

An abstract graphic consisting of several overlapping lines in white, red, and blue, some solid and some dotted, forming a complex, geometric pattern. A white L-shaped line is positioned around the central text, with its top-right and bottom-left corners extending outwards.

NATIONAL HIV PREVENTION INVENTORY

**The State of HIV Prevention
Across the United States**

2019 Survey Report

TABLE OF CONTENTS

Executive Summary	3
Key Findings	4
Introduction	10
Methods	11
Findings	12

MAIN TOPIC AREAS

HIV Prevention Funding	12
HIV Prevention Programming	16
HIV Prevention Priorities	16
Testing	22
HIV Prevention and Health Systems Integration	40
Linkage to Care	44
HIV Planning	48
Policy and Structural Initiatives	51
Community Engagement	54
Condom Distribution Programs	60
Behavioral Interventions	62
Syringe Services Programs	65
Biomedical Prevention	69
Program Integration	73
Data to Care and Surveillance	77
Workforce Development	81
Discussion	84
Acknowledgements	91

EXECUTIVE SUMMARY

In 2016, there were an estimated 38,500 new HIV infections, representing an 8% decline from 2010. Though moving in an overall positive direction, gay and bisexual men, people who inject drugs (PWID), transgender women, Black/African Americans and Latinx populations continue to be disproportionately affected by HIV. The 2017 National HIV Prevention Inventory (NHPI) was designed as a follow-up to [previous NHPI reports](#), to contribute to NASTAD's efforts to support health department (HD) HIV prevention programs and track longitudinal trends.

The survey data was collected during the final year of funding for the Centers for Disease Control and Prevention (CDC) program announcement PS12-1201, and immediately before HDs began implementing PS18-1802. This report presents how HDs evolved their programming in the era of "high impact prevention" and the anticipated steps towards achieving "no new HIV infections" and ostensibly "ending the epidemic." The 2017 NHPI results help illustrate the progress achieved nationally by HDs throughout PS12-1201 and how jurisdictions have responded to changes in the HIV prevention landscape, as well as a look forward at the next five years of HD HIV prevention programming. Fifty-five HDs responded to this survey, representing 97.6% of prevalent HIV cases in the U.S. states and territories.

The survey was organized into two main modules: Funding and Programming. The Programming Module included 13 distinct sections addressing: Testing, HIV Prevention and Health Systems Integration, Linkage to Care, HIV Planning, Policy and Structural Initiatives, Community Engagement, Condom Distribution Programs, Behavioral Interventions, Syringe Services Programs, Biomedical Prevention, Program Integration, Data to Care (D2C) and Surveillance, and Workforce Development.

Survey findings are compared to previous NHPI reports, as appropriate, and will contribute to NASTAD's ongoing technical assistance activities.



KEY FINDINGS

Funding

SOURCES

FIGURE 1



While a wide array of funding streams

SUPPORT HIV PREVENTION SERVICES, two single sources, **CDC PS12-1201 Category A core funding for HD HIV prevention efforts and general state funding**, combined to account for **73%** of funding in CY2017.

PRIORITIES

FIGURE 7

26% of jurisdictions (14) **REDIRECTED FUNDS TO MEET NEW REQUIREMENTS** at the national or state level. Jurisdictions reported redirecting funds toward **linkage to care, PrEP, and third-party billing initiatives**.

PRIORITIES

FIGURE 4



HDs reported **scaling up a range of prevention activities**. **EIGHTY-FOUR PERCENT** of jurisdictions (46) reported scaling up PrEP. More than **TWO-THIRDS** of HDs reported scaling up Linkage to Care (**69%, 38**) and D2C (**67%, 37**) activities. HDs indicated funding increases at the federal and state level and changes due to the National HIV/AIDS Strategy (NHAS) as primary reasons for scaling up these programs.

PRIORITIES

FIGURE 5



HDs reported **scaling up programming for specific population groups**. **TWO-THIRDS** of HDs reported scaling up programming for Black/African American gay and bisexual men (**67%, 37**). **FIFTY-EIGHT PERCENT** of HDs (**32**) reported scaling up programming for PLWH. About **HALF** of HDs scaled up programming for Hispanic/Latinx gay and bisexual men (**52%, 29**), Black/African Americans (**49%, 27**), people who use or inject drugs (**49%, 27**), and transgender women who have sex with men (**47%, 26**).

CHALLENGES

FIGURE 6



Funding decreases across funding sources and HD staff shortages **pose the greatest challenges for program implementation** in the largest number of jurisdictions, with **46% (25)** and **41% (22)** citing these challenges respectively. **LACK OF COMMUNITY-BASED AND CLINICAL PROVIDERS** serving disproportionately impacted populations were the next most frequently reported challenges.



Programmatic

TESTING

FIGURE 8



In 2016, HDs conducted

2,888,624

HIV tests. This indicates a **13% DECREASE** in overall volume of testing when compared with pre-implementation of CDC PS12-1201 (3,324,689 in 2011), but a **1.5% INCREASE** in overall volume of testing from 2013 to 2016.

TESTING



(48) HDs **SUPPORT ROUTINE HIV TESTING IN CLINICAL VENUES**. All HDs support targeted HIV testing programs, operating in both clinical and non-clinical venues.

TESTING

FIGURES 17 AND 18



A majority of HDs **support Hepatitis C (HCV) and STD testing (57% and 64%, respectively)** in some or all venues where HIV testing programs take place.

TESTING



While **50 PUBLIC HEALTH LABORATORIES (PHLs)** perform HIV testing, and **57 do so with Ag/Ab assay**, a minority of jurisdictions (**22%**) require testing providers to **USE THE PHL**, while another **43%** allow providers the **OPTION OF USING THE PHL**.

TESTING

FIGURE 19



THIRTY-SEVEN OF 54 HDS (69%) report **providing HIV testing services directly** (e.g. through PHLs or partner services). Of those, 14 (38%) currently bill health insurance for HIV testing. All of these HDs bill Medicaid and a majority also bill private insurance.

HIV PREVENTION AND HEALTH SYSTEMS INTEGRATION



JUST OVER ONE-QUARTER (26%) of HDs require some or all supported providers to **seek reimbursement** from health insurers, including Medicaid.



Programmatic

LINKAGE TO CARE

FIGURE 32



Disease intervention specialists facilitate

LINKAGE TO CARE in **91% (49)** of jurisdictions and **PROVIDE REFERRALS FOR PREP** in **81% (44)** of jurisdictions.

HIV PLANNING



Integrated planning processes are relatively recent in the majority

of jurisdictions, with **62% (34)** reporting that **INTEGRATION HAS TAKEN PLACE SINCE 2014**. This is largely due to the **CDC/HRSA Integrated HIV Prevention and Care Planning Implementation Guidance** released in June 2015.

POLICY AND STRUCTURAL INITIATIVES

TABLE 22

71% (39)

In 2017, **71% (39)** of jurisdictions **INITIATED AND/OR COMPLETED POLICY CHANGES RELATED TO HIV PREVENTION**, down from the 86% (49) of jurisdictions in 2013. Among the most frequently-cited focus areas of policy changes in 2017 were: syringe access, Naloxone access, data sharing, and PrEP.

COMMUNITY ENGAGEMENT

FIGURE 40



Almost all participating jurisdictions (**93%, 51**)

reported that they **SUPPORT COMMUNITY ENGAGEMENT EFFORTS**. Among those jurisdictions reporting support for community engagement, **88% (45)** focus efforts on gay and bisexual men/men who have sex with men (MSM), **82% (42)** on people living with HIV (PLWH), and **77% (39)** on Black MSM.

CONDOM DISTRIBUTION PROGRAMS



All but one

HD reported **SUPPORTING**

CONDOM DISTRIBUTION PROGRAMS, directly or indirectly. The most common challenges include monitoring and evaluation (**44%, 24**), stakeholder buy-in from parents, school boards, religious leaders, and faculty (**43%, 23**), and HD procurement processes (**39%, 21**).

BEHAVIORAL INTERVENTIONS

TABLE 26

71% (39)

of the responding jurisdictions reported **supporting behavioral interventions** for persons most at-risk for HIV, a level consistent with the 2013 survey. Mpowerment was once again the most frequently reported intervention supported by **44% (24)** of jurisdictions. Many Men, Many Voices (3MV) was the second most frequently-cited behavioral intervention with **29% (16)** of jurisdictions.



Programmatic

SYRINGE SERVICES PROGRAMS

75% (41) of jurisdictions reported **AT LEAST ONE** syringe services program (SSP) in operation within their jurisdiction, **up from 58% (33) of jurisdictions in 2013**. This is likely in response to increases in opioid and other drug injection and to **the 2016 federal guidance** allowing states and local communities, in alignment with local or state law, the opportunity to use federal funds to support certain components of SSPs. Sixteen (16) jurisdictions reported using federal funding in 2017 to support SSPs, up from zero in 2013.

BIOMEDICAL PREVENTION

FIGURE 53



Among the most significant changes reported in the 2017 NHPI is the **NOTABLE INCREASE IN HD SUPPORT OF PREP PROGRAMS**. **Eighty-nine percent (49)** of HDs **currently support a PrEP program**, up from only 15% (8) of HDs in 2013. This reflects the increased acceptance of PrEP as a standard of care following the **May 2014 release of U.S. Public Health Service clinical practice guidelines for PrEP**.

BIOMEDICAL PREVENTION

FIGURE 3



Comparing the 2017 funding allocation results with allocations reported in 2013, the most notable change concerns PrEP. In 2013, no jurisdictions allocated funds to PrEP. In 2017, 60% of jurisdictions (30) distributed an average of 4% of their HIV prevention funds to PrEP services.

PROGRAM INTEGRATION

TABLE 29



The top ten program areas where the majority of jurisdictions reported **DIRECT OVERSIGHT BY NASTAD** members included: HIV prevention, HIV testing, Ryan White HIV/AIDS Program (RWHAP) (care and treatment) services, linkage to HIV-related medical care, partner services, AIDS Drug Assistance Program (ADAP), STD screening, perinatal HIV prevention, HIV surveillance, and STD surveillance. **These areas corresponded with the areas with the highest levels of collaboration.**



Programmatic

PROGRAM INTEGRATION

TABLE 29



Many NASTAD members' purview **INCLUDES DIRECT OVERSIGHT OF OTHER PROGRAMS**

within the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis (TB) (NCHHSTP). More than half of NASTAD members oversee **STD screening (64%, 35)** and **STD surveillance (55%, 30)**, and 51% (28) oversee **viral hepatitis testing and activities**. One quarter or fewer NASTAD members directly oversee **hepatitis surveillance (25%, 14)**, **TB testing (22%, 12)**, and **TB surveillance (18%, 10)**.

PROGRAM INTEGRATION

TABLE 29



HIV programs have **HIGH LEVELS OF COLLABORATION** with other programs

within NCHHSTP. About three-quarters of HIV programs collaborate with **STD screening (78%, 43)** and **STD surveillance (75%, 41)** programs. More than half collaborate with **viral hepatitis testing (71%, 39)**, **activities (69%, 38)**, and **surveillance (chronic: 60%, 33; acute: 56%, 30)**. Slightly less than half collaborate with **TB testing (42%, 23)** and **TB surveillance (40%, 22)**.

PROGRAM INTEGRATION

TABLE 29



Out of 55 responding HDs, **60% (33)** of HIV

SURVEILLANCE PROGRAMS receive direct oversight of the NASTAD member, and **75% (41)** of HIV prevention programs reported **COLLABORATING WITH HIV SURVEILLANCE**.

PROGRAM INTEGRATION

+76% (41)

of HD HIV prevention programs reported that **they work with other HD programs or external partners to SUPPORT HEALTH EQUITY**.

Among the most frequently referenced collaborations to support health equity were with HD offices of minority health or health equity branches within HDs.

PROGRAM INTEGRATION

FIGURE 59



Most of the jurisdictions **(73%)** are in the

planning or implementation stages of **ENDING THE EPIDEMIC** campaigns. Of the 53 jurisdictions responding to the question, **45% (24)** of the jurisdictions report that they are **in the planning process**, **28% (15)** are **in the implementation stage**, and **27% (14)** report that they **have not begun planning**.



Programmatic

DATA TO CARE (D2C) AND SURVEILLANCE FIGURE 60

56% of HDs (30) have **JURISDICTION-WIDE D2C PROGRAMS/ACTIVITIES** in place, **26%** are currently piloting D2C programs (14) and **19%** are planning to implement D2C (10).

CHALLENGES FIGURE 7



Responding jurisdictions have **EXPERIENCED MYRIAD CHALLENGES** since the previous NHPI was conducted in 2013. The most frequently cited challenges since 2013 were related to **HD integration of services (43%), de-funding underperforming community-based providers (36%), and managing HD staff vacancies (34%)**.

WORKFORCE DEVELOPMENT

TABLE 34



BLACK/AFRICAN AMERICAN WOMEN are the **most strongly represented priority population in jurisdictions' HIV prevention staff**, with **37%** of jurisdictions (19) reporting that Black/African American women comprise **25% of more of their HIV Prevention staff**. Jurisdictions have been least able to attract trans-identified individuals with 81% of jurisdictions (39) having no trans-identified HIV Prevention staff.

INTRODUCTION

According to the Centers for Disease Control and Prevention (CDC), HIV incidence nationwide is declining. In 2016, there were an estimated 38,500 new HIV infections, representing an 8% decline from 2010. Though overall new HIV infections are decreasing nationwide, this decline is inconsistent across populations. Gay and bisexual men, people who inject drugs (PWID), transgender women, Black/African Americans and Latinx populations continue to be disproportionately affected by HIV. Despite advances in HIV prevention including Pre-Exposure Prophylaxis (PrEP), expansion of Syringe Services Programs (SSP), and treatment as prevention (TasP), challenges such as increased rates of injection drug use and stigma continue to hinder comprehensive progress.

The 2017 National HIV Prevention Inventory (NHPI) was designed as a follow-up to [previous NHPI reports](#) produced by NASTAD and the Kaiser Family Foundation in 2009, and continued by NASTAD through a series of modules over the course of 2012-2014. This report contributes to NASTAD's continuing efforts to monitor health department (HD) supported HIV prevention programs and track longitudinal HIV prevention trends described in the previous NHPI reports. The findings from this survey report will contribute to the development and prioritization of NASTAD's technical assistance activities, and guide education and advocacy efforts.

The survey data was collected during the final year of funding for the CDC's five-year funding opportunity announcement (FOA) PS12-1201 HIV Prevention Activities for Health Departments, and immediately before HDs began implementing programming under the new integrated surveillance and prevention PS18-1802 notice of funding opportunity (NOFO) Integrated HIV Surveillance and Prevention Programs for Health Departments. This report provides a look at both how HDs evolved their programming in the era of "high impact prevention" and the anticipated steps towards achieving "no new HIV infections" and ostensibly "ending the epidemic." The 2017 NHPI results help illustrate the progress achieved nationally by HDs throughout PS12-1201. The findings also depict the ways in which HDs in many jurisdictions responded to changes in the HIV prevention landscape, including changes in federal funding, developments in HIV care standards, and changes in response to population needs and conditions. Simultaneously, the report provides a look forward at new initiatives, innovations, and challenges that will shape the next five years of HD HIV prevention programming under PS18-1802.

METHODS

The survey instrument was developed by staff at NASTAD with significant input by the NASTAD Prevention Advisory Committee (PAC). Survey data collection began November 1, 2017. A total of 66 HDs were notified via email of the release of NASTAD's 2017 NHPI Survey. These included the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, seven local jurisdictions receiving direct funding from CDC (Baltimore, Chicago, Los Angeles County, Houston, New York City, Philadelphia, and San Francisco), and the six U.S. Pacific Island jurisdictions (American Samoa, the Federated States of Micronesia, Guam, the Marshall Islands, Northern Mariana Islands, and Palau). The email notification included information for accessing the online survey and a PDF file of the survey. HDs were asked to complete the online survey by December 1, 2017. A final reminder email was sent three days prior to the submission deadline. After the response deadline passed, HDs that had not responded to the survey were contacted via email and phone and encouraged to complete the survey. A total of 55 HDs responded to this survey, including 47 states, the District of Columbia, Guam, the U.S. Virgin Islands, and five cities/counties funded directly by CDC for HIV prevention, for an overall response rate of 83%. The responding jurisdictions represent 97.6% of prevalent HIV cases in the U.S. states and territories. CDC cooperative agreement number 1U65PS004487 funded NHPI data analysis and document production.

The survey was organized into two main modules: Funding and Programming. The Programming Module included 13 distinct sections addressing: Testing, HIV Prevention and Health Systems Integration, Linkage to Care, HIV Planning, Policy and Structural Initiatives, Community Engagement, Condom Distribution Programs, Behavioral Interventions, Syringe Services Programs, Biomedical Prevention, Program Integration, Data to Care (D2C) and Surveillance, and Workforce Development.

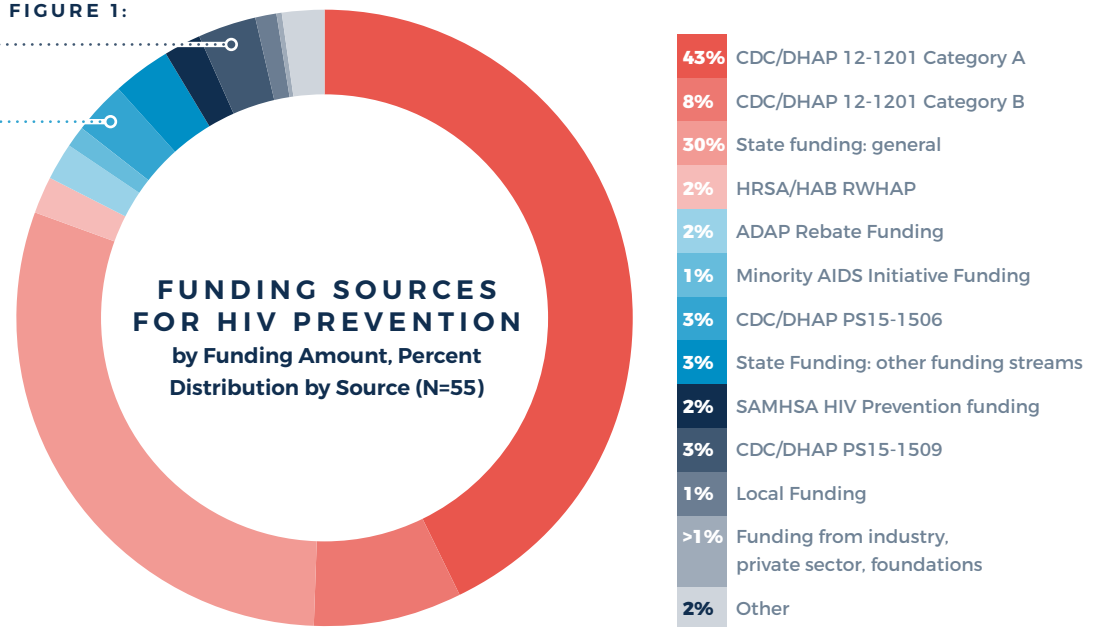
The Program Integration section highlights key programmatic areas that receive oversight from, or collaborate with leadership within the HIV program. Through NASTAD's membership, and within this document, that specified leader is referred to as the "NASTAD Member." In the past, NASTAD referred to its members as "AIDS Directors." Often, this title did not fully represent the breadth of the role due to the ever-expanding purview of AIDS Directors. Many people in this role also oversee programmatic and/or budgetary portfolios including hepatitis, tuberculosis (TB), sexually transmitted diseases (STDs), and more. To remain consistent across jurisdictions, NASTAD now refers to AIDS Directors as the NASTAD member.

