIDS case surveillance is conducted in every state and territory, as well as six cities directly funded by the CDC.¹ Core surveillance programs include monitoring the number of yearly cases of newly diagnosed HIV infections and AIDS cases and identifying trends from surveillance data.

Incidence Surveillance: HIV incidence surveillance was developed to provide reliable and scientifically valid estimates of the number of newly-acquired HIV infections. Jurisdictions conducting incidence surveillance are also eligible to participate in Variant, Atypical, and Resistance HIV Surveillance, a project that collects samples of specific HIV specimens and tracks the different HIV strains seen in the jurisdiction. Jurisdictions funded to conduct incidence surveillance collect and

¹ The six cities directly funded by the CDC are: Chicago; Houston; Los Angeles; New York; Philadelphia and San Francisco.

test blood specimens from all newly reported HIV infections; calculate population-based estimates for HIV incidence; and monitor and track HIV strains for resistance to antiretroviral drugs.

Behavioral Surveillance: The National HIV Behavioral Surveillance project is a multi-year, CDC-sponsored surveillance effort with a goal to measure an extensive set of HIV risk behaviors and related risk factors among selected high-risk populations in 26 cities with the highest number of people living with HIV/AIDS at the end of 2000. The project attempts to identify the prevalence of and trends in men who have sex with men, injection drug users, and heterosexuals with high-risk behaviors.

Medical Monitoring: The Medical Monitoring Project (MMP) is developing a surveillance system that is nationally representative of HIV-infected persons receiving medical care in the U.S. HIV care providers collect the data, with three primary goals: to supplement core HIV/AIDS surveillance data with linked medical record abstractions and patient interviews; to provide data to estimate quality of care, clinical outcomes, risk behaviors, health care utilization and unmet needs among HIV-infected persons receiving medical care; and to provide population-based data to aid in policy planning, resource allocation and evaluation

of prevention and treatment initiatives in the U.S.

Enhanced Perinatal Surveillance:

This program monitors progress made in reducing of perinatal HIV transmission. The near elimination of mother-to-child HIV transmission is the greatest success of HIV prevention in this country. Enhanced perinatal funds have gone to state and local health departments that are in high-

morbidity areas (60 or more HIV-positive women giving birth) that have HIV surveillance.

The **Council of State and Territorial Epidemiologists (CSTE)** convenes an HIV/AIDS Surveillance Coordinators Working Group. A Surveillance Coordinators Handbook has been developed and CSTE is a key HIV/AIDS surveillance resource.

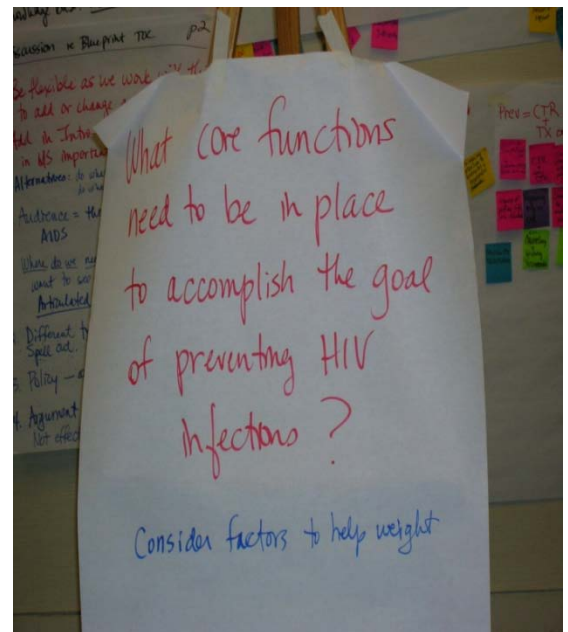
PREVENTION

Each state’s HIV prevention program, or portfolio, may be organized differently and may focus on various HIV prevention strategies and approaches, depending on the nature and size of the local epidemic(s). Many states invest state resources into their HIV prevention programs, which are also funded through cooperative agreements from CDC.

Elements of prevention include:

- Track the Epidemic
- Identify Causes and Solutions
- Implement Prevention Programs
- Build Capacity of State and Local Programs
- Program Evaluation and Policy Development

In response to the National HIV/AIDS Strategy and the imperative to reduce new infections, CDC promoted an approach to prevention they call [Highly Effective Prevention \(HIP\)](#). HIP seeks to target interventions in the populations most at risk for HIV – gay and bisexual men, African Americans, Latinos, people who use injection drugs, and transgender individuals – with scalable and cost effective interventions to “yield a major impact on the HIV epidemic.” The interventions focus on testing and linkages to care, as well as condom availability and prevention for positives.



CDC Prevention Funding to State and Local Health Departments

HIP is a cornerstone of the [funding announcement \(FY 12-1201\)](#) CDC issued in 2011 that directs state and local health department HIV prevention programs. This funding opportunity announcement (FOA), articulated a new CDC FOA 12-1201: Comprehensive HIV Prevention Programs for Health Departments.

In this FOA, CDC articulates three funding streams and specific required and allowed activities for health departments to undertake to realize the goals of HIP.

A. Core prevention programs

With the 2011 FOA, seventy-five percent of the “core” prevention funding must be allocated to CDC’s **required activities**:

- ***HIV testing***: routine testing in health care settings and targeted testing in non-health care settings and venues most likely to reach individuals with undiagnosed infections as well as routine screening for pregnant women and testing for those with other STDs, hepatitis, and tuberculosis.
- ***Comprehensive prevention with HIV-positive individuals***: linkages to care and prevention interventions for those who are HIV positive.
- ***Condom distribution***
- ***Policy initiatives***: Efforts to align structures, policies, and regulations to facilitate prevention and care/treatment.

In addition, up to twenty-five percent of core prevention funding is **allowable** for use to support **other proven HIV activities**, including:

- ***Evidence-based interventions for high-risk populations***: Individual and group-level interventions for HIV-negative people at highest risk of acquiring HIV, community-level interventions to reduce risk behaviors and syringe service programs.
- ***Social marketing, media, and mobilization***
- ***PrEP and nPEP***: support for pre-exposure prophylaxis (PrEP) for men who have sex with men.

These programs must be supported by the following **required activities**:

- ***Jurisdictional HIV prevention planning***: All health departments are required to have in place a prevention planning process, including an HIV prevention planning group (formerly HIV Community Planning Group) composed of a broad range of stakeholders across the continuum of HIV prevention, care and treatment services, and people living with HIV.

- **Capacity building and technical assistance:** Capacity building assistance for local HIV prevention service providers, health department and healthcare facility staff, community-based organizations, and other partners.
- **Program planning, monitoring and evaluation, and quality assurance**

In this FOA, CDC is also continuing to fund [Expanded HIV Testing](#) in locations with high impact (36 jurisdictions with at least 3,000 African American and Hispanic residents living with an HIV diagnosis in 2008), and **Demonstration Projects** – a competitive category for demonstration projects designed to evaluate innovative approaches to HIV prevention.

Prevention Approaches and Resources

Following are overviews and resources on specific prevention approaches.

Counseling, Testing and Referral

(CTR): State health departments received their first federal HIV/AIDS funding in 1988 to conduct HIV testing and counseling services. From that initial infusion, state health department CTR programs have grown and responded to the changes in the epidemic, new testing technologies and new programmatic and administrative structures and reporting requirements. States now have multiple options for testing technologies, including rapid tests, and work with a complex array of lab systems and structures to obtain results and conduct follow-up.

Most recently, states have been working to respond to new recommendations from CDC that seeks to increase the routine use of HIV testing in medical care settings. States have always sought to work with medical providers despite

existing barriers such as reporting requirements, lack of third-party reimbursement for routine HIV screening and (perceived) counseling burdens by medical providers.

However, CDC's [Advancing HIV Prevention approach](#) unveiled in 2003 led to an increased emphasis on the importance of early diagnosis so that infected individuals can gain care and treatment services.

Access [CDC site on testing](#) here

CDC's [recommendations for Counseling, Testing, and Referral \(CTR\)](#)

Partner Services, formerly Partner Counseling and Referral Services (PCRS):

HIV Partner Services, previously known as Partner Counseling and Referral Services (PCRS) reflect the range of services available to HIV infected

persons, their partners, and affected communities. Partner Services has the following goals: Provide services to HIV-infected persons and their sex and needle-sharing partners to avoid infection or if already infected, prevent transmission to others and help partners gain early access to individualized counseling, HIV testing medical evaluation and treatment.

In 2008, CDC is issued [Integrated Guidance for HIV and STD Partner Services](#).

Comprehensive Risk Counseling and Services

Information for CBOs and health departments implementing CRCS (formerly known as Prevention Case Management/PCM) – an intensive, individual level, client-centered risk reduction intervention for people at high risk for HIV infection or transmission.

Effective Behavioral Interventions/DEBIS:

Interventions focused at the individual, group and community level that build skills and strategies to influence changes in behaviors that place people at risk for STD or HIV infection. [Effective behavioral interventions \(EBIs\)](#) have been rigorously evaluated as effective. CDC has packaged a series of these EBIs -, and developed a diffusion program – the Diffusion of Effective Behavioral Interventions (DEBIs) to provide training and technical

assistance on implementation of these strategies.

Community Level Interventions

(CLI): Community level interventions (CLI) seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Group Level Interventions

(GLI): Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. Group-level interventions use peer and non-peer models involving a range of skills, information, education, and support.

Individual Level Interventions

(ILI): Individual Level Interventions are focused at the individual level. Most of these interventions focus on changing behavior based on several theories of health decision-making. Most of the effective behavioral interventions (EBIs) noted below are focused at the individual level.



Structural Interventions:

Structural level interventions focus on the structures, policies and conditions that may contribute to or create risk for HIV/AIDS and viral hepatitis. Within this rubric are things like changing paraphernalia laws related to the possession, sale or exchange of syringes and equipment related to injection drug use.

Link to information on the [Social Determinants of Health](#)

Health Communication/Public Information (HCPI): The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences. The messages are designed to build general support for safe behavior, support personal risk-reduction efforts, and inform people at risk for

infection about how to get specific services. Channels of delivery include electronic media, print media, hotlines, clearinghouses, and presentations/lectures.

Prevention of Perinatal Transmission:

States with remaining perinatal transmission can work with organizations providing prenatal and postnatal care for HIV-infected women to ensure that they receive appropriate prevention counseling and therapies to reduce the risk of transmission of HIV from mother to child.

NASTAD Resources:

NASTAD's **Prevention Advisory Committee (PAC)**, comprised of approximately 10-15 AIDS directors or senior prevention program staff, advises NASTAD on its prevention-focused activities.

NASTAD's **Prevention Networking Group (PNG)** listserv – is a forum for peer-based TA exchange and quarterly calls for dialogue with CDC on prevention issues.

CARE AND TREATMENT

State HIV/AIDS care and treatment programs provide comprehensive HIV/AIDS care, treatment and support services to individuals living with HIV or AIDS. As the “payer of last resort,” the state Ryan White programs are the so-called safety net for primary medical care and essential support services for those individuals who are not covered through public assistance (Medicaid/Medicare) or private insurance. State AIDS programs manage a complex array of services and data needs related to the provision of care and treatment services in their state.

Ryan White Program: The Ryan White Program is enacted through federal legislation to address unmet healthcare needs for persons living with HIV by providing for primary health care and support services that enhance access to and retention in care. Originally enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the Ryan White Program has been reauthorized four times. The Ryan White Program provides funding for services to via “parts” of the program. There are six parts, “A” – “D,” “F” and “G”. Information is available at

Part A: Part A of the Ryan White Program provides funding to cities – Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) - for AIDS services. Designated

EMAs must have 2,000 AIDS cases or more reported in the last five years. The eligibility for TGAs is 1,000 – 1,999 AIDS cases reported in the last five years. Two-thirds of funding is distributed by formula and one-third through a competitive supplemental process.

The grants go directly to the city government, and there are different mandates for Part A grantees, including the requirement for planning councils that make service priority and funding allocation decisions.