HIV PREVENTION FUNDING

Funding Sources

A wide array of funding streams support HIV prevention services, **but two single sources, CDC PS12-1201 Category A core funding for HD HIV prevention efforts and general state funding (of which only 58% [29] jurisdictions contributed), combined to account for 73% of funding in CY 2017.** CDC PS12-1201 Category B, which was intended to support expanded HIV testing for disproportionately affected populations, provided the next most significant source of financial support for HIV prevention services. Overall, **CDC sources accounted for 56% of HIV prevention program funds, ranging from 16% to 100% of individual HD HIV prevention budgets.**

FIGURE 1:



Other frequently cited sources of funding included HRSA/HAB RWHAP support for prevention (42%, 23), and ADAP rebate funding for prevention (35%, 19).

CDC funds also support **innovative, high priority demonstration projects** in a relatively smaller number of jurisdictions:

PS15-1506 Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons funds supported projects aimed at reducing HIV infections and improving engagement in care for **MSM and transgender persons.**

PS15-1509 Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for Men Who Have Sex with Men (MSM) of Color at Risk for and Living with HIV Infection funded projects to provide **comprehensive prevention, care, behavioral health, and social services for MSM of color.**

Of the jurisdictions who had previously been funded for **PS12-1201** Category C demonstration projects to support **innovative, high impact prevention (HIP) non-research projects** (44%, 24), half (12) reported that project activities are continuing with other funding.

HIV PREVENTION FUNDING
TABLE 1:
HIV PREVENTION FUNDING SOURCES

by Jurisdictions Reporting (N=55)

Funding Source	Jurisdictions	Percent	Average Amount	Total for All Jurisdictions
CDC/DHAP 12-1201 Category A	52	95%	\$4,645,555	\$236,923,289
CDC/DHAP 12-1201 Category B	30	55%	\$1,527,815	\$45,834,449
State funding: general	29	53%	\$5,563,453	\$166,903,582
HRSA/HAB RWHAP	23	42%	\$714,255	\$14,285,108
ADAP Rebate Funding	19	35%	\$661,014	\$11,898,259
Minority AIDS Initiative Funding	14	25%	\$475,141	\$5,226,548
CDC/DHAP PS15-1506	10	18%	\$1,596,236	\$14,366,125
State Funding: other funding streams	10	18%	\$1,767,083	\$15,903,749
SAMHSA HIV Prevention funding	8	15%	\$1,613,998	\$12,911,987
CDC/DHAP PS15-1509	6	11%	\$2,432,616	\$14,595,695
Local Funding *	4	7%	\$2,155,656	\$6,466,967
Other	10	18%	\$1,046,625	\$9,419,628
Funding from industry, private sector, foundations	3	5%	\$907,109	\$1,814,218

**Note: Four local jurisdictions responded to the local funding category. One of which reported both local and state funding. No states responded to the local funding category.*

HIV Prevention Funding Trends: 2013 – 2017

Since 2013 (when the last **NHPI Funding Report** was published), **overall HIV prevention funding has increased**. Continued projects and new initiatives, such as demonstrations and D2C activities, contributed to this increase in funding, along with increases in state and local funding.

HIV PREVENTION FUNDING

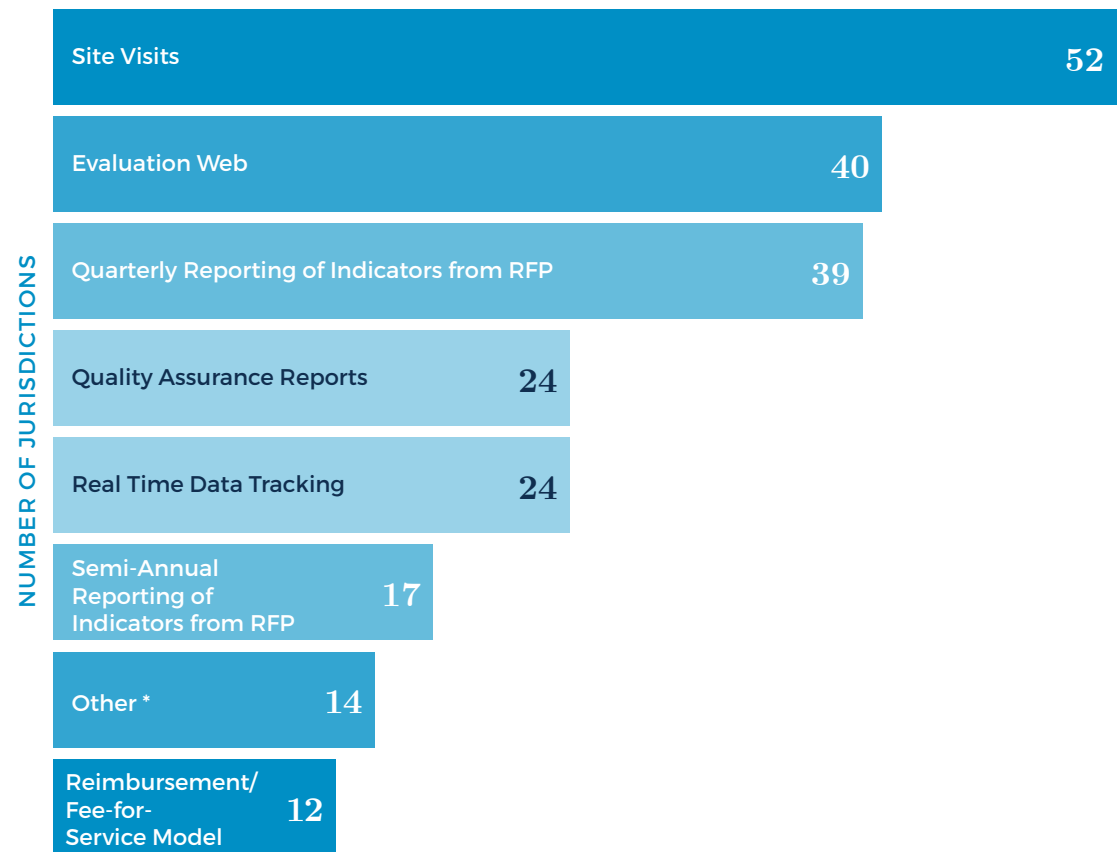
Evaluation and Monitoring of Sub-Grantees

Jurisdictions employ a variety of methods to evaluate and monitor the performance of sub-grantees, though **nearly all jurisdictions reported conducting site visits** (52, 95%).

FIGURE 2:

METHODS FOR EVALUATION OF SUB-GRANTEES

(N=55)



*Note: Other options included monthly calls and reports.

Funding Allocation

Jurisdictions allocated the majority of their resources to direct prevention services (69%), with the remaining 31% allocated to administrative activities and infrastructure. The funding allocation between direct prevention services and administrative activities is consistent with the distribution reported in 2013.

HIV PREVENTION FUNDING

Targeted HIV testing in community settings received the largest average share of jurisdictions' prevention funding and was funded by 96% of reporting jurisdictions (48) (n=50), the majority of whom also allocated funds to targeted testing in clinical settings. **Nearly all jurisdictions (98%, 49) used prevention funding to support condom distribution.**

Since 2013, the most notable funding allocation changes pertain to PrEP. In 2013, no jurisdictions allocated funds to PrEP. In 2017 60% of jurisdictions (30) distributed an average of 4% of their HIV prevention funds to PrEP services.

FIGURE 3:

ALLOCATION OF HIV PREVENTION FUNDS (N=50)



*Note: Median findings for all categories except one fall within 3% of the average. The median for "Targeted HIV testing activities in community-based settings" differs 6% from the average, due to one outlier. Median findings do not alter the order in which HIV prevention activities are reported.

**Note: At the time of the PS12-1201 program announcement, CDC language "Prevention with Positives." When directly referencing these CDC interventions, NASTAD will use this language in quotations. Otherwise, language has been updated to "prevention activities for persons living with HIV."

HIV PREVENTION PROGRAMMING

HIV Prevention Priorities

Jurisdictions scaled programs and addressed challenges to meet the needs of impacted populations and HIV prevention priorities.

Scale Up and Scale Back of HIV Prevention Activities and Services

Increases from a variety of funding sources allowed for the scaling up of a range of prevention activities.

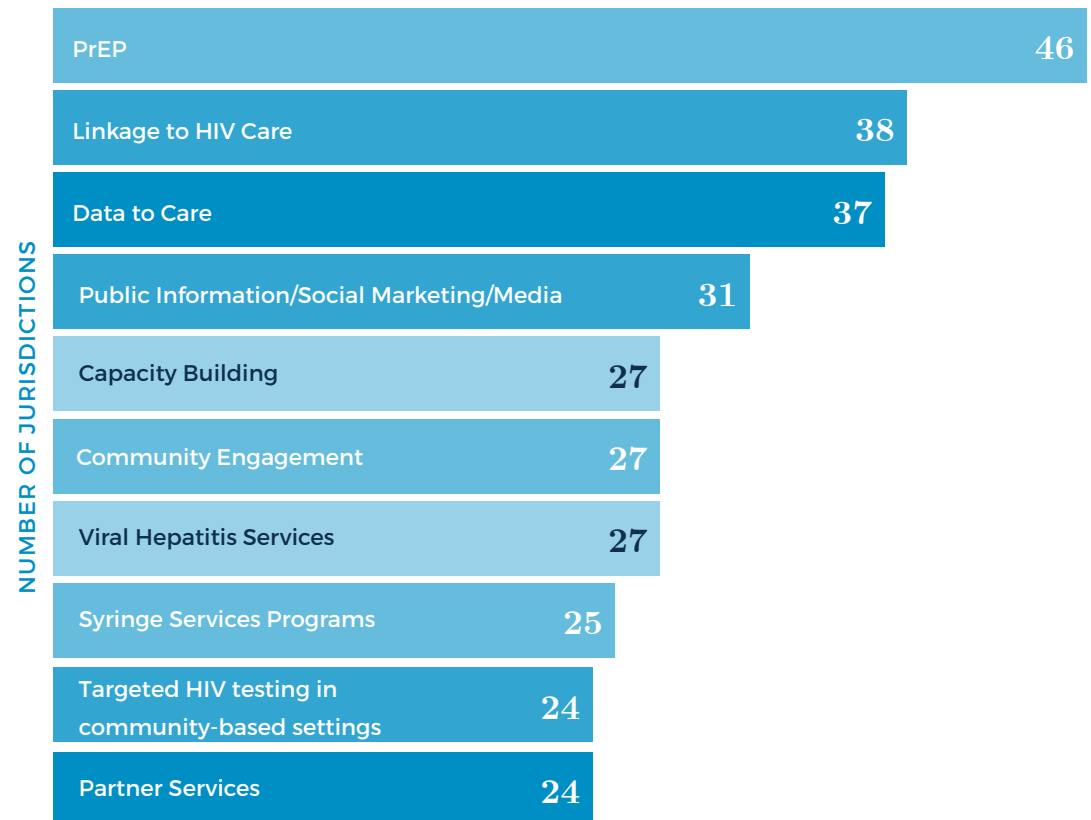
Funding/Policy Sources: Federal and State funding (due to the NHAS)
 Activities: PrEP, Linkage to Care, D2C

Funding/Policy Sources: Integrated jurisdictional plans and associated funding
 Activities: Public information/social media, community engagement

A significant number of HDs also reported scaling up viral hepatitis services, SSPs, and targeted testing in community settings.

FIGURE 4:

NUMBER OF JURISDICTIONS SCALING UP HIV PREVENTION ACTIVITIES AND SERVICES (N=55)







HIV PREVENTION PROGRAMMING

Many jurisdictions reported either scaling up or not changing programming for the majority of prevention activities in 2017. However, **the top two programs that were scaled back included Health Education/Risk-Reduction programs “Prevention with Positives” activities** due to funding prioritization and lack of effectiveness of interventions.

TABLE 2:

SCALE UP AND SCALE BACK
of HIV Prevention Activities and Programs by Jurisdiction



Activity/Service	 Scaled up	 Scaled back	 No change	 Not applicable
PrEP	46	0	3	6
Linkage to HIV care	38	1	14	2
D2C	37	2	10	6
Public information/social marketing/media	31	6	18	0
Capacity building/training/technical assistance	27	5	22	1
Community engagement	27	4	19	3
Viral hepatitis services	27	2	18	8
Syringe services programs	25	2	8	20
Partner services	24	5	25	1
Targeted HIV testing in community-based settings	24	5	24	1
HIV Community/Jurisdiction Planning Group	23	4	25	0
Evaluation/Quality Assurance	22	3	29	1
Condom distribution	18	5	31	0
HIV surveillance	18	2	28	7
Routine HIV testing in health care settings	16	5	26	7
STD services	16	7	23	6
Policy initiatives	15	1	30	8
HIV laboratory support	14	4	30	7
Program administration	14	8	32	1
Targeted HIV testing in clinical settings	13	7	33	2
nPEP	12	2	25	16
“Prevention with Positives”	12	14	26	3
Prevention of mother-to-child transmission	8	0	39	7
Health education/risk reduction	6	17	29	2

HIV PREVENTION PROGRAMMING

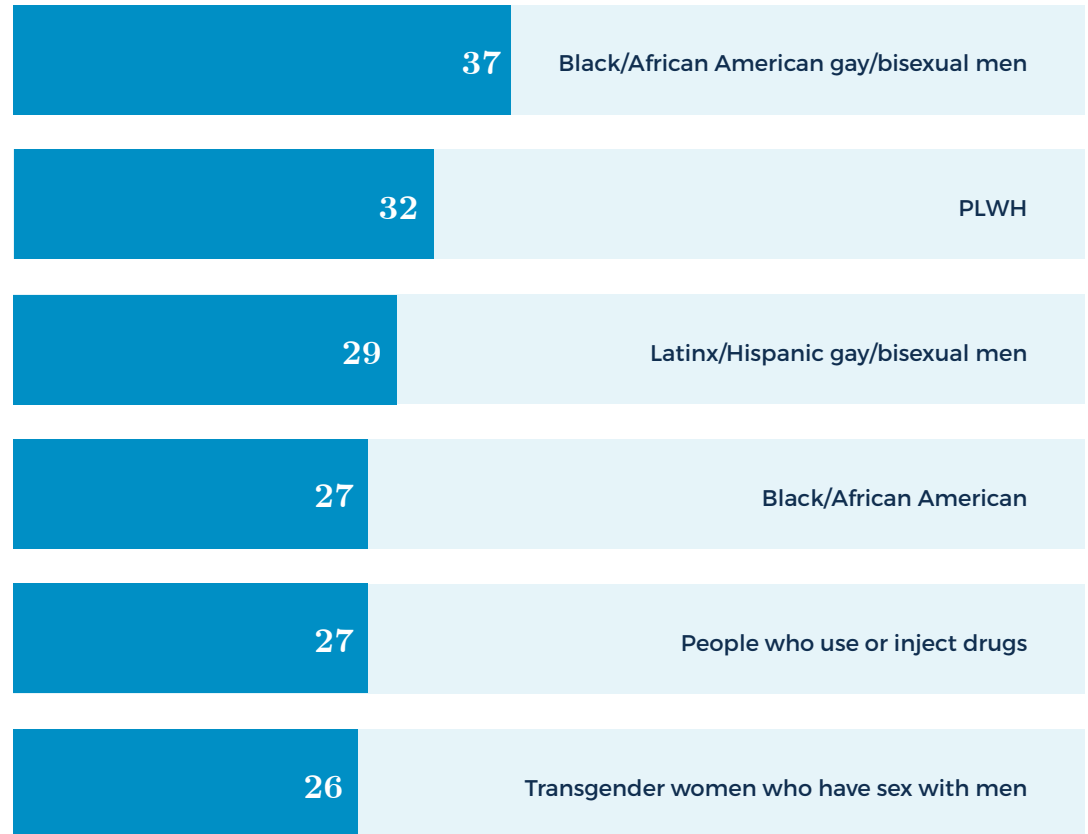
Scale Up and Scale Back of HIV Prevention Programming for Specific Population Groups

About half to two-thirds of jurisdictions reported scaling up HIV prevention programming for the following specific populations:

- Black/African American gay and bisexual men
- Hispanic/Latinx gay and bisexual men
- Black/African Americans
- People who inject drugs
- Transgender women who have sex with men

FIGURE 5: _____

NUMBER OF JURISDICTIONS SCALING UP PROGRAMMING
for Specific Population Groups
(N=55)







HIV PREVENTION PROGRAMMING

Few jurisdictions reported scaling back programming specific to certain population groups. This is in sharp contrast to results from the 2013 survey, in which nearly half of the 47 reporting jurisdictions (47%, 22) had scaled back prevention activities targeting heterosexual men and non-Black heterosexual women due to funding decreases at the time of the 2013 survey.