Part B: Part B of the CARE Act provides funds to all states, the District of Columbia, Puerto Rico, and U.S. territories to improve the quality, availability and organization of care services for people living with HIV. Part B is designed to assure that people living with HIV have access to quality medical care, regardless of whether they live in rural, suburban, or urban areas.

Part B base (non-ADAP) funds may be used to support a wide range of services including outpatient medical and dental care, supportive services (e.g., case management and client transportation services), rehabilitative services, home and community-based health care services, and continuation/purchase of health insurance coverage.

States may also use Part B base funds to support HIV counseling, testing and referral services in care

settings. Part B base funds allow states to provide a continuum of care services that are critical components of comprehensive HIV care, the hallmark of the Ryan White Program.

Part B also provides supplemental grants to states to support HIV services in emerging communities—cities reporting between 500 and 999 reported AIDS cases in the most recent five years.

States also receive \$7 million for outreach to minority communities to bring individuals into ADAP through the Minority AIDS Initiative.

The 2006 reauthorization of the Ryan White program required that 75 percent of Part B funds be used for “core services,” defined as essential medical care to include: outpatient and ambulatory health services; pharmaceutical assistance; substance abuse outpatient services; oral health; medical nutritional therapy; health insurance premium assistance; home health care; hospice services; mental health services; early intervention services; and medical case management, including treatment adherence services.

ADAP: The AIDS Drug Assistance Program (ADAP) provides medications for the treatment of HIV disease. ADAPs are state-administered drug programs that provide access to HIV/AIDS medications for low income,

uninsured and underinsured individuals. Program funds may also be used to purchase health insurance for eligible clients, as well as, for services that enhance access, adherence and monitoring of drug treatments. Each state and territory establishes its own criteria for eligibility.

However, all states require that programs participants document their HIV status. The majority of states (40) provide state general

revenue funding to augment federal ADAP dollars.



Emerging Communities: Emerging Communities (ECs) were set up under the 2000 reauthorization of Ryan White to provide additional funding to metropolitan statistical areas (MSAs) that are ineligible for Title I (now Part A) funds, and had a population of at least 500,000 persons. To be an EC a jurisdiction must have 500-999 AIDS cases reported in the last 5 years. Distribution is all formula. States must agree that the grant will be used to provide funds directly to their EC(s), separately from other Part B funds that are provided by the state to ECs.

ADAP Supplemental: ADAP supplemental grants are funded

through a 5 percent set-aside of the overall ADAP earmark and are intended to assist states in severe need. There is a state match requirement (1 state to every 4 federal dollars). To be eligible, states must meet these criterions:

- Financial requirement of Federal Poverty Level (FPL) < 200 percent;
- Limited formulary compositions for all core classes of antiretroviral medications (ARVs);
- Waiting list, capped enrollment or expenditures; and
- An unanticipated increase of eligible individuals with HIV/AIDS.

[Statewide Coordinated Statement of Need \(SCSN\)](#): Part B programs are responsible for coordinating the Statewide Coordinated Statement of Need (SCSN), which is meant to assess needs across all Parts of the Ryan White Program – all Parts are expected to participate. The stated goal for the SCSN is to enhance coordination across Ryan White Programs. If you are an AIDS director in a state with Part A EMAs in your jurisdiction, your program will be expected to work closely with the Part A grantees, including involving them and the other Parts of the Ryan White Program in developing the Statewide Coordinated Statement of Need.

According to HRSA, “The SCSN must reflect, without replicating, existing needs assessments. The SCSN

process should include a brief overview of epidemiologic data, existing quantitative and qualitative information, and emerging trends/issues affecting HIV/AIDS care and service delivery in the State. The SCSN must identify broad goals, cross-cutting issues, and critical gaps in services for PLWH throughout the State.”

[Part C](#) funds early intervention services for primary care providers. Services including case management, risk reduction counseling and ARVs are provided through health centers, family planning clinics, community and faith based agencies funded through this part of the Ryan White Program.

Federally funded Health Centers strive to reduce and eliminate health disparities among medically underserved communities by providing comprehensive, affordable care that is responsive and customized to low-income, racial and ethnic minority communities.

There are over 1000 community, migrant, and homeless health centers located in over 3600 urban and rural communities. Health Centers provide accessible, affordable and high quality care to nearly 16 million patients nationally. [Federally Qualified Health Centers \(FQHCs\)](#) are a large subset of health centers and include all organizations receiving grants under Section 330 of the Public Health Service Act.

They may be located in rural and urban areas, but must serve a medically underserved area or population.

Part D grants support services for women, infants, children & youth (WICY). Part D recipients provide primary and specialty medical care, support services and logistical support and coordination to women, infants, children and youth living with HIV. Information available at:

Part F - four program areas:

1. [Special Projects of National Significance](#) – grants to support research and development grants on innovative and effective service delivery models.
2. [AIDS Education & Training Centers](#) – funds eleven regional centers that train Ryan White providers
3. [Dental Programs](#) – a program to provide dental services and education and training for oral health providers
4. [Minority AIDS Initiative](#) – Parts A, B, C and D receive funding to provide services to address the disproportionate impact of HIV/AIDS in racial/ethnic minority communities.

Part G was added during the most recent extension of the Ryan White Program and relates to the notification of emergency response employees upon exposure to

infectious diseases. It is not solely focused on HIV nor does it affect the implementation of Ryan White Programs and grants.

MEDICAID AND MEDICARE

Part D

Medicaid and Medicare are administered out of the [Center for Medicaid and Medicare Services \(CMS\)](#).

Medicaid is the nation's major public health program for low-income Americans and is the largest source of funding for HIV/AIDS care in the U.S. Half of all adults and 90% of children with HIV/AIDS are enrolled in the program. Medicaid is a means tested entitlement program jointly funded by the federal and state governments. To be eligible for Medicaid, individuals must be in a qualifying category and meet state-defined income and asset criteria. Since each state administers its own ADAP, they have their own criteria for determining the eligibility of Medicaid recipients for ADAP. Most ADAPs have electronic access to their state Medicaid databases, which enables them to verify client eligibility and compliance with their requirements. Some states support "wrap-around" coverage for HIV-positive Medicaid beneficiaries to receive the full complement of their needed medications.

Medicare Part D is a prescription drug benefit enacted with the Medicare Modernization Act in December 2004. Meant to mirror private insurance managed care programs, Medicare Part D is the part of this act which allows beneficiaries to purchase a prescription drug plan. This program requires the payment of a monthly premium and has specific benefits outlined. A key problem with this program has been what has been called the “donut hole,” whereby after the beneficiary reaches both the deductible limit and the initial coverage limit, they must pay 100% of the drug costs until they reach the out-of-pocket threshold (a total of \$4,550 in 2010).

ADAPs are required to ensure that all [Medicare Part D eligible clients](#) are enrolled in a prescription drug plan. Most ADAPs work to provide wrap around coverage for their clients who are enrolled in Medicare Part D.

ADULT VIRAL HEPATITIS

Millions of Americans are at risk of hepatitis A virus (HAV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infection and millions more are living with chronic viral hepatitis. Transmitted in many of the same ways, viral hepatitis and HIV/AIDS are infectious diseases that have drastic, long-term medical, economic, and social consequences for those infected with either or both viruses. State health departments, in collaboration

with federal partners, local health departments and community based organizations, have been responding to the complex viral hepatitis prevention and care needs of their constituencies for many years. Meeting the challenges posed by viral hepatitis requires close coordination with existing state and territorial HIV/AIDS programs.

The Division of Viral Hepatitis (DVH) at CDC provides the scientific and programmatic foundation for the prevention, control, and elimination of hepatitis virus infections in the U.S., and assists the international public health community in these activities. In FY2007 DVH received \$17.8 million to address viral hepatitis, of which nearly \$5 million was provided to states to address adult viral hepatitis prevention. CDC provides funding to 48 states, three cities and the District of Columbia to support an adult viral hepatitis prevention coordinator position.



The role of the coordinator is to work with other public health programs to integrate viral hepatitis

prevention services into existing settings (e.g., STD and HIV clinics). The average funding award of \$80,000 in FY2007 supports little more than personnel costs, leaving no funds for service provision (e.g., hepatitis A and B vaccine, hepatitis B and C testing). CDC's budget for addressing chronic adult viral hepatitis was \$17.8 million in FY2007.

As historical context, state health departments were first funded by CDC in 2000 to develop and implement HCV prevention programs. This funding supported a HCV coordinator position in each funded jurisdiction. Since that time, HCV coordinators have strengthened state responses to adult viral hepatitis prevention and care. However, due to limited federal and state funding for viral hepatitis prevention, health department programs are struggling to provide comprehensive prevention services to individuals at risk.

Most states still do not have HCV counseling and testing programs, adult HAV/HBV vaccination programs, or the capacity to collect surveillance data to monitor the epidemic in their state.

Despite these real barriers, some states have been able to develop hepatitis plans, implement provider trainings, institute limited HCV counseling and testing programs

and provide limited adult HAV/HBV vaccination programs.

The Adult Viral Hepatitis Prevention Coordinators (AVHPCs) are the backbone of our nation's effort to provide high quality primary and secondary prevention to individuals at risk and link infected persons to appropriate support and treatment providers. A hallmark of AVHPCs is their ability to work collaboratively with partners within and outside of the health department to integrate hepatitis prevention messages into existing HIV/AIDS, STD and immunization programs. AVHPCs provide support to one another but also rely heavily on health department HIV/AIDS, STD and immunization programs to construct their state's response to viral hepatitis.

Most states are now poised to mount a more robust prevention program should additional funds become available to support hepatitis services to communities at risk. In the meantime, programs require consistent, high quality and in depth technical assistance to support their efforts in their jurisdictions and as they continue to mature and grow into a strong coordinated national viral hepatitis prevention program.

Since 2004, the NASTAD Viral Hepatitis Work Group (VHWG) has been the primary vehicle within NASTAD to provide support and technical assistance to health

department hepatitis and HIV/AIDS program staff. The VHWG, which is comprised of state and city health department viral hepatitis, HIV and STD program staff, holds monthly conference calls which serve as a forum for health department staff to discuss program development, implementation, and integration and evaluation issues.

In 2007, CDC's DVH was relocated into the National Center for HIV/AIDS, *Viral Hepatitis*, STD and TB Prevention (NCHHSTP). This change will increase coordination across HIV, STD, TB and viral hepatitis programs, which provide prevention services to similar populations.

LINKED PROGRAMS

Note: Among the programs outlined below, STDs, TB, and global AIDS are co-located at the CDC National Center for HIV/AIDS, STD, TB and Viral Hepatitis (NCHHSTP).

STDs: State and local public health agencies administer both HIV and [STD prevention and care services](#) and have worked to closely link these programs to strengthen efforts in addressing these co-morbidities.

Federal funding for STD prevention and treatment has been in existence since the early part of this century and is currently administered by CDC under general authority. CDC's total FY2005 STD prevention and treatment budget is approximately

\$160 million. Of this, approximately \$121 million was provided directly to state and local health departments. State STD prevention programs also provide surveillance and data management, leadership and program management, outbreak response plans, and evaluation activities.

The Division of STD Prevention (DSTDP) conducts surveillance; epidemiologic, behavioral, and operations research; and program evaluation related to STDs, including syphilis, gonorrhea, Chlamydia, human papillomavirus and genital herpes. The Division assists States and selected localities in reaching those at risk for infection with STDs.

The [National Coalition of STD Directors \(NCSDD\)](#) represents the 65 Directors of public health sexually transmitted disease prevention programs in states, large cities/counties and territories of the United States. NCSDD strengthens STD Programs by advocating for effective policies, strategies, and sufficient resources.

[TUBERCULOSIS \(TB\)](#): The nation's response to tuberculosis (TB) is housed in the same Center at CDC as HIV. The Division of TB Prevention distributes funds to state TB Control programs and conducts research and evaluation. TB is a nationally notifiable disease reported in the TB Surveillance System.