TABLE 3:

SCALE UP AND SCALE BACK
of HIV Prevention Programming for Specific Population Groups by Jurisdiction

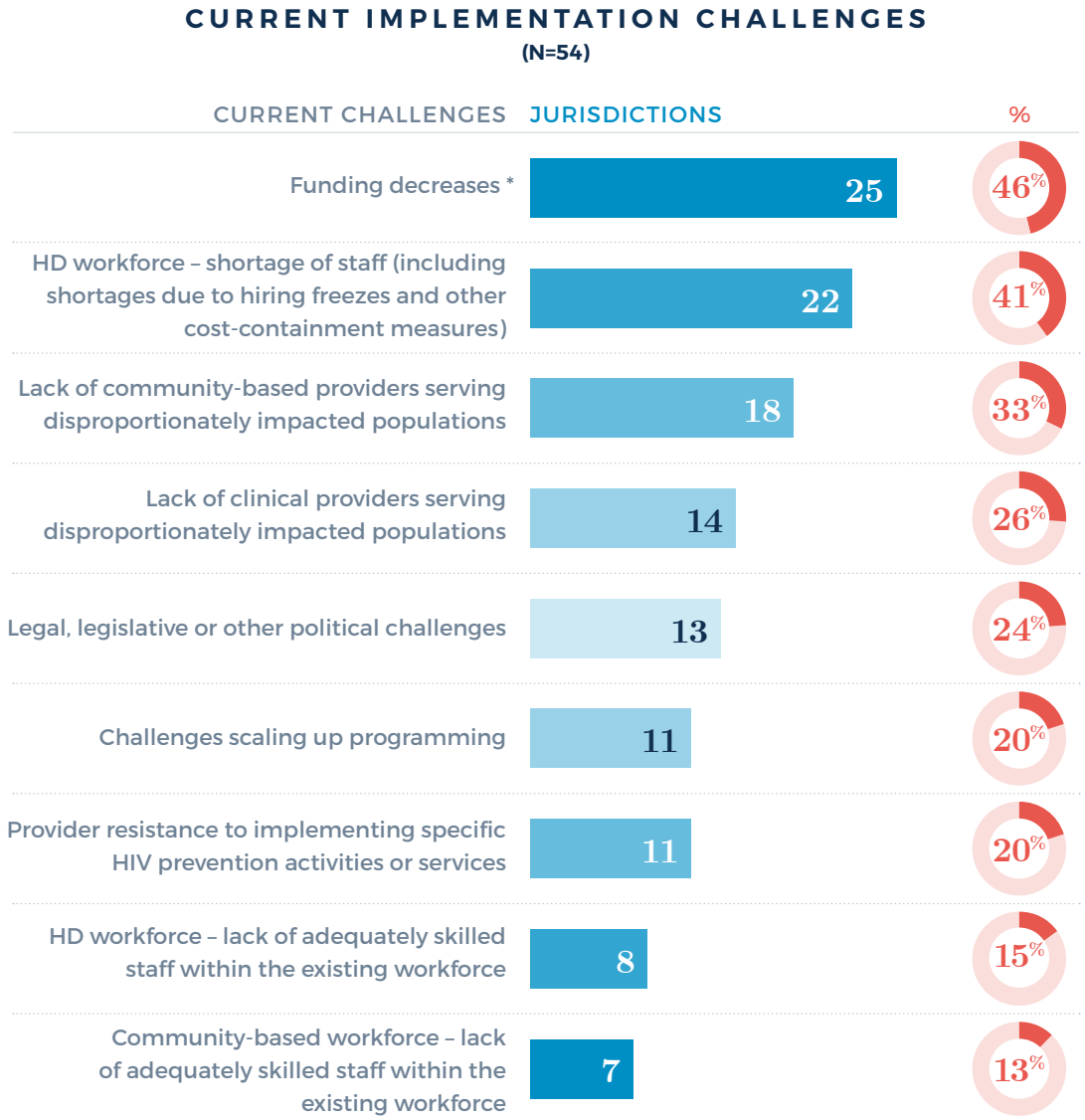


Activity/Service	 Scaled up	 Scaled back	 No change	 Not applicable
Black/African American gay and bisexual men	37	1	13	4
People Living With HIV	32	1	22	0
Hispanic/Latinx gay and bisexual men	29	0	20	6
Black/African American	27	1	22	5
People who use or inject drugs	27	2	23	3
Transgender women who have sex with men	26	1	22	6
White gay and bisexual	20	0	31	4
Latinx	19	1	26	9
Transgender men who have sex with men	19	1	28	7
Youth	18	2	28	7
Persons living in rural areas	12	1	32	10
Black/African American cisgender heterosexual women	10	3	31	10
Heterosexual cisgender women	7	0	34	13
Immigrant/Migrant workers	7	0	30	16
Persons involved in sex work	7	1	37	9
Perinatal individuals	6	0	38	11
White	4	1	40	10
Heterosexual cisgender men	3	0	37	14
American Indian/Alaskan Native	2	0	27	26
Asian	2	0	29	23
Native Hawaiian/Pacific Islander	2	0	30	23

HIV PREVENTION PROGRAMMING

Jurisdictions ranked the top three challenges they currently face implementing HIV prevention programs. **Funding decreases¹ pose the greatest challenge for HDs overall. Shortages of HD staff, community-based and clinical providers serving disproportionately impacted populations, pose the next most frequent challenges.**

FIGURE 6:



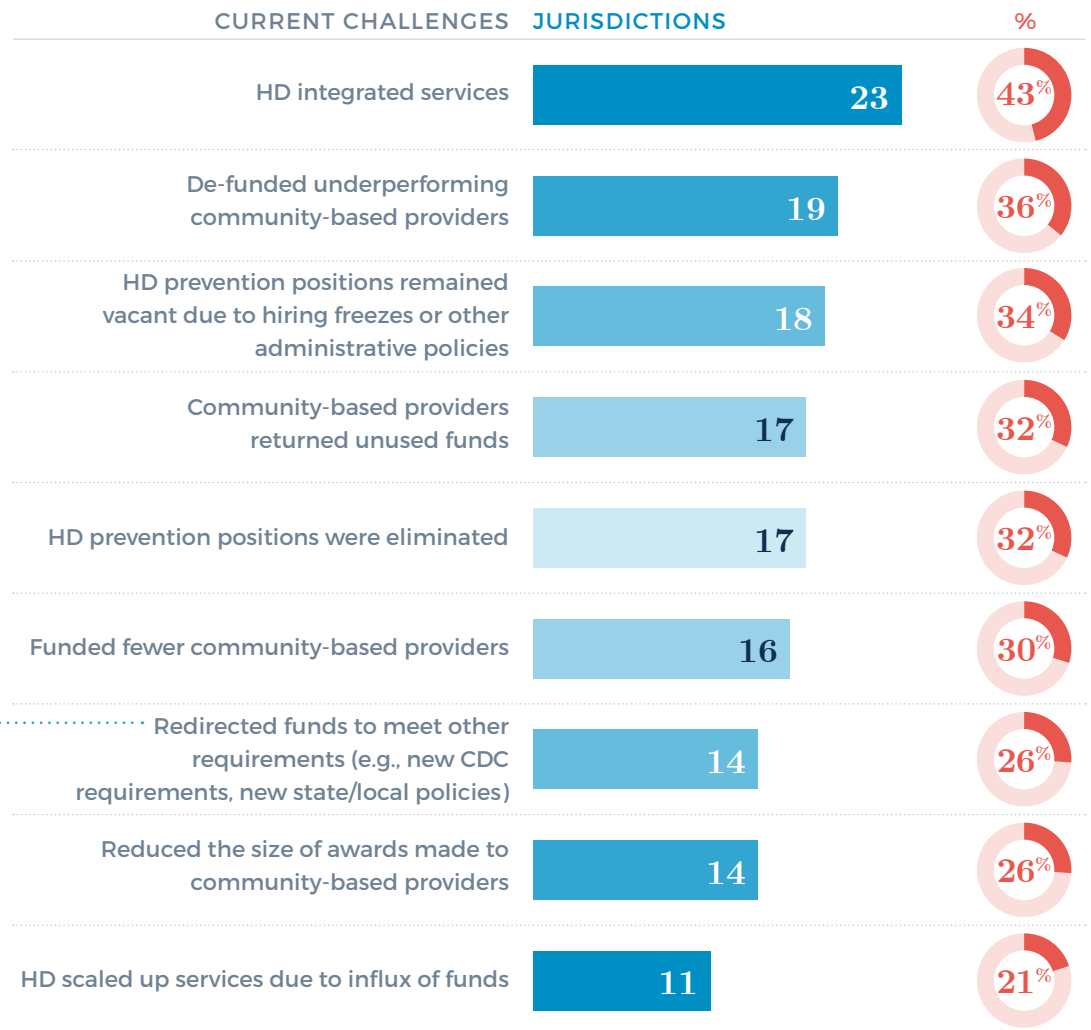
**Note: While federal funding from CDC increased for most HDs during this time period, HDs receive prevention funding from a variety of sources (Figure 1). For this particular question, HDs were not asked to specify which source(s) saw decreased funding.*

HIV PREVENTION PROGRAMMING

Responding jurisdictions have experienced myriad challenges since the previous NHPI was conducted in 2013. The table below shows the **challenges encountered by at least 10 reporting jurisdictions.**

FIGURE 7:

CHALLENGES EXPERIENCED SINCE 2013 NHPI (N=53)



Jurisdictions reported redirecting funds toward linkage to care, PrEP, and third-party billing initiatives, among other activities.

TESTING

Testing Volume

In 2016, HDs conducted 2,888,624 HIV tests. This indicates a 13% decrease in overall volume of testing when compared with pre-implementation of CDC PS12-1201 (3,324,689 in 2011), but a 1.5% increase in overall volume of testing from 2013 to 2016.

FIGURE 8:

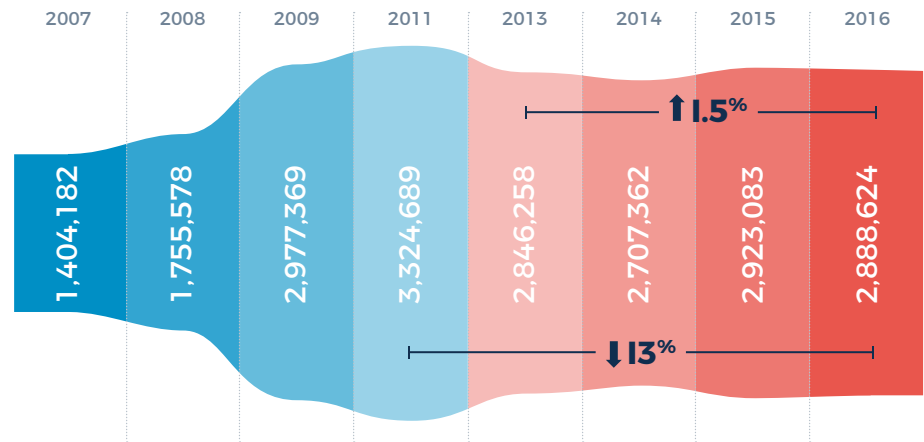
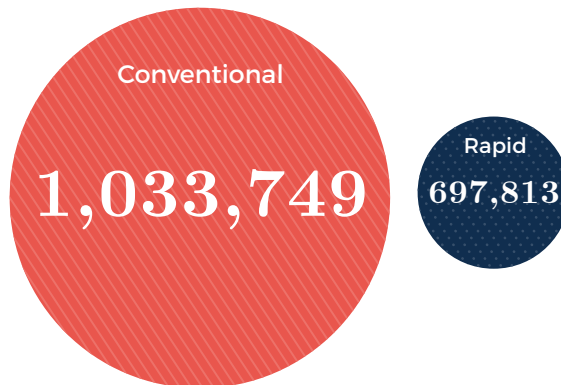


FIGURE 9:

Sample type of HIV test, when available:



Sample type not available for 47% of all tests performed in 2016.

TESTING

FIGURE 10:

2016 HIV TESTING VOLUME BY TEST, SAMPLE TYPE

(N=2,888,624)

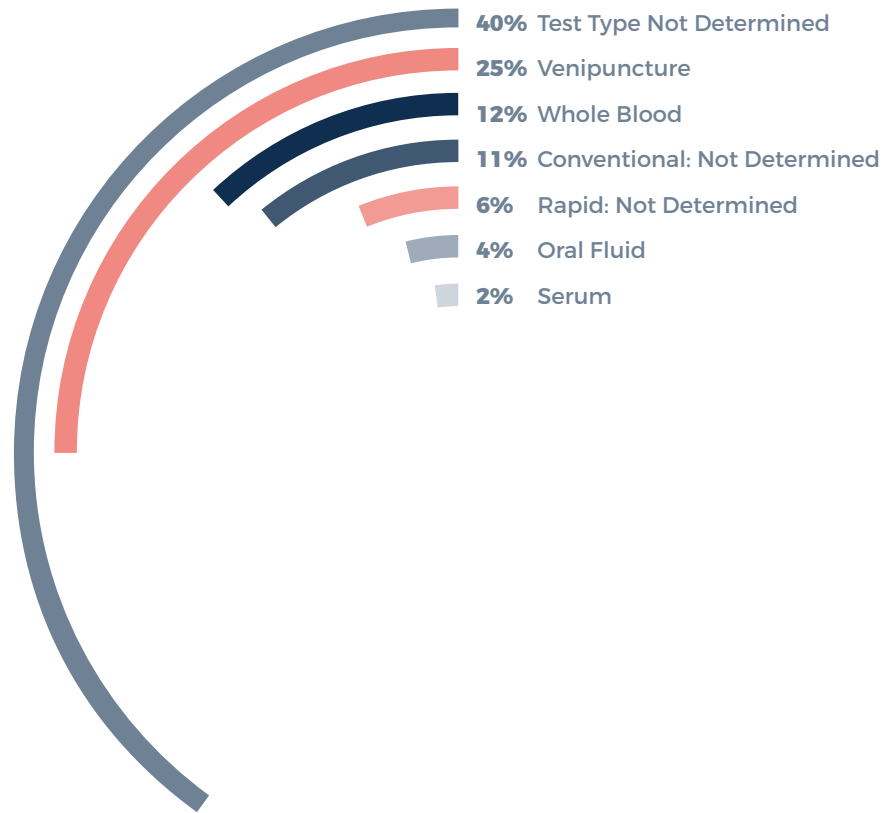


TABLE 4:

HIV TESTING VOLUME TRENDS BY TEST, SAMPLE TYPE

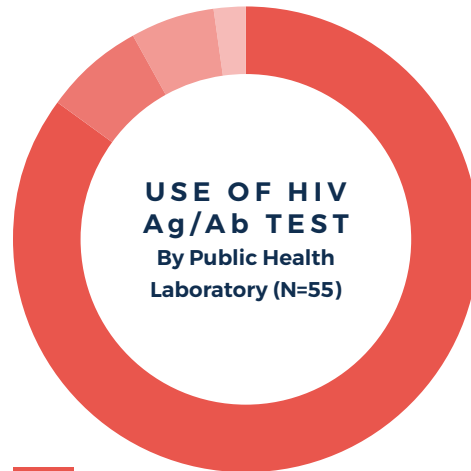
	2007 (N=39)	2008 (N=39)	2009 (N=53)	2011 (N=55)	2013 (N=52)	2014 (N=52)	2015 (N=51)	2016 (N=51)
Venipuncture	499,433	474,489	938,509	1,255,129	1,158,689	1,082,081	731,788	703,532
Dried Blood Spot	-	-	0	1,684	964	904	362	419
Oral Fluid	139,784	149,175	140,993	98,379	51,851	40,259	6,505	4,189
Sample Type Not Determined	87,050	73,278	72,863	29,013	169,598	182,645	272,823	325,609
Subtotal Conventional	726,267	696,942	1,152,365	1,384,205	1,381,102	1,305,889	1,011,478	1,033,749
Rapid Test - Whole Blood	207,419	356,194	865,404	918,739	898,112	922,333	359,460	351,854
Rapid Test - Oral Fluid	112,394	154,312	752,462	747,227	273,502	204,632	148,688	123,259
Rapid Test Not Determined	358,102	548,130	137,138	274,518	292,941	274,015	133,359	125,975
Rapid Test - Serum	-	-	-	-	601	493	40,545	61,512
Subtotal Rapid	677,915	1,058,636	1,755,004	1,940,484	1,465,156	1,401,473	737,800	697,813
Test Type Not Determined	-	-	-	-	-	-	1,173,805	1,157,062
TOTAL TESTS	1,404,182	1,755,578	2,977,369	3,324,689	2,846,258	2,707,362	2,923,083	2,888,624

TESTING

Test Technologies And Strategies

Most (85%) HDs use a public health laboratory (PHL) to perform testing which utilizes a combined HIV Ab/Ag assay.

FIGURE 11:

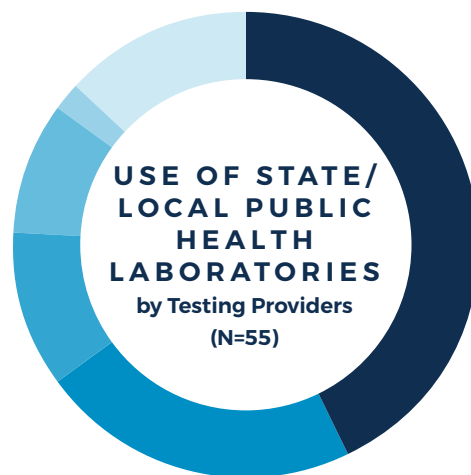


- 85%** Yes
- 7%** No, PHL does not perform HIV testing
- 6%** No, PHL performs HIV testing but does not use Ag/Ab test
- 2%** Not Determined

While **50 PHLs perform HIV testing**, and **57 do so with Ag/Ab assay**, a minority of jurisdictions (**22%**) require testing providers to use the PHL, while another **43% allow providers the option** of using the PHL.

Of the five HDs that require testing providers to use commercial or clinical laboratories, four (**80%**) require those providers to use a lab which performs HIV testing using an Ag/Ab assay.

FIGURE 12:



- 43%** Testing providers have the options to use the PHL
- 22%** Testing providers are required to use the PHL
- 11%** Yes, testing providers use PHL only for confirmatory testing
- 9%** Testing providers are required to use commercial/clinical laboratories
- 2%** Testing providers use POC RT for both screening and confirmatory tests
- 13%** Other

TESTING

Ninety-eight percent (52) of HDs conduct rapid testing at point-of-care. Ten percent (5) of HDs use one rapid test product exclusively, while the remainder use two or more products.

TABLE 5:
RAPID HIV TESTS
 Used Point of Care by HD-Supported Testing Providers

	No. (N=53)	%
Determine™ HIV-1/2 Combo.....	38	72%
OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test.....	29	55%
INSTI® HIV-1/HIV-2 Antibody Test.....	25	47%
Clearview® COMPLETE HIV 1/2.....	18	34%
UniGold™ Recombigen® HIV-1/2.....	13	25%
Other.....	6	11%
Clearview® HIV1/2 STAT-PAK.....	5	9%
DPP® HIV-1/2.....	2	4%
Not applicable, we do not use rapid HIV tests.....	1	2%

A majority (96%, 50) of HDs using rapid tests use **whole blood obtained from fingerstick**. Three (6%) HDs use **whole blood obtained from venipuncture**, exclusively, and one HD reports conducting rapid testing on **serum**, exclusively. All of the HDs who use **oral fluid** rapid HIV testing also report using other sample types.

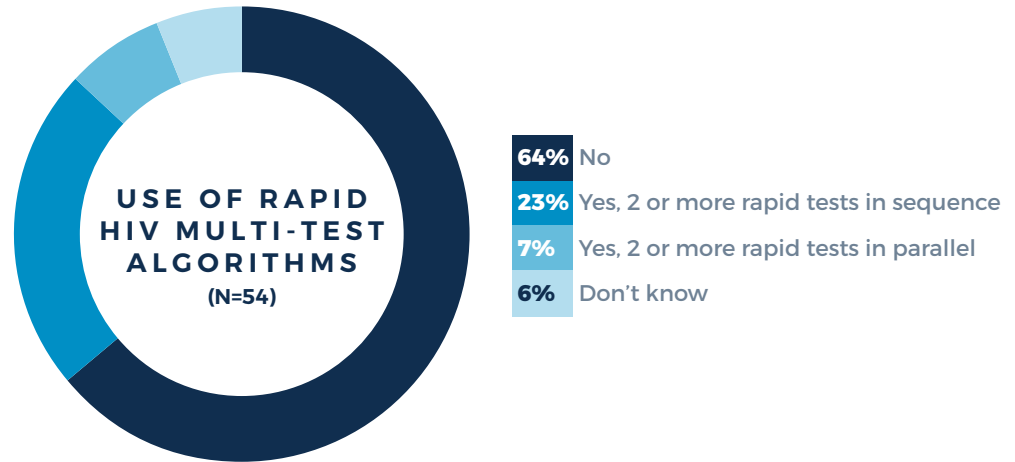
TABLE 6:
SAMPLE TYPE USED
 with Point of Care Rapid HIV Testing

	No. (N=52)	%
Whole blood fingerstick.....	50	96%
Oral fluid.....	25	48%
Whole blood venipuncture.....	21	40%
Serum.....	8	15%
Other.....	1	2%

TESTING

Thirty-one percent of HDs use a **multi-rapid test algorithm**; of these three-quarters reported using **2 rapid tests** in sequence. This is a modest increase from 2015, when 29% of HIV testing providers reported conducting point-of-care rapid HIV testing using a multi-test algorithm.

FIGURE 13:



Of the 14 HDs that report plans to purchase a different rapid test in the next 12 months, **Determine** and **INSTI** were each cited by two-thirds of respondents.

FIGURE 14:

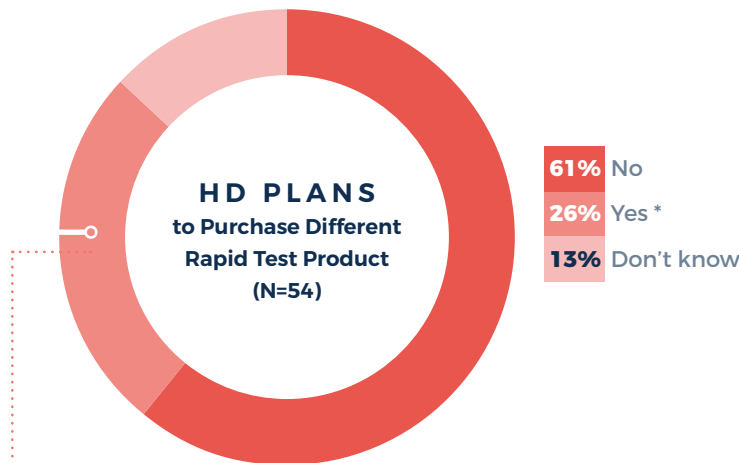


TABLE 7:

RAPID TESTS to be Purchased Next 12 Months

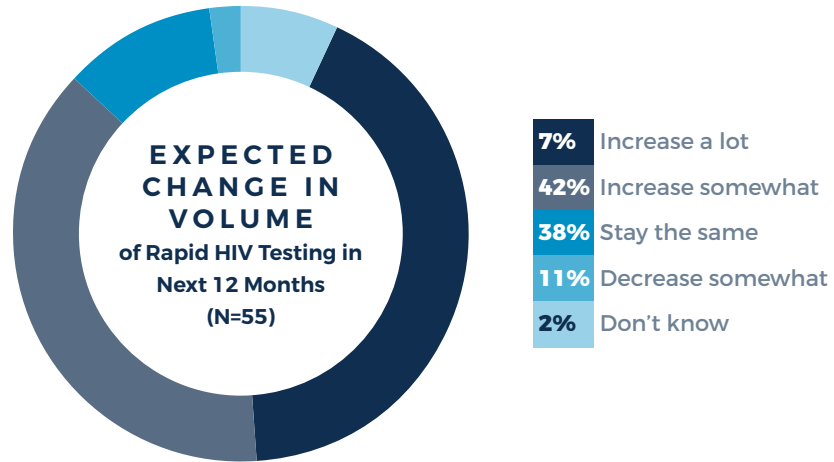
Rapid Tests	No. (N=14)	%
Determine™ HIV-1/2 Combo	9	64%
INSTI® HIV-1/HIV-2 Antibody Test	9	64%
DPP® HIV-1/2	2	14%
OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test	2	14%

*Note: No HDs reported plans to purchase Clearview® COMPLETE HIV 1/2, Clearview® HIV1/2 STAT-PAK, nor UniGold™ Recombigen® HIV-1/2 in the next 12 months.

TESTING

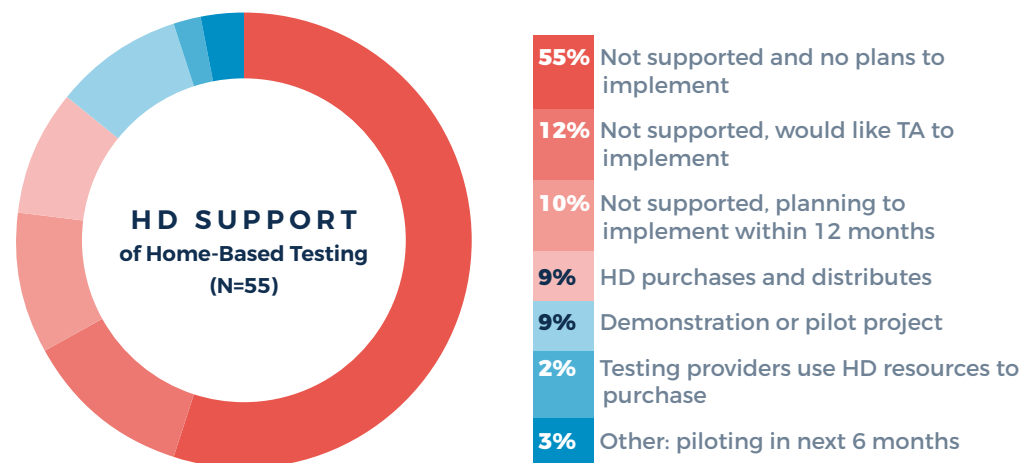
Generally speaking, HDs **project either level or modestly increased volume of HIV testing** in the upcoming year.

FIGURE 15:



A majority (55%) of HDs **do not support home-based HIV testing**, and do not plan to do so. However, this represents an increase in interest compared to the **previous NASTAD HIV Testing Report** in 2016, at which point only 8% of HDs were either implementing or planning to implement home-based testing within 12 months, and 79% had no plans to implement.

FIGURE 16:



TESTING

All HDs support targeted HIV testing programs, operating in both clinical and non-clinical venues. Common venues are consistent over time.

TABLE 8:

SETTINGS WHERE TESTING IS PERFORMED

Settings	No. (N=55)	%
Community-based organizations	52	95%
Partner services	49	89%
Outreach (e.g., bars, health fairs)	46	84%
Sexually transmitted disease clinics	45	82%
Community health centers	42	76%
Mobile van	36	65%
Substance use treatment facilities	34	62%
Correctional settings	33	60%
Syringe services program	30	55%
Family planning clinics	28	51%
Hospital emergency departments	21	38%
Faith-based settings	17	31%
Drugstores/community pharmacies	14	25%
TB clinics	12	22%
Prenatal/obstetrical clinics	9	16%
Hospital inpatient settings	6	11%
Labor and delivery settings	6	11%
Hospital outpatient settings	5	9%
Other	5	9%
Dental care settings	4	7%
Urgent care clinics	4	7%

TESTING

Eighty-seven percent (48) of HDs support routine HIV testing in clinical venues.

TABLE 9:

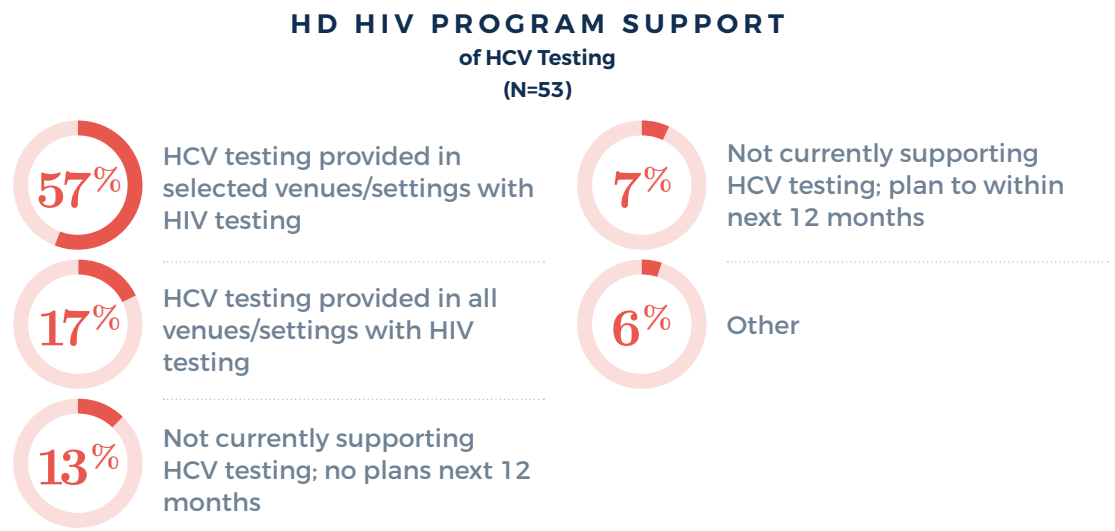
SETTINGS FOR ROUTINE TESTING		
Settings	No. (N=55)	%
Community health centers	39	81%
Sexually transmitted disease clinics	33	69%
Hospital emergency departments	24	50%
Family planning clinics	23	48%
Correctional settings	18	38%
Substance use treatment facilities	15	31%
Prenatal/obstetrical clinics	14	29%
Primary care clinics	13	27%
Labor and delivery settings	12	25%
TB clinics	10	21%
Hospital inpatient settings	9	19%
Hospital outpatient settings	9	19%
Urgent care clinics	7	15%
Dental care settings	6	13%
Other	5	10%

Integrated Testing

HIV and HCV Testing:

HDs are widely implementing HCV testing in settings/venues where HIV testing is also offered. Only seven (13%) of HDs are not currently supporting HCV testing and have no plans to do so in the upcoming 12 months.

FIGURE 17:



TESTING

A majority of HDs offer HCV testing consistent with national screening recommendations (i.e. birth cohort and risk-based). Two HDs reported co-testing for HIV and HCV.

TABLE 10:
STRATEGY FOR DETERMINING WHICH PATIENTS ARE TESTED FOR HCV

Strategy	No. (N=39)	%
HCV testing is only offered to patients/clients		
pursuant to national screening recommendations	13	33%
All patients/clients tested for HIV are also offered testing for HCV	10	26%
Risk-based testing	9	23%
All patients/clients tested for HIV are also tested for HCV	2	5%
Other	5	13%
Total	39	100%

HDs support **HCV testing in a variety of settings** where HIV testing is also provided. Importantly, many support HCV testing in settings where PWID may be reached including **SSPs** (46%, 18) **substance use treatment facilities** (41%, 16), and **correctional settings** (38%, 15).

TABLE 11:
SETTINGS FOR HCV AND HIV TESTING

Settings	No. (N=39)	%
Community-based organizations	29	74%
Sexually transmitted disease clinics	21	54%
Community health centers	20	51%
Outreach (e.g., bars, health fairs)	19	49%
Syringe services program	18	46%
Substance use treatment facilities	16	41%
Correctional settings	15	38%
Partner services	10	26%
Family planning clinics	9	23%
Hospital emergency departments	6	15%
Faith-based settings	3	8%
Hospital inpatient settings	3	8%
Other *	3	8%
Hospital outpatient settings	2	5%
TB clinics	2	5%
Urgent care clinics	1	3%
Dental care settings	0	0%
Drugstores/community pharmacies	0	0%
Labor and delivery settings	0	0%
Mobile van	0	0%
Prenatal/obstetrical clinics	0	0%

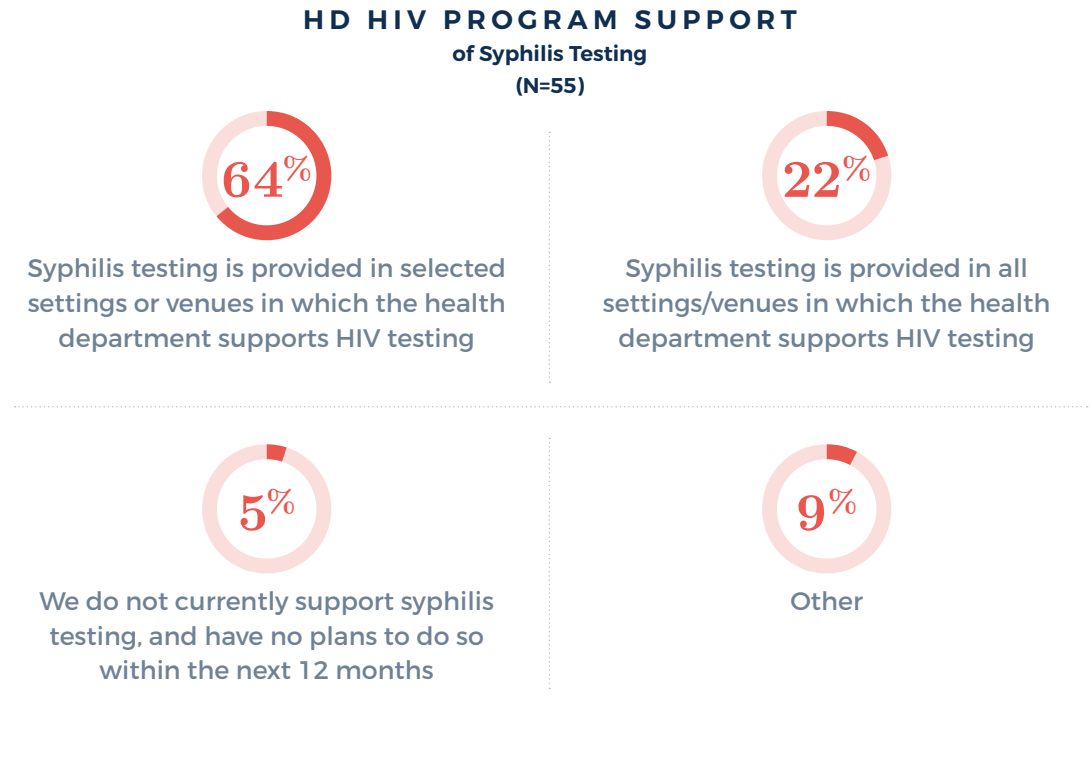
*Note: All other responses indicated local health departments.

TESTING

HIV and STD Testing:

HDs are widely implementing syphilis testing in settings/venues where HIV testing is also offered. Only three (5%) of HDs are not currently supporting syphilis testing and have no plans to do so in the upcoming 12 months.

FIGURE 18:



A majority of HDs offer syphilis testing consistent with national screening recommendations. Four (8%) HDs co-test for HIV and syphilis.

TABLE 12:

STRATEGY FOR DETERMINING WHICH PATIENTS ARE TESTED FOR SYPHILIS

Strategy	No. (N=52)	%
All patients/clients tested for HIV are also offered testing for syphilis.....	22	42%
Syphilis testing is only offered to patients/clients pursuant to national screening recommendations.....	16	31%
Other	10	19%
All patients/clients tested for HIV are also tested for syphilis.....	4	8%

TESTING

HDs **support syphilis testing in a variety of settings** where HIV testing also provided. Importantly, **many support HCV testing in settings where people with sexual risk for HIV and STDs may be reached** including **STD clinics (79%), community-based organizations providing services to priority populations such as MSM (58%)** and in the context of **partner services (46%)**.

TABLE 13:
SETTINGS FOR SYPHILIS AND HIV TESTING

Settings	No. (N=52)	%
Sexually transmitted disease clinics	41	79%
Community-based organizations	30	58%
Community health centers	26	50%
Partner services	24	46%
Family planning clinics	17	33%
Outreach (e.g., bars, health fairs)	15	29%
Mobile van	14	27%
Correctional settings	13	25%
Substance use treatment facilities	6	12%
Hospital emergency departments	5	10%
Hospital outpatient settings	5	10%
Prenatal/obstetrical clinics	5	10%
Syringe services program	5	10%
Hospital inpatient settings	4	8%
Labor and delivery settings	4	8%
Other *	3	6%
Faith-based settings	2	4%
Urgent care clinics	2	4%
TB clinics	1	2%
Dental care settings	0	0%
Drugstores/community pharmacies	0	0%

*Note: All other responses indicated local health departments.

Extra-Genital Nucleic Acid Amplification Testing (NAAT) for Sexually Transmitted Infections

Combined, a majority of HDs provide, support, and/or promotes extra-genital testing.

TABLE 14:
HIV PROGRAM SUPPORT OF EXTRA-GENITAL NAAT FOR STD

Support	No. (N=52)	%*
HD provides extra genital testing	19	37%
HD funds extra genital testing for funded agencies	19	37%
HD does not fund, but promotes extra genital testing	10	19%
HD does not fund or promote extra genital testing	10	19%

*Note: Responses total 112% due to categories not being mutually exclusive.

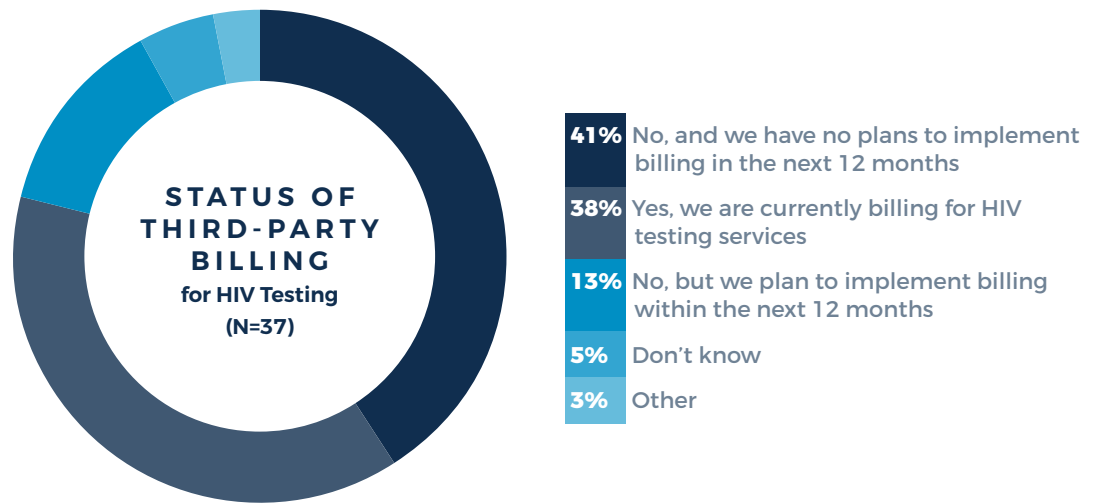
TESTING

Third-Party Billing For HIV Testing Services

Third-Party Billing for HIV Testing Services (HD-Provided Services)

Thirty-seven of 54 HDs report providing HIV testing services directly (e.g. through PHLs or partner services). Of those, 14 (38%) currently bill health insurance for HIV testing.

FIGURE 19:



Of the 14 HDs that currently bill third-party insurance for HIV testing, all bill Medicaid and a majority also bill private insurance.

TABLE 15:

PAYERS AMONG HDs SEEKING REIMBURSEMENT FOR HIV TESTING		
Payers	No. (N=14)	%
Medicaid	14	100%
Private	10	71%
Medicare	7	50%

TESTING

Top three challenges associated with implementation of third-party billing:

- 1) Revenue generated from billing may not come back to the HIV program
- 2) HD capacity (knowledge of staff needed to implement billing, IT infrastructure, support for providers, etc.)
- 3) Patients served by the HD lack health insurance

TABLE 16:

CHALLENGES TO HDs IMPLEMENTING THIRD-PARTY BILLING AND REIMBURSEMENT FOR HIV TESTING

Challenges	No. (N=51)	%	Score	Rank
N/A, HD does not provide testing services directly	25	49%	26	5
HIV program staff lack knowledge about billing and reimbursement needed to plan for implementation	16	31%	40	2
Revenue generated from billing does not come back to the HIV program	13	25%	44	1
A majority of patients/clients do not have insurance	13	25%	32	3
HD lacks the IT capacity needed to pursue reimbursement	12	24%	31	4
HIV program lacks capacity to support providers in implementation	9	18%	26	5
HD does not use electronic health records	8	16%	23	7
Challenges in contracting with health insurers	5	10%	18	8
Confidentiality/privacy concerns related to explanation of benefits	5	10%	17	9
State or local regulations do not permit billing for HD provided tests	5	10%	15	10
Capitated payment structures do not allow reimbursement	4	8%	12	11
Testing services not covered by insurance	3	6%	9	12
Other	3	6%	3	15
Don't know	3	6%	6	13
Difficulty in becoming a qualified provider	2	4%	3	15
Insurance networks do not allow reimbursement	1	2%	4	14
Privacy concerns related to HIPAA	1	2%	1	17
Global payment structures do not allow reimbursement	0	0%	0	18

TESTING

Third-Party Billing for HIV Testing Services (Contracted Testing Services):

Just over one-quarter (26%) of HDs require some or all supported providers to seek reimbursement from health insurers, including Medicaid. Among HDs that require some providers to bill, most indicated that clinical providers are required to bill for HIV testing services, while community-based organizations are not.