Because individuals with HIV are at high risk for TB disease, CDC recommends that all those screened for TB receive HIV screening as well. There are specific treatment regimens for TB patients who are co-infected with HIV.

Furthermore, TB disproportionately impacts racial/ethnic minority populations – CDC reports that 82 percent of all TB cases in the U.S. in 2004 were among racial/ethnic minorities.

SUBSTANCE ABUSE/MENTAL HEALTH: Contemporary approaches to HIV/AIDS prevention and care recognize a much more complex set of needs among those we serve than simply HIV/AIDS services. These needs include access to stable housing, mental health and substance use services. While HIV/AIDS programs in health departments and in community-based organizations may not be professionally-qualified to provide these services there is always room to better inform providers so they can, in turn, provide informed referrals for these essential services.

There is considerable overlap across mental illness diagnoses, substance use issues, and HIV risk. Given this overlap, HIV/AIDS programs can often build more collaborative relationships with counterparts in mental health and substance abuse state agencies. This collaborative relationship can help to model similar relationships among

providers who may, more often than they realize, be shuffling the same client from program to program. The desired result through collaboration can be a more holistic approach in meeting the clients' needs.

The [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) and the [Center for Mental Health Services \(CMHS\)](#) lead the Federal efforts in expanding the availability and accessibility of high-quality, community-based services for adults with serious mental illnesses and children with serious emotional disturbances. CMHS administers the Mental Health Services Block Grant Program, as well as a portfolio of discretionary grant programs that include efforts to help prevent mental health problems.

The Center collects, analyzes and disseminates national data on mental health services and supports SAMHSA's National Mental Health Information Center that provides a one-stop source for free information, resources and referrals on mental health topics. Additional centers at SAMHSA include the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT).

Established in 1993, this funding is used by states for substance abuse prevention and treatment, including provisions for addressing injection

drug use, and to provide HIV testing and services.

In 2005, SAMHSA administered a rapid HIV testing initiative to provide funds to sites that had capacity to conduct these type of HIV tests.

HOUSING: The [Housing Opportunities for People with AIDS \(HOPWA\) program](#) is administered through the Department of Housing and Urban Development (HUD) and is the federal program to provide housing support for people living with HIV/AIDS. Created in 1990, HOPWA is a formula-funded, flexible program that gives states and localities hardest-hit by the AIDS epidemic desperately needed resources and local control over the use of these resources to meet the housing needs of people with HIV/AIDS.

In FY2007, states and local jurisdictions received \$286 million for HOPWA services. HOPWA will serve approximately 63,000 people with these funds. In some states, the HIV/AIDS program administers the HOPWA funds, and in others, it is housed elsewhere in the state bureaucracy.

CORRECTIONS: The role of state health departments in delivering HIV/AIDS programs to incarcerated populations varies widely from state to state. In some states, the health department educates inmates about HIV/AIDS and provides counseling

and testing in certain correctional facilities. It may also fall to the health department to educate the staff in correctional facilities about HIV/AIDS transmission and the importance of HIV/AIDS prevention education in addition to care and treatment for inmates. For those incarcerated individuals who are HIV-positive, the health department can play a part in developing a discharge plan for those individuals that will help them identify HIV service providers in the community to which they are returning.

It is imperative that health departments build a relationship with the department of corrections within the state bureaucracy but also with the individual prison or jail facilities' administrators where the health department would like to work. Once invited into a facility, a health department needs to adhere to the stipulations established by that prison or jail facility and accept that these requirements are in place for a reason.

Given the fact that the same communities that are disproportionately impacted by HIV/AIDS are the same communities that are disproportionately affected by incarceration, working with the department of corrections and with individual facilities presents an important opportunity to educate, counsel and test, and provide discharge planning support for

inmates who will return to the communities from which they came.

ADDRESSING RACIAL/ETHNIC HEALTH DISPARITIES

In the HIV/AIDS epidemic, most racial/ethnic minority populations are disproportionately impacted by the epidemic compared to their proportion in the overall U.S. population. The impact is particularly acute in African American communities.

Minority AIDS Initiative: The Minority AIDS Initiative (MAI) was created in response to the growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. In October 1998, President Clinton declared HIV/AIDS to be a severe and on-going health crisis in racial and ethnic minority communities. In response, the Administration, the Department of Health and Human Services (HHS), the Congressional Black Caucus, and the Congressional Hispanic Caucus announced a special package of initiatives aimed at reducing the impact of HIV/AIDS on racial and ethnic minorities.

Since its passage in 1999, the Minority HIV/AIDS Initiative (MAI) has worked to address health disparities within communities of color in various federal programs. The Minority HIV/AIDS Initiative provides funds to community-based organizations, faith communities, research institutions, minority-

-serving colleges and universities, health care organizations, state and local health departments, and correctional institutions to help them address the HIV/AIDS epidemic within the minority populations they serve.

Administration of the MAI is decentralized across eight federal agencies and offices, primarily within the Department of Health and Human Services (DHHS). The MAI is funded through the Labor, Health and Human Services appropriations bill, and report language for the bill directs the vast majority of MAI funds to specific DHHS agencies for use in programs serving racial and ethnic minority communities. These agencies and offices provide funding to eligible entities through grants and cooperative agreements. Today, the MAI supports over 50 distinct programs targeting racial and ethnic minorities, including the highest risk and hardest to serve populations.

The Minority AIDS Initiative (MAI) has been codified by the Congress under Title XXVI of the Public Health Service (PHS) Act by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program). The MAI includes competitive grants for eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) funded under Part A of the Ryan White Program for the purpose of improving "...HIV-related health outcomes to reduce existing racial

and ethnic health disparities” and Part B for the purpose of “education and outreach services to increase the number of eligible racial and ethnic minorities who have access to treatment through” the Part B AIDS Drug Assistance Program (ADAP).

Additional resources can be accessed by the [Office of Minority Health Resource Center](#).