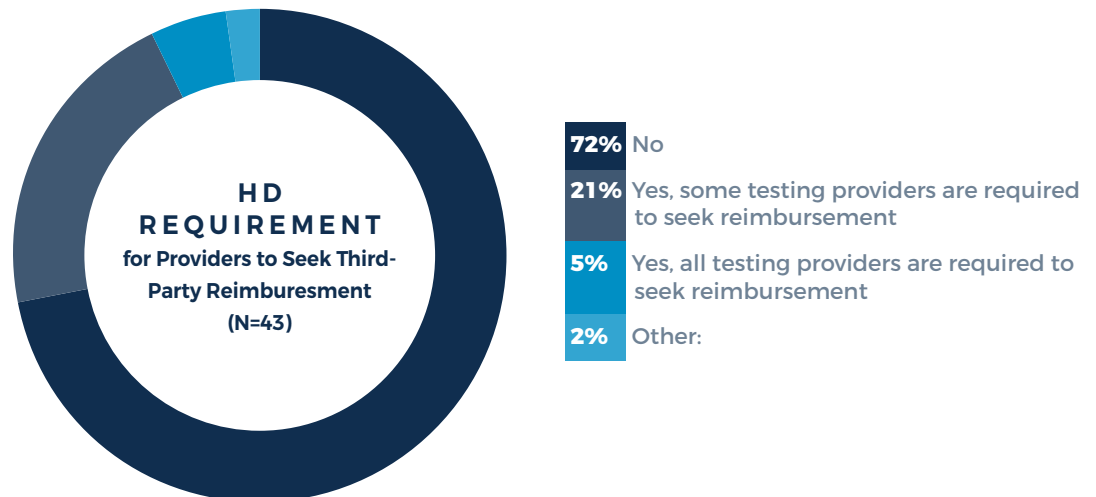
TABLE 17:

TYPE OF TESTING PROVIDERS SEEKING THIRD-PARTY REIMBURSEMENT FOR HIV TESTING

Type of Testing	No. (N=54)	%
Sexually transmitted disease clinics	25	46%
Community health centers	25	46%
HD clinics	22	41%
Hospitals	19	35%
Family planning clinics	17	31%
Community-based organizations	13	24%
Other clinical providers	13	24%
Don't know	6	11%
Substance use treatment facilities	5	9%
None of the above	5	9%
TB clinics	4	7%
Other	3	6%
Correctional settings	0	0%

HDs which require billing for some or all testing providers monitor compliance with multiple strategies.

FIGURE 20:



TESTING
TABLE 18:
STRATEGIES USED TO MONITOR COMPLIANCE WITH THIRD-PARTY BILLING REQUIREMENT

Strategies	No. (N=11)	%
HD supported programs must attest to billing	6	67%
Compliance is assessed through fiscal review	6	67%
Other	2	22%
Budgets must include income from billing	1	11%
Invoicing must reflect third-party revenue	0	0%

Among the most important **challenges associated with implementation of third-party billing for testing providers** are that patients served by these providers **lack health insurance**, and **lack of capacity and other barriers** associated with contracting with health insurance plans, notably for community-based/non-clinical providers.

TABLE 19:
CHALLENGES TO IMPLEMENTING THIRD-PARTY BILLING AND REIMBURSEMENT FOR HIV TESTING FOR HD-SUPPORTED PROVIDERS

Challenges	Rank	No. (N=50)	%	Score
A majority of patients/clients do not have insurance	1	28	56%	96
Challenges in contracting with health insurers or other third-party payers	2	29	58%	92
Difficulty in becoming a qualified provider	3	23	46%	71
Community-based/non-clinical providers lack capacity and/or infrastructure to pursue reimbursement/Providers lack the capacity to follow-up on unpaid bills	4	35	70%	67
Confidentiality/privacy concerns related to explanation of benefits (EOB) statements	5	14	28%	49
Poor reimbursement rates	5	13	26%	49
Community-based/non-clinical providers do not use electronic health records	7	25	50%	48
Don't know	8	14	28%	46
Other	9	11	22%	27
Testing services not covered by insurance	10	8	16%	25
Capitated payment structures do not allow reimbursement	11	7	14%	16
Insurance networks do not allow reimbursement	12	4	8%	13
Global payment structures do not allow reimbursement	13	2	4%	4

TESTING

Laboratory Reporting

All HDs report that Ab and Ag/Ab positive results are reportable and most (92%) report that quantitative viral load and CD4 (89%) results are reportable. A minority of jurisdictions report that negative results concurrent to positive results are reportable.

TABLE 20:

LABORATORY REPORTABLE TEST RESULTS

Test Results	No. (N=53)	%
Positive HIV Ab and/or Ag	53	100%
Positive NAT (qualitative)	50	94%
HIV viral loads	49	92%
CD4 counts	47	89%
HIV viral loads below detectable levels	43	81%
Sequences from HIV genotyping	26	49%
Negative NAT (qualitative) concurrent to Ab and/or Ab/Ag+	18	34%
Negative HIV Ab concurrent to Ab or Ag/Ab+	15	28%
Other	6	11%

The majority of laboratory reports appear to be submitted by laboratories to HDs electronically. Commercial laboratories are the most compliant in submitting results electronically, with 88% of HDs reporting receipt of results electronically, followed by clinical laboratories (74%), state public health laboratories (72%), and local public health laboratories (53%).

FIGURE 21:

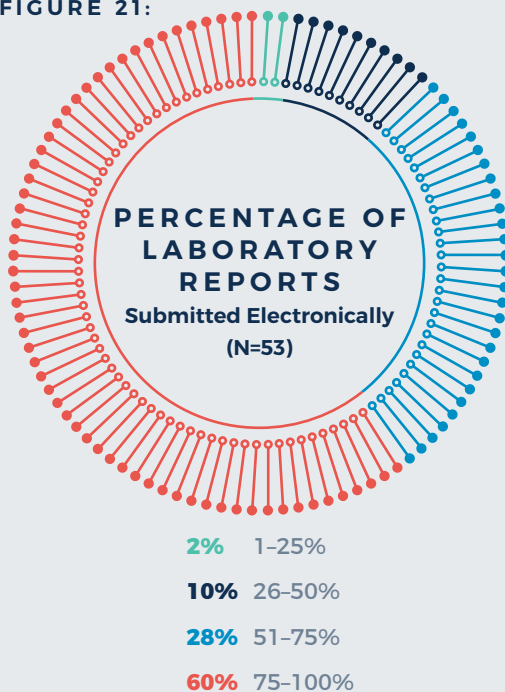
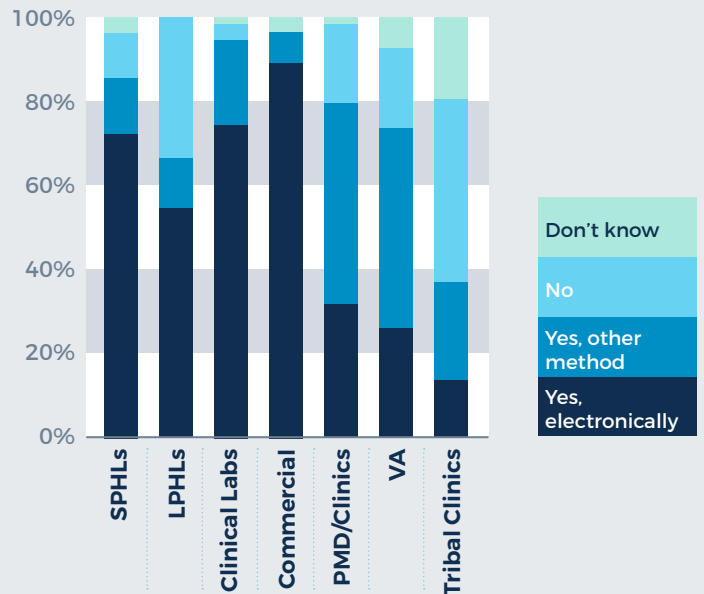


FIGURE 22:

LABORATORY REPORTING STATUS AND METHOD, by Laboratory Type (N=53)



TESTING

HDs report a **wide variety of challenges associated with laboratory reporting of HIV test results**. Most important among these are that laboratories fail to report complete patient information, do not report results to the HD electronically, do not use correct coding for reporting, and do not report results from referred laboratories. HD capacity to follow-up with laboratories to improve the quality and completeness of data is also a significant challenge.

TABLE 21:
CHALLENGES TO LABORATORY REPORTING OF HIV TEST RESULTS TO HDs

Challenges	No. (N=51)	%
Laboratories do not report complete patient information	24	47%
Some laboratories do not report HIV test results to the HD electronically	21	41%
Some laboratories do not report HIV test results to the HD	18	35%
Laboratories do not report results of tests referred to other laboratories	14	27%
The HD lacks capacity to provide training and technical assistance to laboratories to improve reporting compliance and data quality and completeness	13	25%
The HD lacks capacity to conduct quality assurance and follow-up with laboratories to improve data timeliness and completeness	12	24%
Laboratories do not report results with correct coding for test results	12	24%
Some laboratories do not report HIV test results to the HD timely	12	24%
The HD lacks capacity to follow-up on missing or incomplete data received from laboratories	12	24%
Other	11	22%
Laboratories do not report results with appropriate interpretation of test results	8	16%
Laboratories do not report results with clear or complete names of tests performed	7	14%
Laboratories do not report HIV test results comparably	6	12%
The HD lacks the authority to receive test results	6	12%
Laboratories located outside of the jurisdiction do not report HIV test results to the HD	5	10%
The HD lacks infrastructure to receive HIV test results electronically	4	8%
The HD lacks the capacity to maintain electronic reporting of HIV laboratory test results	4	8%
The HD lacks the capacity to manage test results received electronically into eHARS	3	6%

TESTING

HDs employ a variety of strategies to laboratories to improve the quality, completeness, and timeliness of laboratory reported data, with a majority (57%) providing technical assistance to individual laboratories.

FIGURE 23:

STRATEGIES TO ASSESS AND PROMOTE
Quality and Completeness of Laboratory Reported Data (N=53)



HIV PREVENTION AND HEALTH SYSTEMS INTEGRATION

Third-Party Billing

Billing Medicare, Medicaid, or private health insurers for HIV prevention services is not common for HDs. Many HDs do not offer direct services and others have experienced administrative and infrastructure challenges to billing third parties. In contrast, third-party billing is much more common for HD-supported providers with community health centers as the most frequently cited type of provider billing third parties, followed by STD clinics, hospitals, HD clinics, and community-based organizations. **PrEP initiation and counseling is the most commonly billed service.**

FIGURE 24:

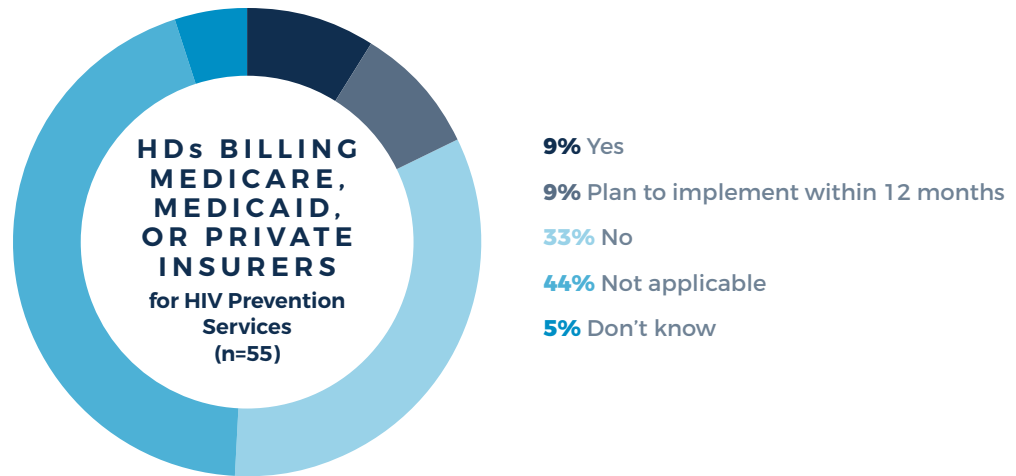


FIGURE 25:

HD SUPPORTED PROVIDERS IN 75% OF JURISDICTIONS BILL INSURERS FOR HIV PREVENTION SERVICES (n=55)

22
JURISDICTIONS

Community Health Centers

17
JURISDICTIONS

STD Clinics

16
JURISDICTIONS

Hospitals

15
JURISDICTIONS

HD Clinics

14
JURISDICTIONS

CBOs

14
JURISDICTIONS

No HD supported providers seek reimbursement

HIV PREVENTION AND HEALTH SYSTEMS INTEGRATION

FIGURE 26:

HIV PREVENTION SERVICES BILLED TO INSURERS BY HD-SUPPORTED PROVIDERS

(N=55)

NUMBER OF JURISDICTIONS

18	PrEP initiation or counseling
7	Risk reduction counseling
5	Care coordination services
5	Screening, Brief Intervention, and Referral to Treatment
4	Case management
4	Linkage assistance
4	Mental health assessment
4	Other
2	Self-management education and counseling

Of the jurisdictions (37%, 20) undertaking activities in the past year to increase third-party billing capabilities, most common activities include assessing contracted providers' billing practices and capabilities, and identifying technical assistance resources for either contracted providers or the HD

FIGURE 27:

ACTIVITIES TO INCREASE THIRD-PARTY BILLING CAPACITY

(N=55)

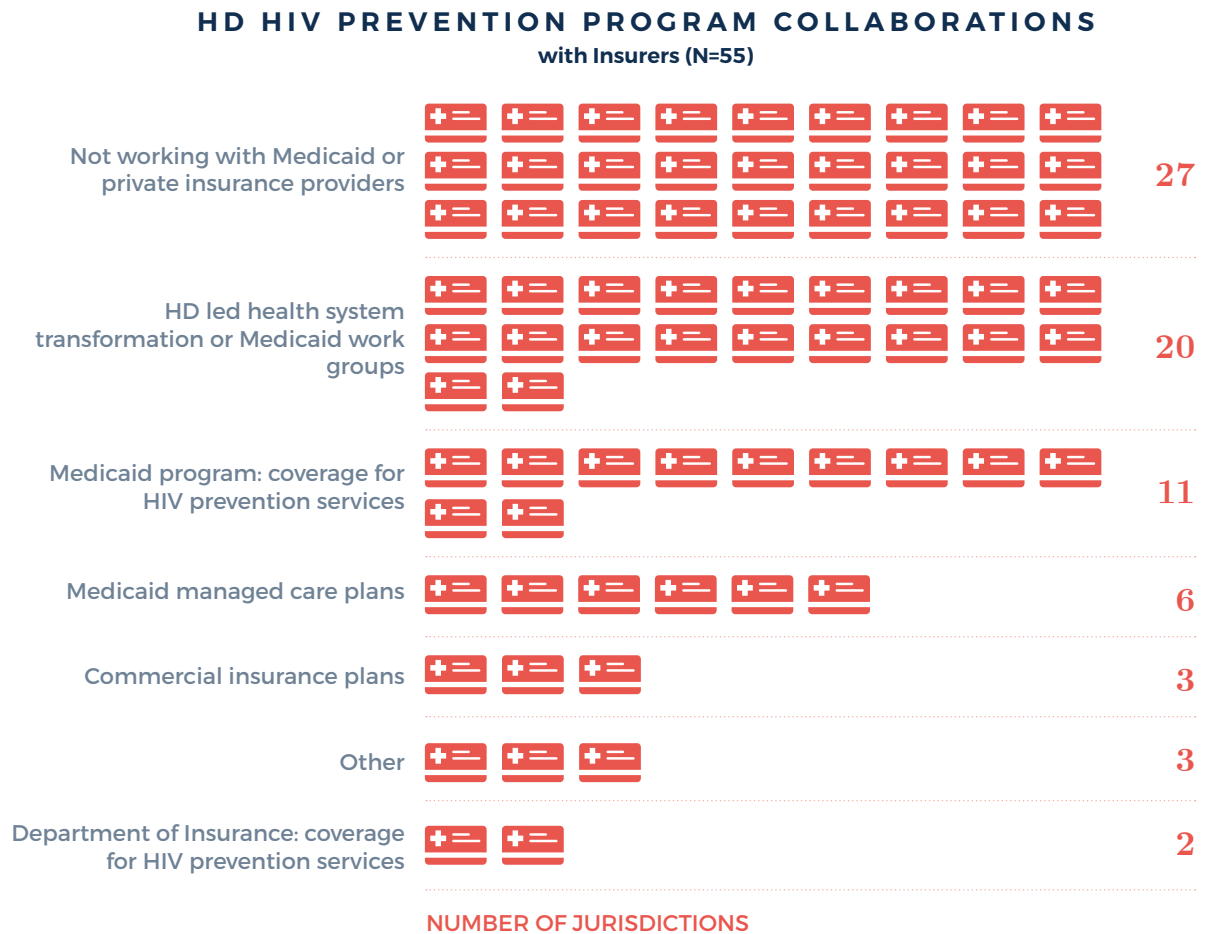
No activities to increase billing capacity	\$	34
Assessed third-party billing practices/capacity of contracted providers	\$\$\$\$\$\$\$\$\$\$\$\$\$\$\$\$	12
Identified billing technical assistance resources for contracted providers	\$\$\$\$\$\$\$\$\$\$\$\$	11
Identified billing technical assistance resources for HD	\$\$\$\$\$\$\$\$\$\$\$\$	11
Developed or increased internal HD billing infrastructure	\$\$\$\$\$\$	6
Engaged with other public health programs on HD billing capacity	\$\$\$\$\$\$	6

NUMBER OF JURISDICTIONS

Collaboration with Medicaid and Private Insurers

Half of the HIV prevention programs partner with Medicaid or private insurance stakeholders in some way, though collaboration with Medicaid is more common than collaboration with private insurance. These stakeholders include state Medicaid agencies, Medicaid Managed Care Organizations (MCOs), state departments of insurance, and private health insurance plans. **The most common collaborative activities include working with the Medicaid program to use Medicaid claims data and serving on HD-led health care transformation or Medicaid working groups.**

FIGURE 28:



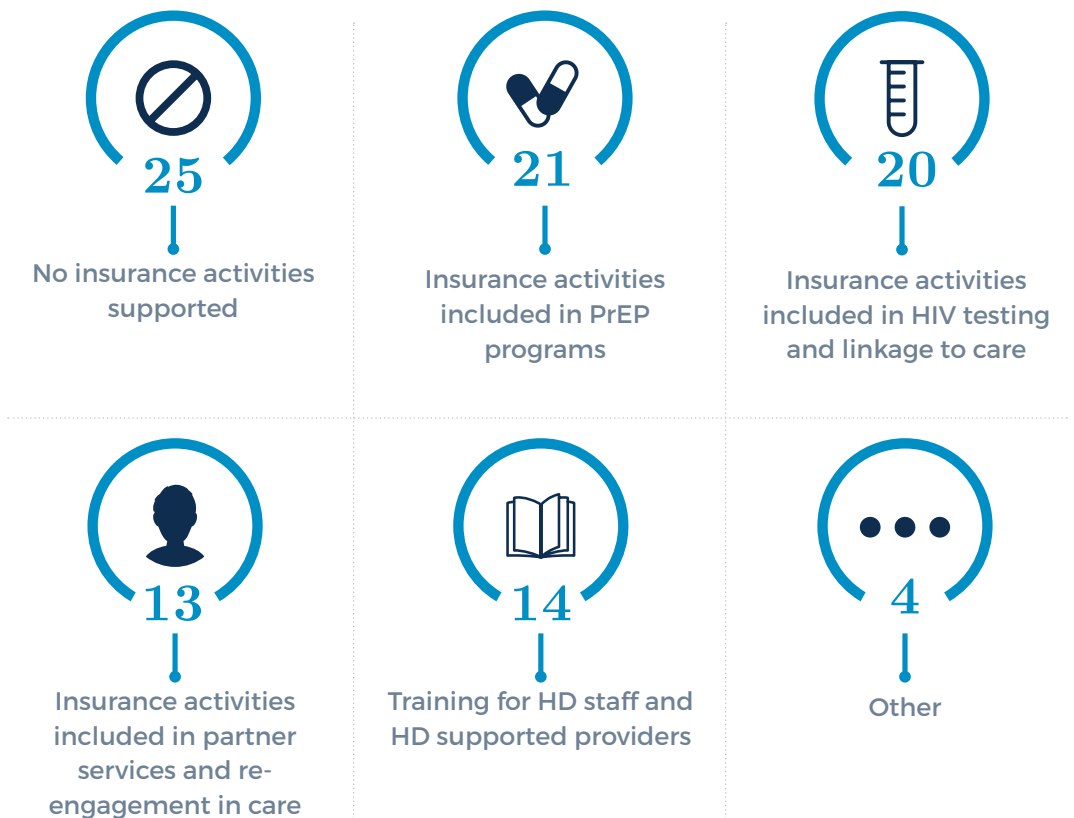
Insurance Education, Outreach, Referral and Enrollment

Fifty-five percent of HDs (30) reported including insurance education, outreach, referral, or enrollment activities in HIV prevention programs. Of those, 70% (21) incorporate insurance related activities into HD-supported PrEP programs. Sixty-seven percent (20) incorporated insurance related activities into HIV testing and linkage to care programs.

FIGURE 29:

55% OF JURISDICTIONS SUPPORT INSURANCE EDUCATION, OUTREACH, REFERRAL AND ENROLLMENT SERVICES

(N=55)



LINKAGE TO CARE

Linkage to care refers to the process of initiating HIV-related medical, psychological, and social services for newly diagnosed HIV-positive persons.

Accountability for Linkage to Care

Holding HD-supported HIV testing providers accountable for linkage to care is standard practice for most jurisdictions. Most utilize multiple strategies. Only 11% of survey participants (6) reported that they did not hold their testing providers accountable for linkage to care and another 2% (1) did not know.

HDs most frequently hold testing providers accountable for linkage to care through:

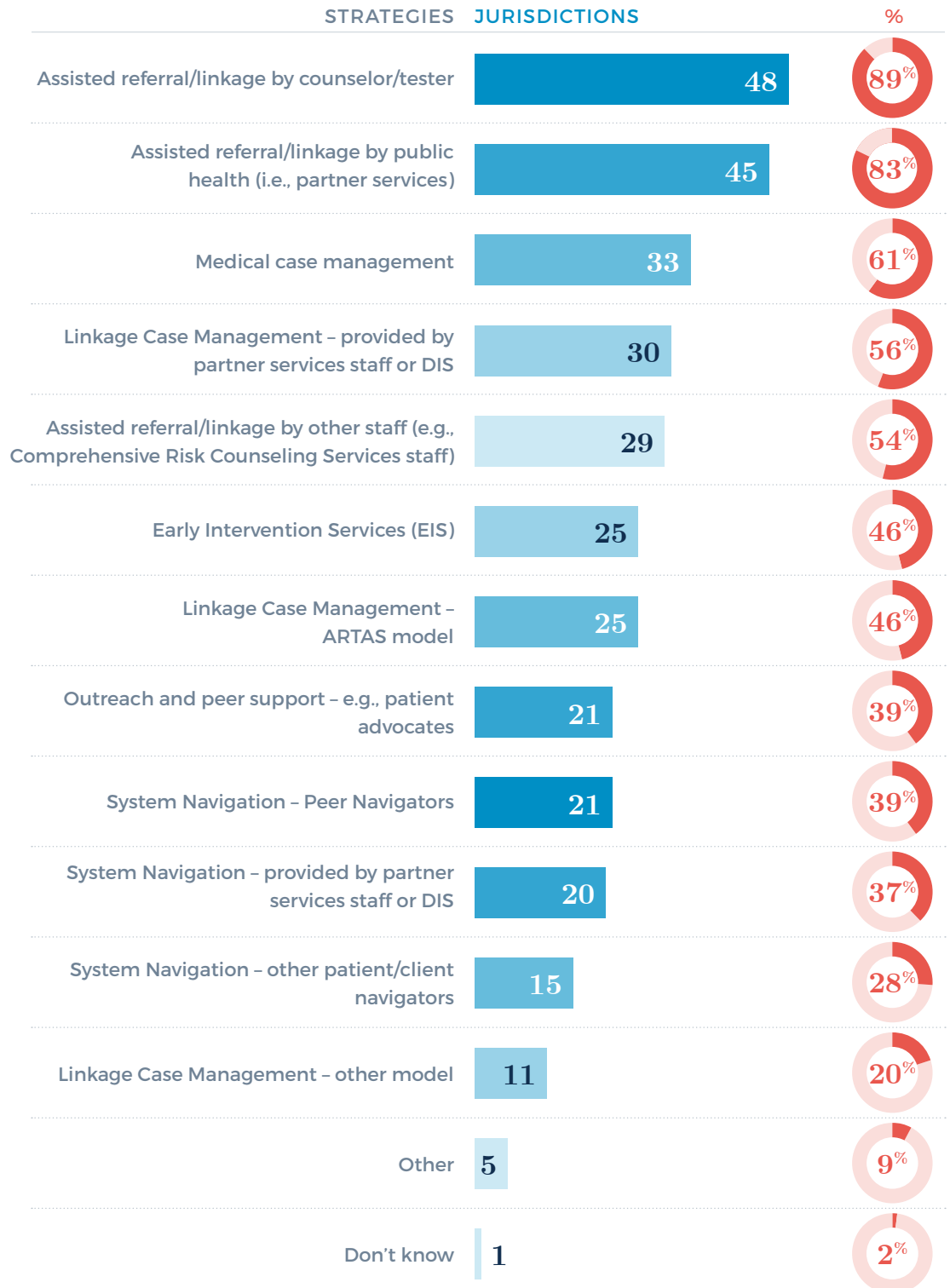
- Contractual requirements
- Performance metrics
- Incentives
- HD monitoring (including use of EvaluationWeb) and feedback to providers
- Setting specific timeframes for linkage (e.g., 21 days)

LINKAGE TO CARE

FIGURE 30:

LINKAGE TO CARE STRATEGIES

Used by HD Supported Providers (N=53)

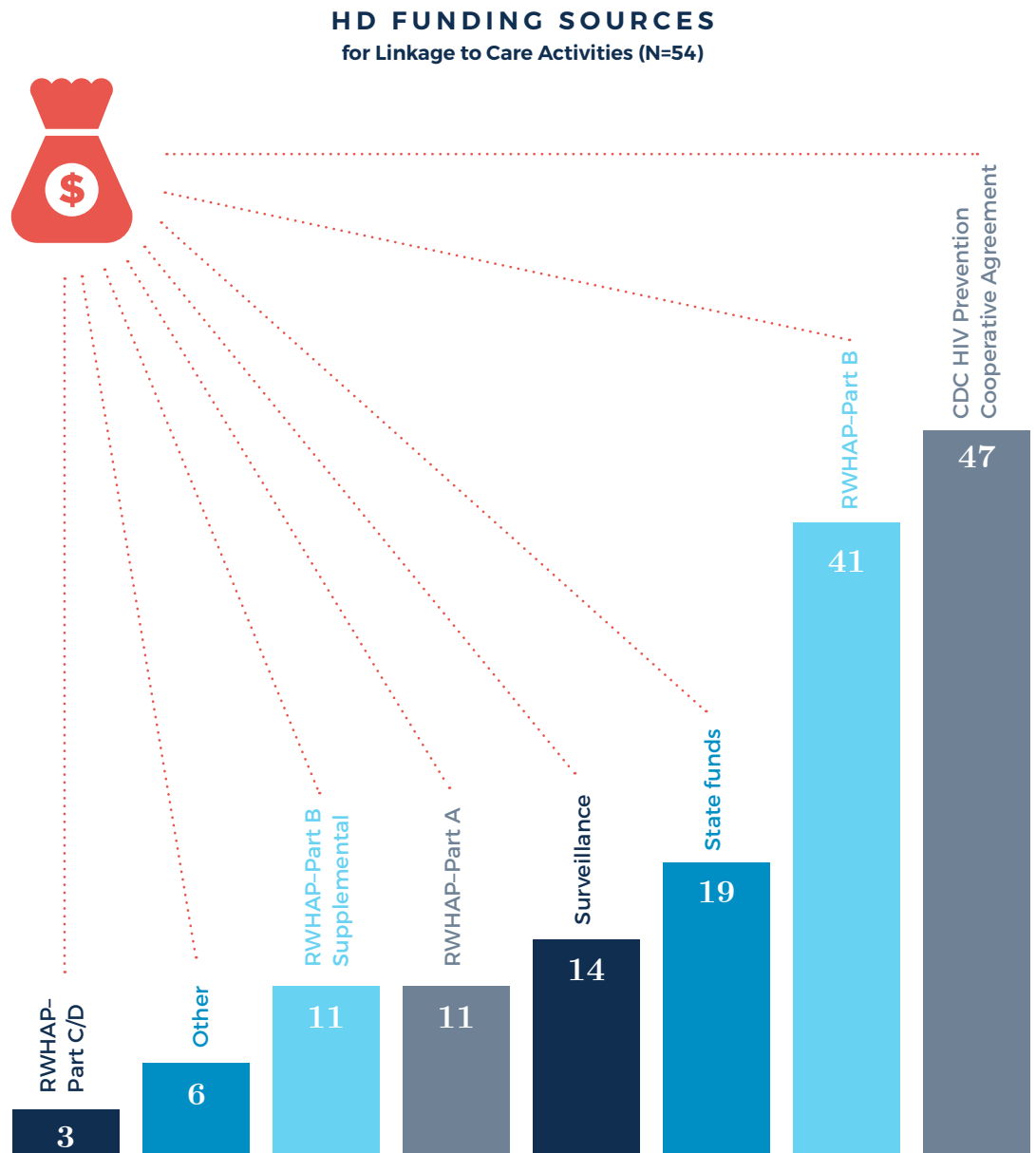


LINKAGE TO CARE

Funding Sources for Linkage to Care Activities

The vast majority of jurisdictions rely on a combination of **CDC HIV Prevention Cooperative Agreement and RWHAP Part B funds to support linkage to care activities**, 87% (47) and 76% (41) of jurisdictions, respectively; 35% of jurisdictions (19) allocated **state resources** for this purpose.

FIGURE 31:

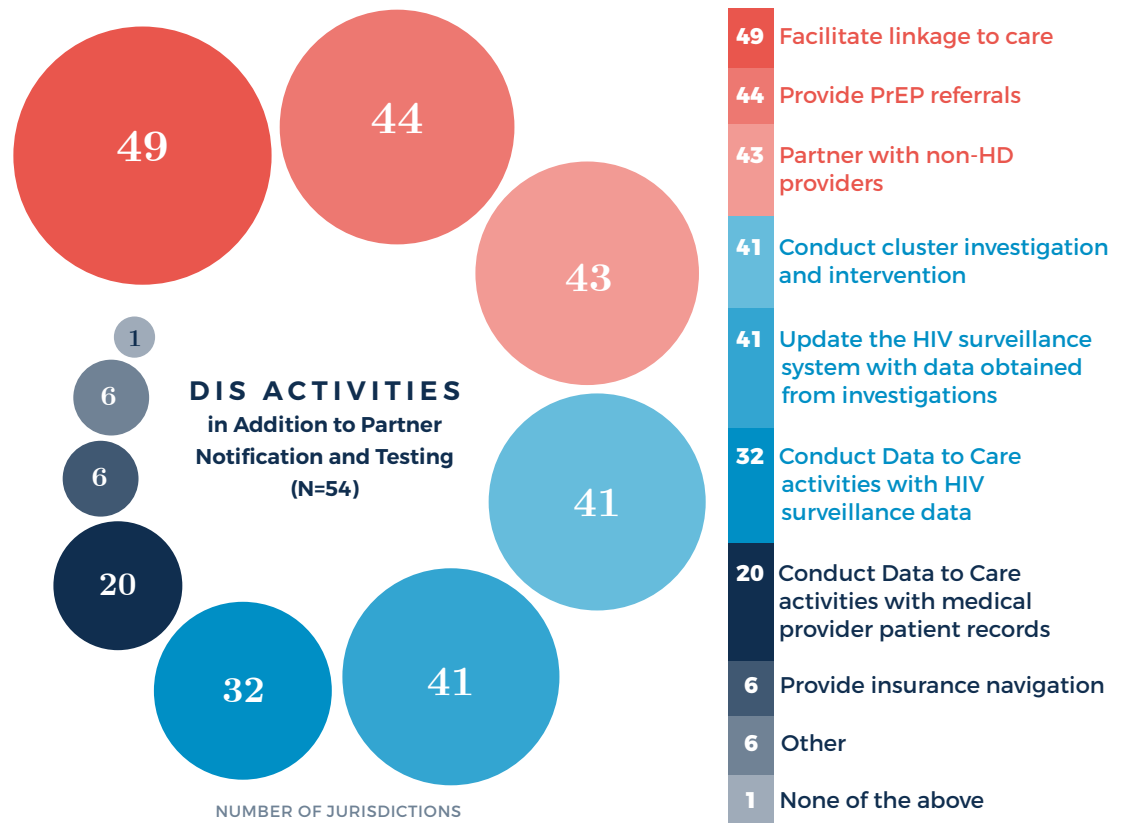


LINKAGE TO CARE

Disease Intervention Specialist Responsibilities

Disease Intervention Specialists (DIS) in most jurisdictions are responsible for an array of activities that extend far beyond the traditional partner services role of testing and partner notification. Of note, **DIS in 91% of jurisdictions (49) facilitate linkage to care and 81% (44) provide referrals for PrEP.**

FIGURE 32:

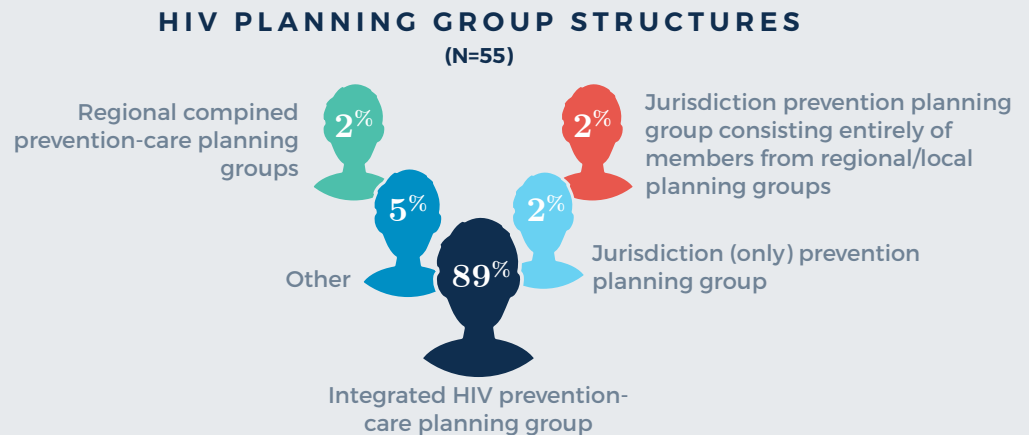


HIV PLANNING

HIV planning groups are comprised of service providers, state agency representatives and community members. The planning process is a critical function that helps guide efforts to increase access to HIV prevention and care services, and identify and address barriers. Planning groups are also reflective of the HIV epidemic in the jurisdiction. Historically, planning groups operated under an HIV prevention lens, however due to the integration process, groups now work towards achieving prevention and care-related goals noted in the Integrated HIV Services Plan (or Statewide Coordinated Statement of Need).

HIV planning in 89% of jurisdictions (49) integrates prevention and care.

FIGURE 33:



For most jurisdictions (62%), the integrated planning processes are recent (since 2014). This is largely due to the CDC/Health Resources and Services Administration (HRSA) *Integrated HIV Prevention and Care Planning Implementation Guidance*, released in June 2015.

Integrated HIV planning groups ranged from eight to 112 voting members (mean = 49.2; median = 42).

FIGURE 34:

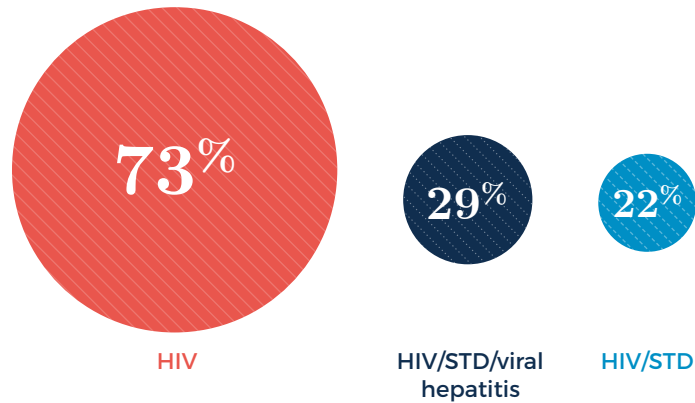
INTEGRATION OF HIV PREVENTION AND CARE PLANNING PRIOR TO 2014
(N=55)



HIV PLANNING

Seventy-three percent of jurisdictions (40) reported that **the scope of the HIV jurisdictional plan** included HIV prevention and care. HIV jurisdictional plans encompassed **HIV/STD/viral hepatitis prevention and care** in 29% (16) of jurisdictions and HIV/STD prevention and care in 22% (12). Seven respondents reported that their plans covered other areas including **housing, LGBT health, and surveillance**.

FIGURE 35:



HIV prevention staff are included in **evaluation and monitoring** of the **HIV Jurisdictional Plan** in 64% of jurisdictions (35). An evaluation and monitoring strategy was in development in another 29% of jurisdictions (16). Only 7% of respondents (4) did not have an evaluation and monitoring strategy for the HIV jurisdictional plan.