State Responses: State health department HIV/AIDS programs should be aggressively addressing this disproportionate impact. NASTAD has made addressing racial/ethnic health disparities in the HIV/AIDS and viral hepatitis epidemics a strategic organizational priority, and has issued numerous policy and technical resources to support these efforts. These and other resources articulate the particular socio-economic and cultural factors that impact HIV/AIDS risk among various racial/ethnic minority populations. They also provide ideas and strategies currently underway in several states to address disparities.

States are expected to address the disproportionate impact of HIV/AIDS in communities of color through their various planning activities for HIV prevention and care and treatment planning, and to fund culturally-specific and relevant interventions and programs. Many states have implemented or adapted effective behavioral interventions as

part of CDC’s DEBI project for minority populations in their state. Many states have also created specific testing and outreach campaigns aimed at African Americans or other racial/ethnic minority populations that are in these communities.

Offices of Multicultural Health:

In state health departments, many HIV/AIDS programs have successfully worked with their multicultural health office, or some other specific branch or unit focused on multicultural health. These offices/units can access support from the Office of Minority Health Regional Minority Health Consultants in the 10 Department of Health and Human Services (HHS) Regional Offices around the country. These offices provide TA to the state minority health personnel and community groups. Additionally, the OMH Resource Center (OMHRC) provides information and capacity building assistance on addressing health disparities.

SCHOOL HEALTH/School Based Comprehensive Sex Education:

The Division of Adolescent and School Health (DASH) is the division within CDC that provides support to state, territorial, and local education agencies for programs focused on child and adolescent health in the following areas: abstinence, asthma, coordinated school health programs, food safety and HIV prevention.

Abstinence-only versus Comprehensive Sexuality Education

Three basic concepts guide the abstinence versus comprehensive sex education debate:

- **Abstinence-only:** the programs that support only an abstinence message, usually focusing on a heterosexually-based abstinence-until-marriage approach.
- **Abstinence-based:** programs which may support abstinence as the primary message, but which also provide accurate information about disease and pregnancy prevention for those youth who are sexually active.
- **Comprehensive sexuality education:** provides comprehensive information about sexuality, including information about disease prevention, pregnancy prevention, abstinence and respect for various sexual identities.

Both the abstinence-based and comprehensive sexuality education approaches endorse the view that delay of sexual debut is beneficial for youth, and will help prevent not only pregnancy but sexually transmitted disease. HIV and adolescent health advocates have long denounced abstinence-only programs as not only an attempt to promote a specific morality, but also ineffective in achieving the desired results of sustained abstinence, and decreased disease and pregnancy. However, the growing body of science demonstrating that abstinence-only programs are ineffective has helped bolster the willingness of scientists to stand with advocates and speak out against these programs.

Two agencies with detailed information and dedicated efforts to support comprehensive sexuality education are the [Sexuality Information and Education Council of the United States \(SIECUS\)](#) and [Advocates for Youth](#).

ADVICE FROM THE FIELD

- Find out where programs are located within the government structures.
- Build relationships and take advantage of cross training.



5. TA AND RESOURCES

As an AIDS director, you should become familiar with the Technical Assistance (TA) and Capacity Building Resources (CBA) resources that are available to support your programs and services. Usually, there is some form of TA and/or capacity building that your own program provides to its funded grantees. In addition, you may contract with a local university or other provider for TA or capacity building services. For example, many states contract out management and TA for the community planning process.

Is it TA or CBA?

Technical Assistance (TA) is generally considered to be information sharing or skills building around a specific topic or programmatic area or concern. TA may be one-time only or provided over a short-term timeframe. It may be delivered on-site, electronically, or via webinars/telephone, as well as at regional and national conferences and meetings. It is geared towards building skills or knowledge to make a specific change or action for program improvement.

Capacity building is generally considered to be sustained support and training to build the competencies of an organization or individual to carry out the duties for that organization or individual's responsibility.

Within CDC, [Capacity Building Assistance \(CBA\)](#) is the overarching rubric around which all TA and CBA is organized.

In other venues, including HRSA, TA is the generally accepted and acknowledged rubric for all assistance provided to achieve program improvements.

CDC-Funded Capacity Building Assistance (CBA) and Regional Training: CDC funds several national and regional organizations to provide TA and CBA to the community based organizations they fund directly, as well as to state and local health departments. Health departments that wish to request CDC-funded TA/CBA should work with their project officer and make the request through CDC's on-line Capacity Building Request Information System (CRIS).

[Prevention Training Centers \(PTCs\)](#): CDC funds ten Prevention Training Centers (PTCs) to provide STD and HIV technical assistance and training on STD clinical services, behavioral interventions, partner services and program support, and satellite broadcasts.

[National Prevention Information Network \(NPIN\)](#): The NPIN is an on-line resource for HIV, STD and TB information, training and resources sponsored by CDC.

NPIN also has a [daily news summary/listserv](#).

HRSA TA

HRSA funds the [Target Center](#), which organizes the technical assistance services available via HRSA. This includes TA focused on ADAPs (via NASTAD), assessing unmet need, capacity development, consumer involvement, care delivery, evaluation and data and strategies to combat stigma. HRSA funds these programs through cooperative agreements with national organizations and TA providers.

AIDS Education and Training Centers (AETCs)

There are eleven regional [AIDS Education Training Centers \(AETCs\)](#) and four national centers to support provider training for HIV/AIDS care and treatment services. The eleven regional centers serve multi-state areas.



NASTAD TA

NASTAD provides peer-based TA across HIV/AIDS prevention and care and treatment and viral hepatitis programs. Peer-based TA is provided by health department staff in other HIV/AIDS and viral hepatitis programs through NASTAD's TA program. NASTAD staff work closely with the requesting jurisdiction to match them up with peers that can respond to the specific request. NASTAD also gathers materials and supports electronic networking and sharing of peer-based materials. Visit: www.NASTAD.org.

Advice from the Field

- Don't be afraid to ask for help – from your peers, your project officer, CBA/TA resources.
- Get to know the systems and best way to request TA...and how to request that the TA be tailored to *your* needs.