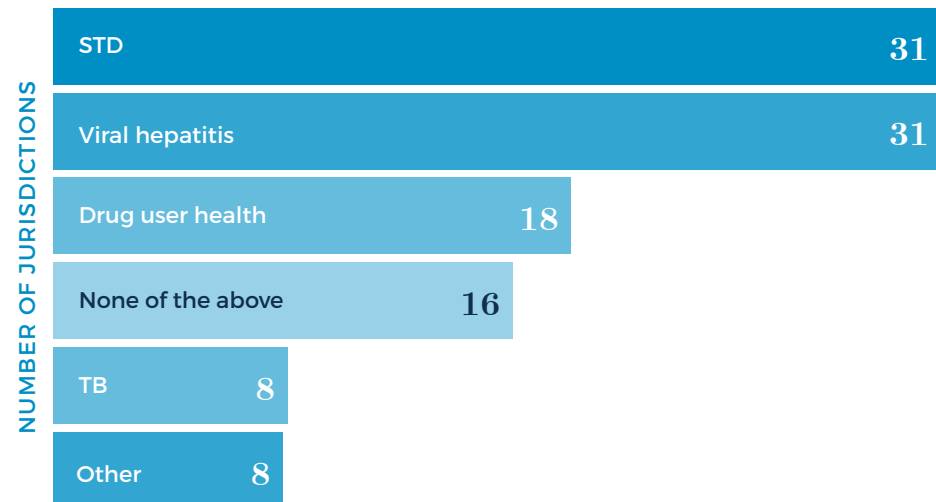
Incorporation of Other Public Health Areas in HIV Planning

Seventy percent of jurisdictions' HIV planning groups have incorporated other public health areas, including STDs and viral hepatitis (each 57%) and drug user health (33%) among others.

FIGURE 36:

INTEGRATION OF OTHER PUBLIC HEALTH AREAS WITH HIV PLANNING

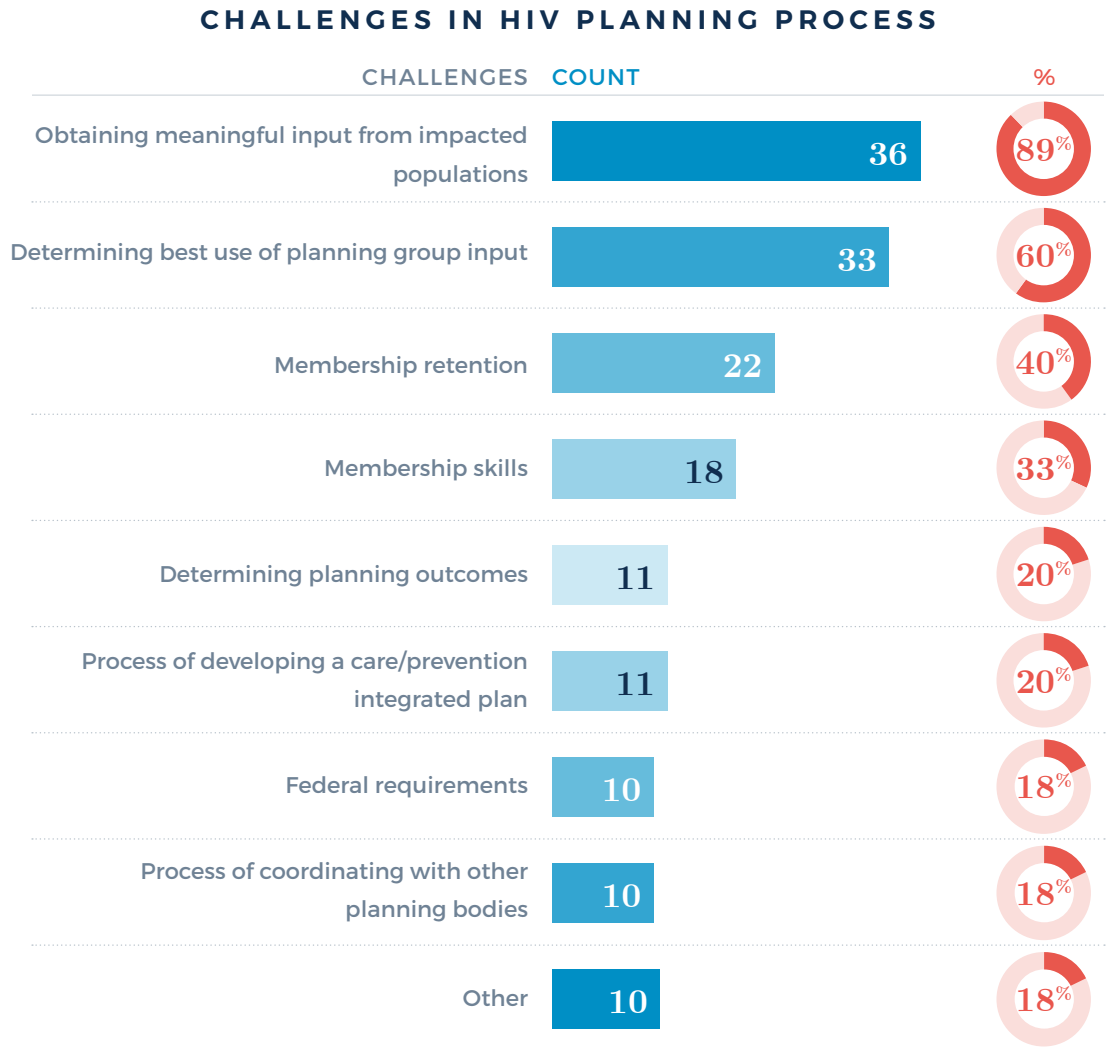
(N=54)



HIV PLANNING

Challenges for HIV Planning

FIGURE 37:



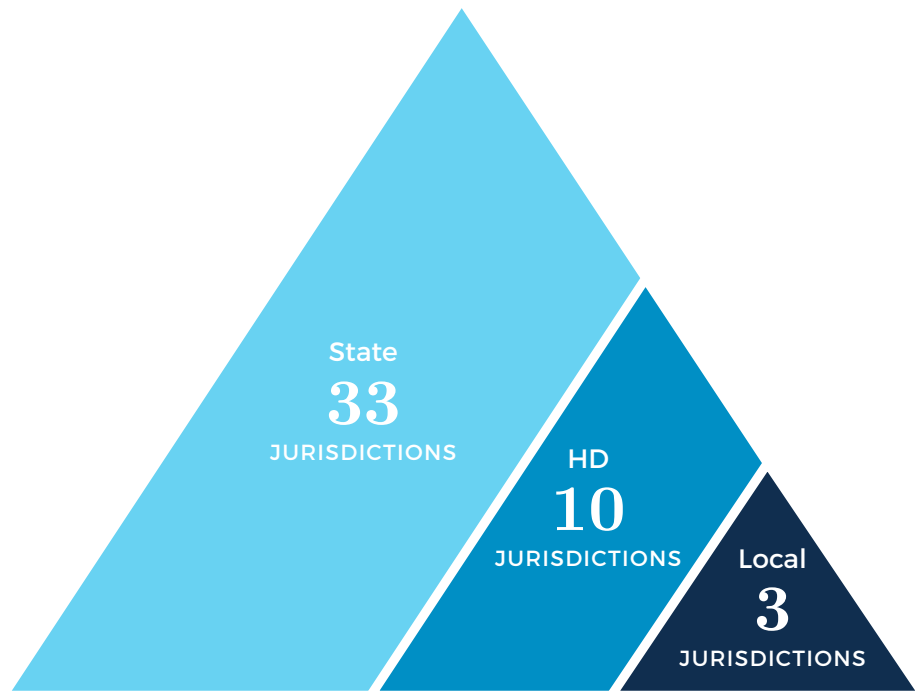
Respondents' perceptions about challenges in the HIV planning process have somewhat shifted since the 2014 NHPI. The challenge of **obtaining meaningful input from impacted populations was the leading concern in 2014 with similar proportions of respondents experiencing this challenge for both years of the survey**. An increased percentage of jurisdictions reported **concerns about determining the best use of planning group input** - 60% of respondents compared to 42% in 2014. Responses to this question for this round of the survey appear to **reflect a somewhat greater degree of comfort with the planning process**, with large decreases in the percentage of jurisdictions reporting challenges with: determining planning outcomes (37% in 2014); developing a care/prevention integrated plan (33% in 2014); and coordinating with other planning bodies (33% in 2014).

POLICY AND STRUCTURAL INITIATIVES

Seventy-one percent of jurisdictions (39) reported initiating and/or completing policy changes at the state, HD, and/or local level related to HIV prevention since 2014. Response categories are not mutually exclusive.

FIGURE 38:

LEVEL OF POLICY INITIATIVES ON HIV PREVENTION
(N=39)



Policy Focus Areas

Focus areas for jurisdictions' policy initiatives on HIV prevention reflect the impact of the opioid crisis, advances in information technology, and evolution of clinical practice.

POLICY AND STRUCTURAL INITIATIVES

TABLE 22:

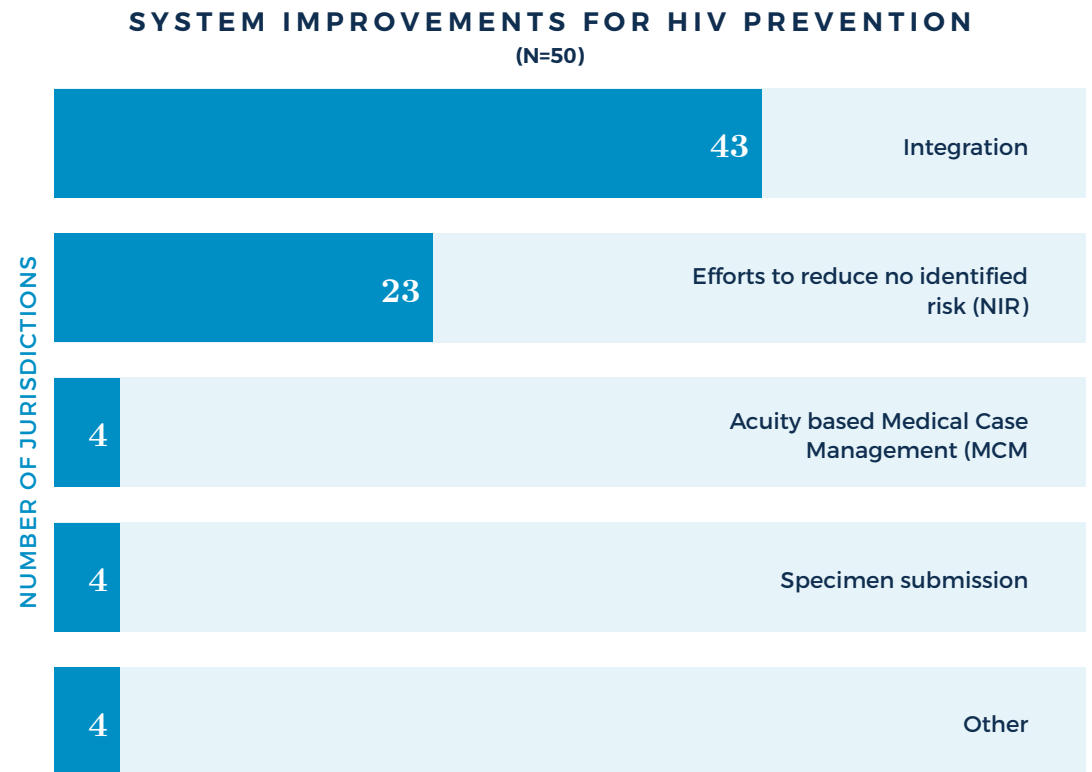
HIV PREVENTION POLICY INITIATIVES

Policy Initiative	Jurisdictions (N=39)	%
Naloxone access	19	49%
Syringe access	19	49%
Data sharing	16	41%
PrEP	15	39%
HIV screening (routinizing HIV testing)	12	31%
HIV testing	12	31%
Electronic lab reporting of CD4 and viral load	10	26%
Overdose Good Samaritan laws/drug overdose immunity	10	26%
Expedited partner therapy (EPT)	9	23%
HIV decriminalization/policy modernization	8	21%
Linkage/retention/reengagement in HIV medical care	8	21%
nPEP	8	21%
Syringe decriminalization	8	21%
Partner services	7	18%
Medicaid expansion	6	15%
Population-specific outreach (including people who inject drugs, justice-involved populations, Black MSM, etc.)	6	15%
STD/access to integrated services	6	15%
Viral hepatitis/access to integrated services	6	15%
Billing & reimbursement	4	10%
Other	4	10%
Comprehensive sex education for youth	3	8%
Safer injection facilities	3	8%
Substance use including medication assisted therapy (MAT)	3	8%
Infectious disease integration - treatment	2	5%
Other aspects of health reform	2	5%
Condoms	1	3%
Infectious disease integration - screening	1	3%
Mental health	1	3%
Provision of HIV-related medical care/ART	1	3%

POLICY AND STRUCTURAL INITIATIVES

Integration was the most prevalent system improvement aimed at enhancing HIV prevention.

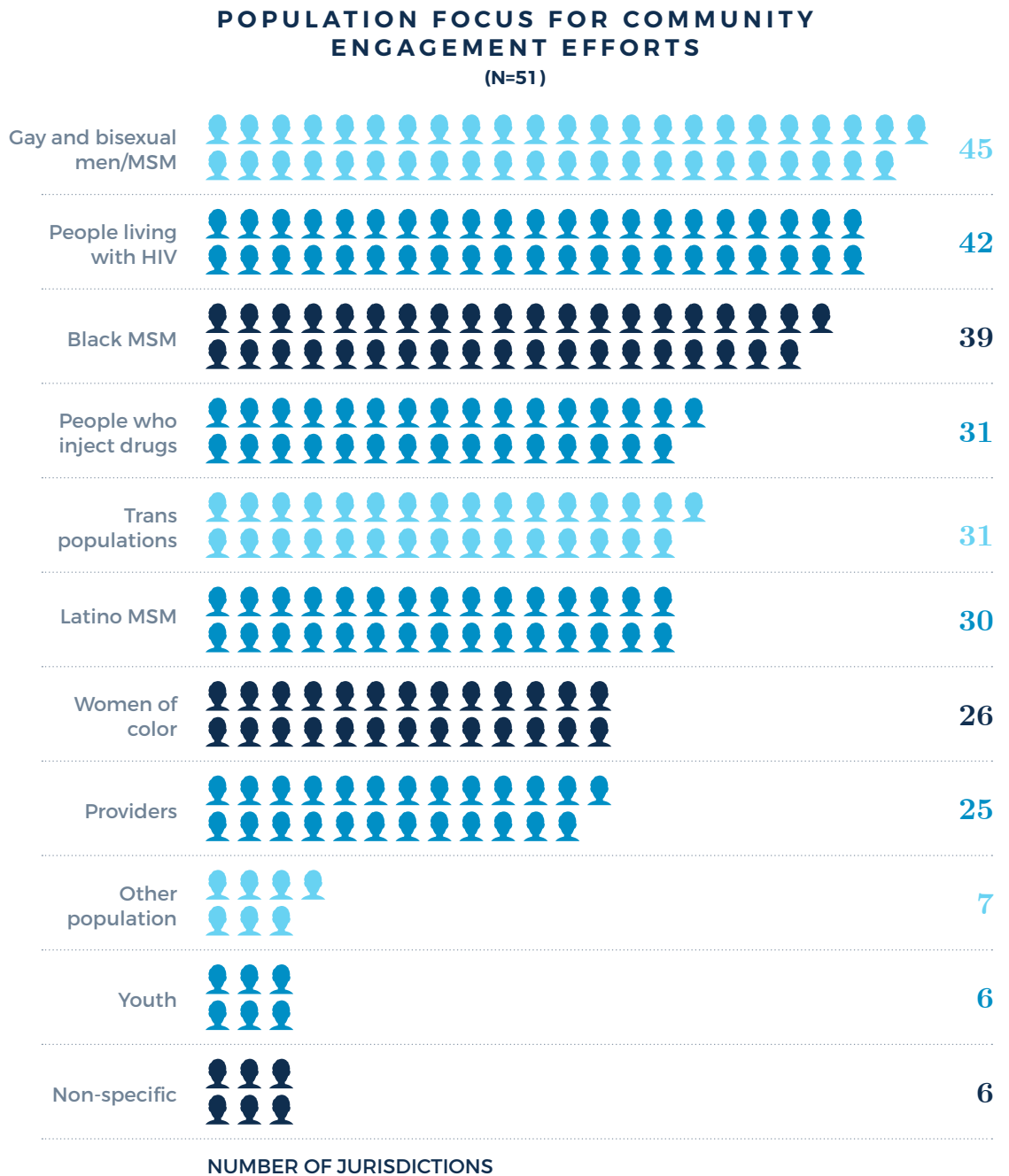
FIGURE 39:



COMMUNITY ENGAGEMENT

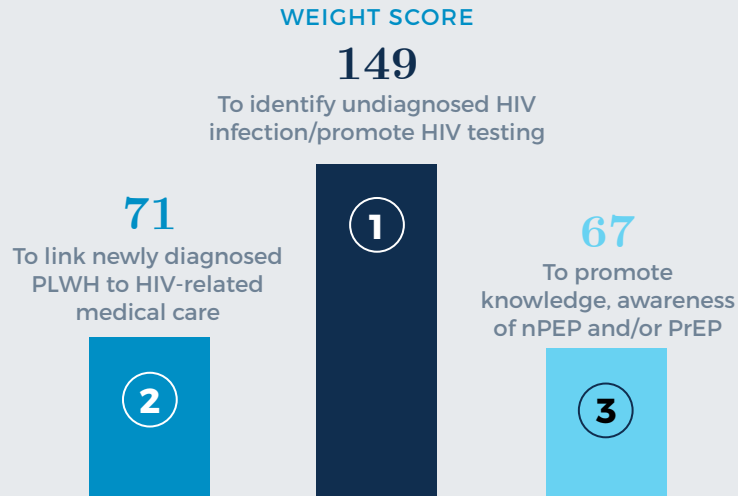
Nearly all jurisdictions (93%, 51) support community engagement efforts, with a particular focus on gay and bisexual men/MSM (88%, 45), PLWH (82%, 42), Black MSM (77%, 39), and an overarching goal of identifying undiagnosed HIV infection/promoting HIV testing.

FIGURE 40:



COMMUNITY ENGAGEMENT

FIGURE 41: TOP THREE COMMUNITY ENGAGEMENT PRIORITIES (N=50)



Community Engagement Activities

Jurisdictions supported a wide range of activities as part of their community engagement efforts, with social media (80%, 41) and media campaigns (75%, 38) leading the effort.