6. GLOSSARY & Acronyms

Many of these terms are further defined within the body of this Toolkit or in Appendix 1 (AIDS 101), but are listed here to clarify the acronyms. Online HIV/AIDS Glossaries are also available:

- <http://www.thebody.com/content/art12815.html#>
- <http://www.aidsinfo.nih.gov/Glossary/GlossaryDefaultCenterPage.aspx>

Abstinence-only:

programs that promote the concept of abstaining from sexual intercourse, to the exclusion of safer-sex messages. Usually includes a context of abstinence until heterosexual marriage.

ADAP: AIDS Drug

Assistance Programs. Program managed out of state Part B (formerly Title II) of the Ryan White Program, administered by HRSA that provide AIDS drugs to eligible individuals.

AIDS: Acquired Immune Deficiency Syndrome.

AETC: AIDS Education and Training Centers

Anonymous: In HIV/AIDS, this relates to the availability of testing for HIV without providing identifying information. The results of anonymous tests are not counted in surveillance systems.

APR: Annual Progress Report

ARV: Anti-Retro Virals – a drug that stops or suppresses the activity of a retrovirus

ASO: AIDS Service Organization, local AIDS-specific services agency.

CADR: Ryan White CARE (Comprehensive AIDS Resources Emergency) Act Data Report. This report is now called the Ryan White HIV/AIDS Program Report.

CBA: Capacity Building Assistance. Term used by CDC to encompass technical assistance and support to build capacity to provide HIV prevention services.

CBO: Community based organization that may have HIV/AIDS program among other services available to the local community.

CDC: Centers for Disease Control and Prevention. Main federal agency within the Department of Health and Human Services which oversees disease investigation and prevention services. Based in Atlanta, GA.

CD4: the part of the cell that allows HIV to attach and enter the cell. The destruction of CD4 cells drive the progression of HIV infection.

CMS: the federal Centers for Medicare & Medicaid Services

Code-based: A surveillance system that generates a unique identifier, or code to keep and track information on individual HIV/AIDS cases. Originally designed to address confidentiality concerns, health departments are phasing into name-based systems to meet CDC and HRSA requirements.

Co-factors: Other things impacting HIV/AIDS risk or exacerbating HIV disease progression.

Combination Therapy: using more than one drug simultaneously to combat a specific disease.

Community Planning: Planning processes that involve the input of infected and affected communities in the determination of needs, priorities and funding for HIV/AIDS prevention, care and treatment programs.

Confidential: In HIV/AIDS, this means information that is collected on individual HIV/AIDS cases is kept confidential and is not

NASTAD AIDS Director Planning Guide and Toolkit

shared outside a specific section or person within the health department.

Core Services/Core

Medical Services: Specific services provide through care and treatment programs, as articulated in the Ryan White Program.

CPG: Community Planning Group. Common acronym for HIV prevention planning groups mandated by CDC.

Consortia: Commonly used to refer to community planning bodies allowed but not required for planning of statewide care and treatment programs. Have fewer parameters and requirements than either prevention planning or Part A planning councils.

CRCS: Comprehensive Risk Counseling and Services. Broadened scope and new acronym to refer to services for partners of HIV infected individuals.

CTR: Counseling, Testing and Referral Services.

DASH: Division of Adolescent and School Health at CDC

DEBI: Diffusion of Effective Behavioral Interventions – a set of interventions that have been demonstrated to be effective and which are packaged and endorsed by CDC.

DHAP: Division of HIV/AIDS Prevention – main CDC domestic HIV/AIDS division, including surveillance and

epidemiology, program management, capacity building, evaluation and science branches. Part of NCHHSTP

DVH: Division of Viral Hepatitis at CDC. Part of NCHHSTP

EBI: Effective Behavioral Intervention

ELISA: Standing for Enzyme-Linked Immunosorbent Assay this is a type of assay to determine whether there are HIV antibodies present in blood or oral fluids. Should be followed by a confirmatory/validation test (western blot).

FSR: Financial Status Report, final report required by funding agencies 90 days after the end of the budget period, that details expenditures, obligations, un-obligated balances and carryover.

GLI: Group Level Interventions

HAART: Highly Active Anti Retro Viral Therapy. Aggressive treatment regimen to suppress HIV replication and disease progression. Combination therapy of 2 or more classes of drugs.

HAB: HRSA's HIV/AIDS Bureau

HAV: Hepatitis A virus

HBV: Hepatitis B virus

HCV: Hepatitis C virus

HERR: Health Education and Risk Reduction.

HHS: U.S. Department of Health and Human Services

HIV: Human Immunodeficiency Virus

HOPWA: Housing Opportunities for People Living with HIV/AIDS. Administered by HUD (Department of Housing and Urban Development).

HRSA: Health Resources and Services Administration. Federal agency administering the various Parts of the Ryan White Program for care and treatment of persons living with HIV/AIDS. Based in Rockville, MD.

IDU: Injection Drug Use

ILI: Individual Level Intervention

Informed Consent: Usually required in writing, indication that a person participating in a research, evaluation study or taking an HIV test is aware of the purpose of the study, the risks and benefits of participation, and how their information will be used.

IPR: Interim Progress Report

IRB: Institutional Review Board

Incidence: the number of new cases of disease

occurring over a specific period of time.

Indicators: those measures or benchmarks that indicate whether a goal has been met.

MAI: Minority AIDS Initiative

Medicare Part D: A prescription drug benefit enacted with the Medicare Modernization Act in December 2004.

Meth: Crystal Methamphetamine. A club drug, also known as "Tina" or "crystal," popular with MSM, but also broadening in its reach, especially in rural areas.

Name-based: In HIV/AIDS, the surveillance system that collects information on HIV/AIDS confidentially by name.

NASTAD: National Alliance of State and Territorial AIDS Directors

NCHHSTP: National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention at CDC.

NCSD: National Coalition of STD Directors

PCRS: Partner Counseling and Referral Services. Partner Notification is another, earlier term for work to follow up with partners of infected individuals.

PGO: Procurement and Grants Office. The office in each federal agency responsible for disbursement of funding and oversight of federal grant and cooperative agreement funds.

PEMS: Program Evaluation Management System, the system for evaluating HIV prevention programs at CDC.

Planning Council: Ryan White Part A requires local jurisdictions to convene a planning council to assess care and treatment needs and make funding service priority and decisions for use of Part A funds.

Prevalence: The proportion of people living with a disease at a given time.

Protease Inhibitor: Drugs which inhibit the protease enzyme which then prohibits replication of the HIV virus.

Rapid Test: Visually-interpreted HIV screening tests that provide results in a short time frame, may be administered at point of service or non-traditional settings in some cases, and require no instrumentation. Positive tests require confirmation.

Retrovirus: a virus that stores its genetic information in the cell, and then inserts this information into the DNA of that cell.

Reverse Transcriptase

Inhibitor: RTIs inhibit/impact the cell process of converting RNA to DNA. AZT is an RTI.

RWCA: Ryan White CARE Act, with CARE standing for Comprehensive AIDS Resources Emergency. The program, named in honor of the Indiana youth who championed increased acceptance of those living with HIV/AIDS and provision of comprehensive services, that provides the safety-net for funding care and treatment of persons living with HIV/AIDS who are not otherwise covered through private insurance or public assistance.

SAMHSA: Substance Abuse and Mental Health Services Administration

Seroprevalence: the proportion of individuals who have presence of HIV infection

Serostatus: for HIV, the results of a test that confirm whether or not there is HIV present.

SPNS: Special Projects of National Significance, demonstration projects funded through the Ryan White Program via HRSA

STD: Sexually Transmitted Diseases also known as STI.

Surrogate Marker: Presence of another disease or condition which would, by association with related risk behavior for

NASTAD AIDS Director Planning Guide and Toolkit

transmission of HIV/AIDS, indicate risk for HIV/AIDS.

TA: Technical Assistance

Title I, Title II: Previous to the 2006 reauthorization of the Ryan White Program, this program referred to the various parts of the program as Titles. Title I was for funding to cities, Title II to states, etc.

T-cell: white blood cells that find and fight infection

VCT: Voluntary Counseling and Testing. Commonly used in global HIV/AIDS

Vertical Transmission: Transmission of infection from pregnant mother to child.

Viral Load: the amount of virus RNA contained in the blood of someone infected with HIV.

Western Blot: A confirmatory HIV laboratory test for repeatedly reactive HIV antibodies

ADAP Related Acronyms

ACTF - ADAP Crisis Task Force

ACTG – AIDS Clinical Trials Group

ADAP - AIDS Drug Assistance Program

ADR – Adverse Drug Reaction

AETC- AIDS Education Training Center

AHRQ – Agency for Healthcare Research and Quality

AMDP – Alternative Methods Demonstration Project

AMP - Average Manufacturer Price

AQR – ADAP Quarterly Report

ARC – AIDS - Related complex

ARV – Antiretroviral

ASO – AIDS Service Organization

AWP - Average Wholesale Price

BP - Best Price

BPHC – Bureau of Primary Health Care

CBO – Community Based Organization

CCR5 – Chemokine receptor 5

CD4 - Cluster of Differentiation 4 co-receptor

CDC – Centers for Disease Control and Prevention

COB – Coordination of Benefits

CMS - Centers for Medicare and Medicaid Services

COBRA - Consolidated Omnibus Budget Reconciliation Act

CPCRA – Community Programs for Clinical Research on AIDS

CPI – Consumer Price Index

CXCR4 – Chemokine receptor 4

DCBP - The Division of Community-Based Programs inside HIV/AIDS Bureau

DHHS - Department of Health and Human Service

DRP - Dental Reimbursement Program

DSP - The Division of Science and Policy inside HIV/AIDS Bureau

DSS - The Division of Service Systems inside HIV/AIDS Bureau

DTTA - The Division of Training and Technical Assistance inside HIV/AIDS Bureau

EIS – Early Intervention Services

EMA- Eligible Metropolitan Area

FCP - Federal Ceiling Price

FDA – Food and Drug Administration

FPC – Fair Pricing Coalition

FSR – Financial Status Report

FSS - Federal Supply Schedule

HAART- Highly Active Antiretroviral Therapy

HAB - HIV/AIDS Bureau

HBV – Hepatitis B Virus

HCFA – Health Care Financing Administration

HCV – Hepatitis C Virus

HICP – Health Insurance Continuation Program

HOPWA – Housing Opportunities for Persons with AIDS

HRIP – High-risk insurance pool

HRSA - Health Resources and Services Administration

HUD – Department of Housing and Urban Development

IDU – Injection Drug User

IFN – Interferon

NASTAD AIDS Director Planning Guide and Toolkit

II - Integrase Inhibitor
IVIG – Intravenous Immunoglobulin
LIS – Low Income Subsidy
MAI - Minority AIDS Initiative
NASTAD – National Alliance of State and Territorial AIDS Directors
NDA – New Drug Application
NDC – National Drug Code
NIAID – National Institute of Allergy and Infectious Diseases
NIH – National Institutes of Health
NNRTI – Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI – Nucleoside Reverse Transcriptase Inhibitor
OAR – Office of AIDS Research
OBT – Optimized Background Therapy
OI – Opportunistic Infection
OMB – Office of Management and Budget
OPA - Office of Pharmacy Affairs
PAP - Patient Assistance Program
PBM - Pharmacy Benefits Manager
PEP – Post-Exposure Prophylaxis
PEPFAR – President’s Emergency Plan for AIDS Relief
PHS – Public Health Service
PI - Protease Inhibitor
POLR – Payer of Last Resort
QA – Quality Assurance
QI - Quality Improvement
QM – Quality Management
SPNS - Special Projects of National Significance
RDR – Ryan White Data Report
RFA – Request for Applications
RFP – Request for Proposals
RSR – Ryan White Services Report
SAMHSA – Substance Abuse and Mental Health Services Administration
SCSN – Statewide Coordinated Statement of Need
SPAP – State Pharmaceutical Assistance Program
STD – Sexually Transmitted Disease
STI – Sexually Transmitted Infection
TA – Technical Assistance
TGA – Transitional Grant Area
TrOOP - True Out of Pocket Expenditures
VL – Viral Load