TABLE 23:

HIV PREVENTION COMMUNITY ENGAGEMENT ACTIVITIES

Community Engagement Activities	Jurisdictions (N=51)	%
Social media outlets (e.g., Facebook, Twitter)	41	80%
Public information media campaigns (e.g., radio, billboards, palm cards)	38	75%
HIV prevention programming at community events	36	71%
Social marketing campaigns (e.g., Greater than AIDS, Act Against AIDS, Testing Makes Us Stronger)	34	67%
Community level interventions	33	65%
Stakeholder groups (independent of official planning group)	27	53%
Campaign website	25	49%
Meetings/town halls with community stakeholders	25	49%
Focus groups	21	41%
Peer advocates/support	20	39%
Community health workers	18	35%
Local/jurisdiction-wide telephone information/referral line	12	24%
Text messaging (e.g., reminders of testing, medical appointments)	12	24%
Newspaper campaigns	9	18%
Community report outs	7	14%
Other	6	12%

COMMUNITY ENGAGEMENT

Community Engagement Challenges

The most common challenges with engaging community relate to **resources (staff and funding), capacity to engage prioritized communities, and HD procurement policies.**

HIV Prevention Advertising on Mobile Apps

Seventy-three percent of jurisdictions advertise on mobile apps. Sixty-seven percent (37) support community partners to advertise and 40% (22) do so directly.

FIGURE 42:



Use of Social Media

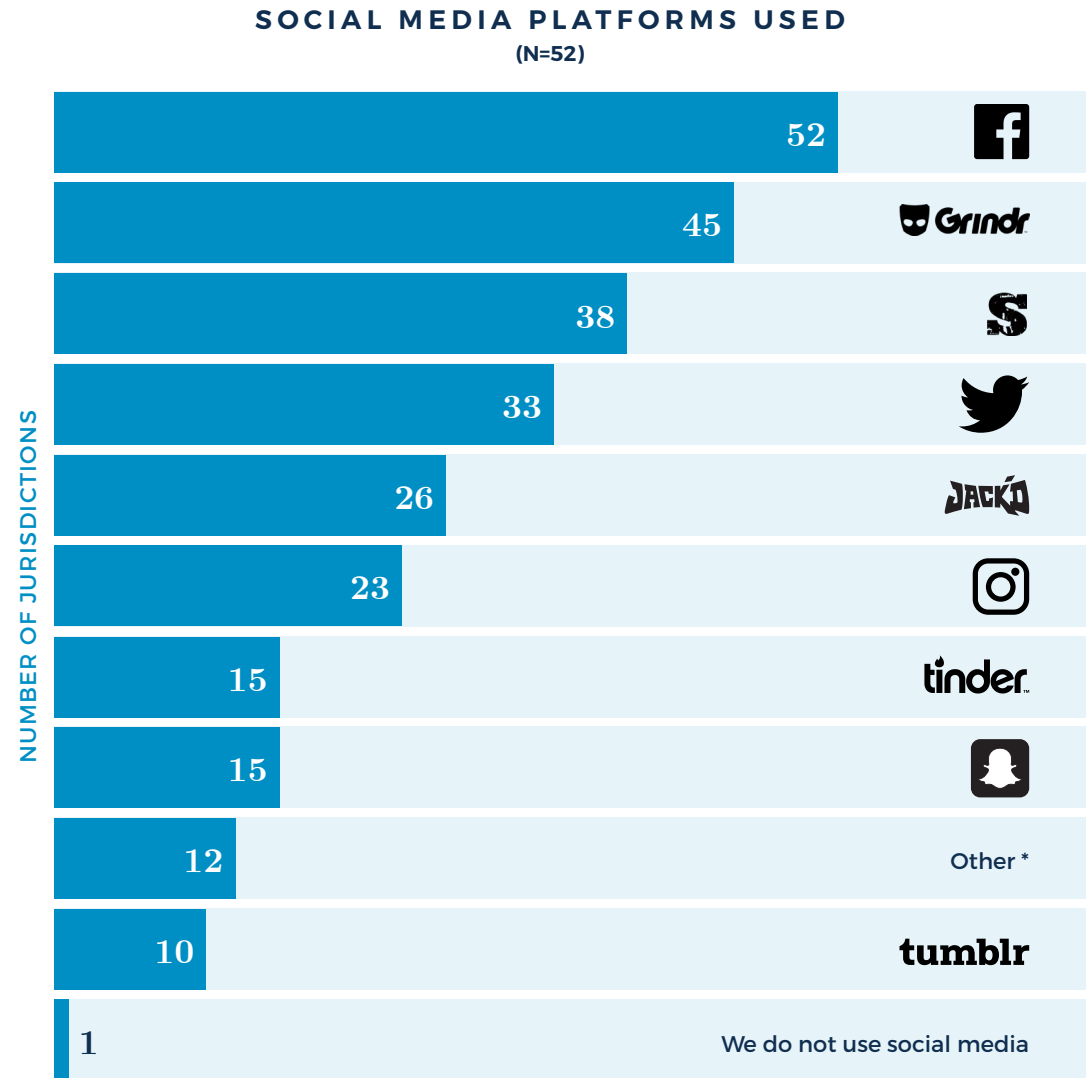
Ninety-eight percent of jurisdictions (HDs and/or supported community partners) utilize **social media** to engage communities in HIV prevention.

Most frequently utilized social media outlets:

- Facebook (95%, 52)
- Grindr (82%, 45)
- Scruff (69%, 38)
- Twitter (60%, 33)

COMMUNITY ENGAGEMENT

FIGURE 43:



*Note: Other options included Craigslist and Adam4Adam.

Of the 72% (39) of jurisdictions who use social media platforms to track social media metrics, Facebook (77%, 30) and Grindr (56%, 22) yielded the most significant community engagement.

COMMUNITY ENGAGEMENT

More than half of HDs prioritize MSM in social media campaigns:

FIGURE 44:

SOCIAL MEDIA CAMPAIGN PRIORITY POPULATIONS (N=55)

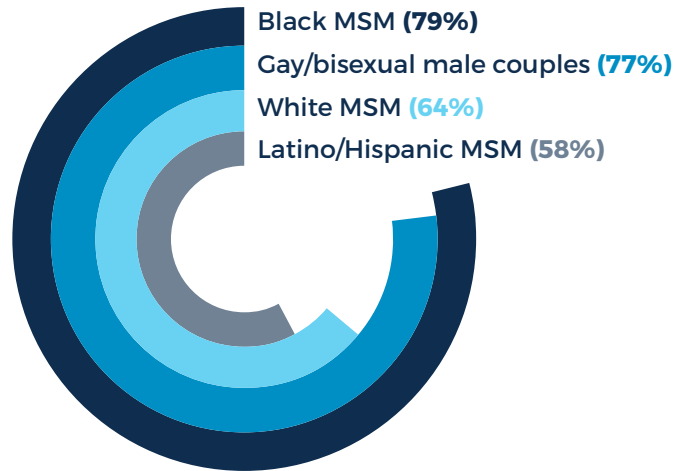
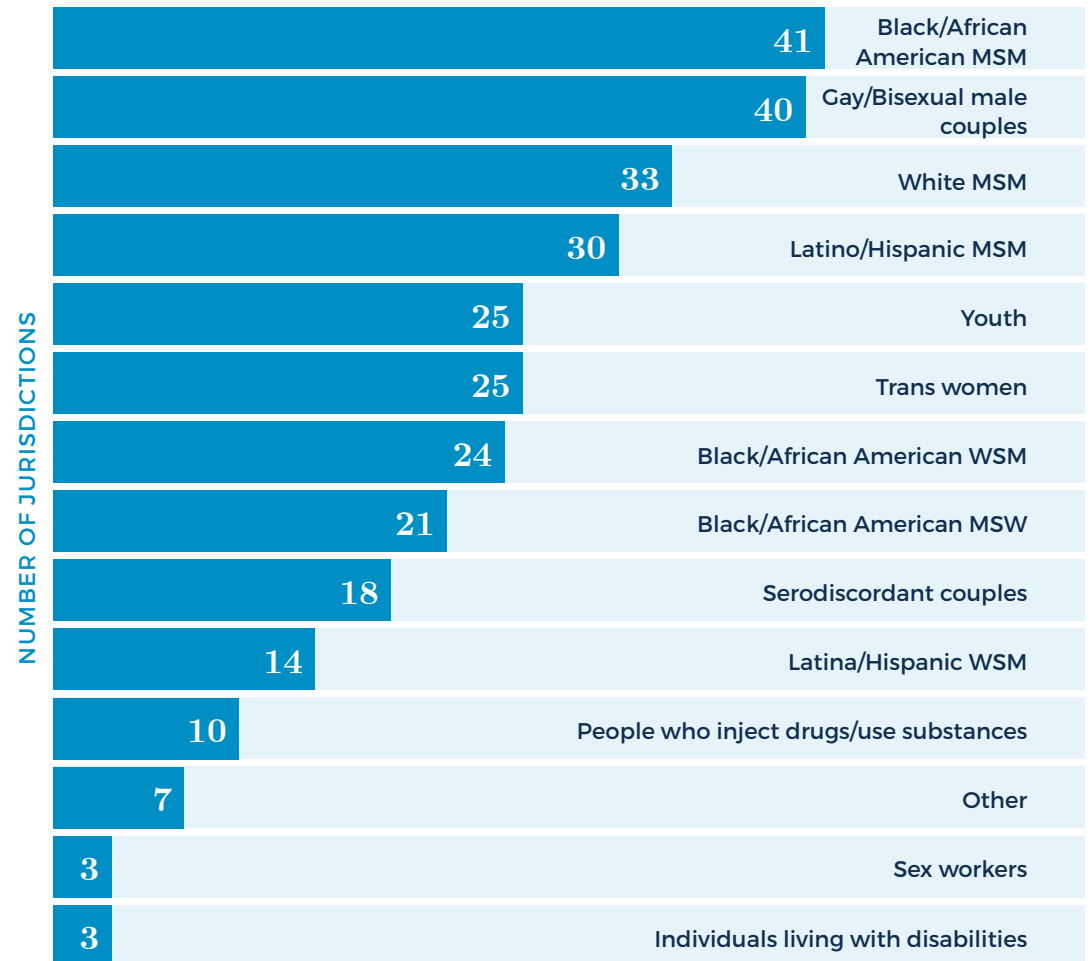


FIGURE 45:

POPULATIONS REPRESENTED IN SOCIAL MEDIA CAMPAIGNS (N=55)



COMMUNITY ENGAGEMENT

HIV Prevention Methods in Social Media Campaigns

Social media campaigns are used to promote HIV prevention methods. The most common messages entail **HIV testing** (93%, 51), **PrEP** (78%, 43), and **condoms** (69%, 38).

TABLE 24:

HIV PREVENTION METHODS FEATURED IN HD AND HD-SUPPORTED SOCIAL MEDIA

Prevention Methods	Jurisdictions (N=55)	%
HIV testing.....	51	93%
PrEP.....	43	78%
Condoms.....	38	69%
Combating HIV stigma.....	36	66%
STD testing.....	29	53%
Discussing STDs.....	21	38%
Knowing your partners.....	12	22%
HCV testing.....	11	20%
Couples testing.....	9	16%
nPEP.....	6	11%
Other *.....	6	11%
Partner Services.....	5	9%
Transmission pathways.....	4	7%
Consent.....	2	4%

*Note: Other options included Treatment as Prevention and U=U (undetectable=untransmittable).

CONDOM DISTRIBUTION PROGRAMS

All but one HD supports condom distribution programs, either implemented directly by the HD (31%, 17), indirectly through CBOs and ASOs (31%, 17), or through a combination of both approaches (36%, 20).

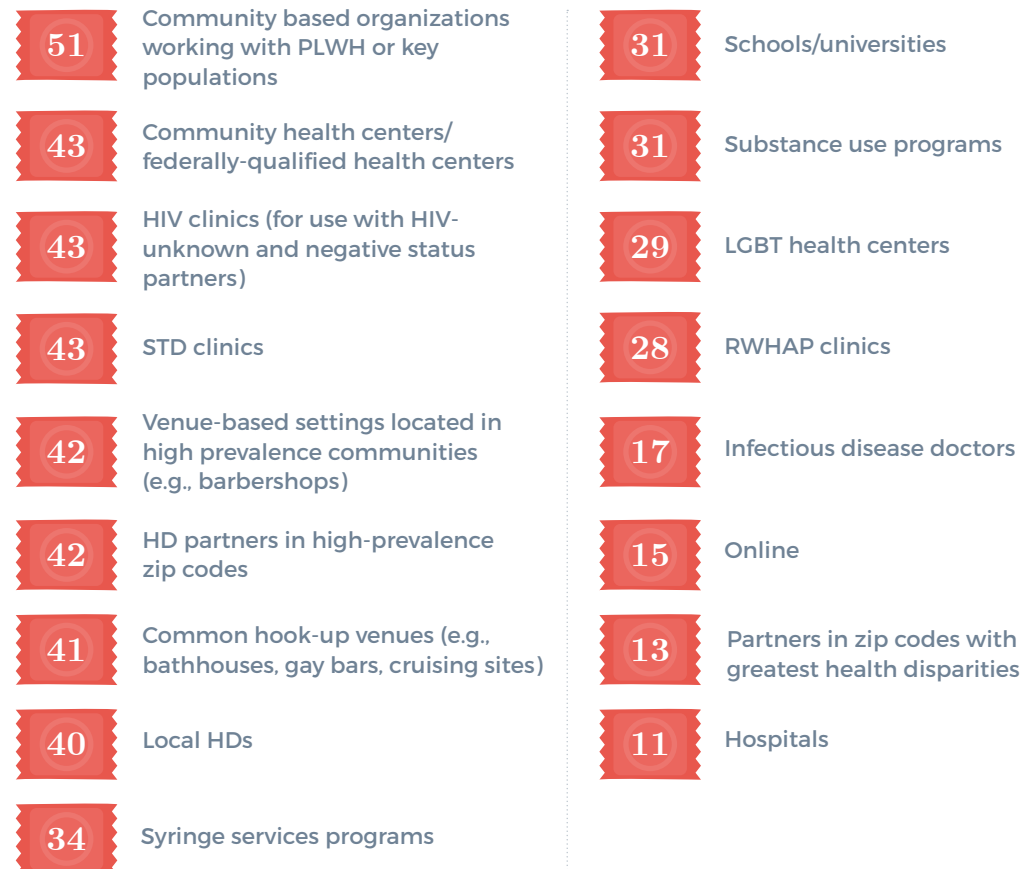
Condoms must reach individuals living with HIV and those vulnerable to HIV infection to be effective HIV prevention tools. Though condoms are distributed through a vast array of venues, most HDs utilize **CBOs** (94%, 51), **community health centers** (83%, 45), and **HIV/STD clinics** (80%, 43) to distribute condoms to PLWH and priority populations.

FIGURE 46:

VENUES HDs USE TO DISTRIBUTE CONDOMS

(N=54)

NUMBER OF JURISDICTIONS



CONDOM DISTRIBUTION PROGRAMS

HDs report that they **distribute more than just condoms**, but other products as well, including **lubricants** and **educational materials** in addition to **female/internal and male/external condoms**.

FIGURE 47:

PRODUCTS AVAILABLE VIA CONDOM DISTRIBUTION

(N=53)

NUMBER OF JURISDICTIONS



Challenges to condom distribution:

- Monitoring and evaluation (44%, 24)
- Stakeholder buy-in from parents, school boards, religious leaders, faculty (43%, 23)
- HD procurement processes (39%, 21)

BEHAVIORAL INTERVENTIONS

Persons Living with HIV

Promoting HIV prevention among PLWH is a core component of HD programs. The top three program components geared towards PLWH most frequently reported by jurisdictions in 2017 were **partner services** (95%, 52), **linkage to care** (93%, 51), and **STI screening** (71%, 39), the same top three components reported in the previous survey in 2013. **D2C** (67%, 37) was a new entry to the list in 2017 and it was the fourth most frequently cited activity.

TABLE 25:

ACTIVITIES IN HD PROGRAMS PROMOTING HIV PREVENTION AMONG PLWH

Prevention with Positives Activities	Jurisdictions (N=55)	%
Partner services	52	95%
Linkage to care activities	51	93%
STD screening	39	71%
Data to care	37	67%
Retention-in-care activities	31	56%
Antiretroviral medication adherence counseling	29	53%
Antiretroviral Treatment and Access to Services (ARTAS)	27	49%
Patient navigation	26	47%
STD treatment	25	46%
Risk screening	24	44%
Viral hepatitis screening	24	44%
Counseling & Comprehensive Risk Reduction Services (CRCS)	23	42%
Couples' HIV testing and counseling	19	35%
Viral hepatitis treatment	18	33%
Peer-delivered support services	17	31%
Antiretroviral medication adherence strategies (e.g., texts)	14	26%
Reproductive health care	4	7%
Other care coordination models	4	7%
Other intensive prevention counseling models	4	7%

BEHAVIORAL INTERVENTIONS

Forty-two percent (22) of HD HIV prevention programs find **coordination among local providers** to be the most frequent **barrier to engaging PLWH** in care. This finding is consistent with the 2013 NHPI.

FIGURE 48:

THE MOST FREQUENT CHALLENGES TO SUPPORTING ACTIVITIES

geared toward HIV prevention among PLWH remain consistent with 2013 NHPI

(N=55)

NUMBER OF JURISDICTIONS

22	Coordination among local providers (including ASOs, CBOs, clinical providers)
20	Cultural responsiveness (cultural competency) of providers to engage PLWH in care
16	Use of surveillance data to prioritize prevention with positives activities
14	Provider staff capacity to engage PLWH in care
8	Coordination of HD staff to engage PLWH in care

Persons Most At-Risk

Seventy-one percent (39) of HDs support **behavioral interventions for persons most at-risk for HIV**. **Mpowerment** and **Many Men, Many Voices (3MV)** top the list of utilized interventions. This is consistent with the 2013 NHPI.

Mpowerment is a community-level intervention for young gay and bisexual men to reduce sexual risk taking, encouraging regular HIV testing, building positive social connections and supporting peers to have safer sex.

3MV is a group-level HIV and STD prevention intervention for black men who have sex with men that addresses factors that influence behavior, including cultural, social, and religious norms.

BEHAVIORAL INTERVENTIONS

TABLE 26:

BEHAVIORAL INTERVENTIONS FOR PERSONS MOST AT-RISK FOR HIV

Interventions	Jurisdictions (N=55)	%
MPowerment	24	44%
Many Men, Many Voices	16	29%
None	16	29%
Popular Opinion Leader	11	20%
Community Promise	10	18%
VOICES/VOCES	10	18%
D-up	7	13%
CLEAR	6	11%
SISTA	5	9%
Healthy Relationships	5	9%
Locally adapted interventions	3	5%
Safety Counts	2	4%
Personalized Cognitive Counseling	2	4%
RISE (Rewriting Inner Scripts)	2	4%
SIHLE	1	2%
Holistic Health Recovery Program	1	2%
5 P's of sexual health	1	2%
HNS	1	2%
MANDATE, RISE, Safe in the City, PCC	1	2%
Social media activities	1	2%
Wise Guys and AIM	1	2%
Engagement and referral to PrEP	1	2%
ARTAS, Telemedicine, NIA, ARTAS/FOCUS, RESPECT	1	2%

Just over half of the jurisdictions (53%, 29) are supporting interventions for transgender women, up from 44% (18) jurisdictions in 2013.

SYRINGE SERVICES PROGRAMS

According to the CDC, Syringe Services Programs (SSPs) are an effective component of a comprehensive, integrated approach to HIV prevention among PWID. SSPs provide access to sterile syringes and injection materials, disposal services, referrals and linkage to infectious disease treatment and services, PrEP, substance use treatment (inclusive of MAT), and medical and behavioral health care.

FIGURE 49: _____



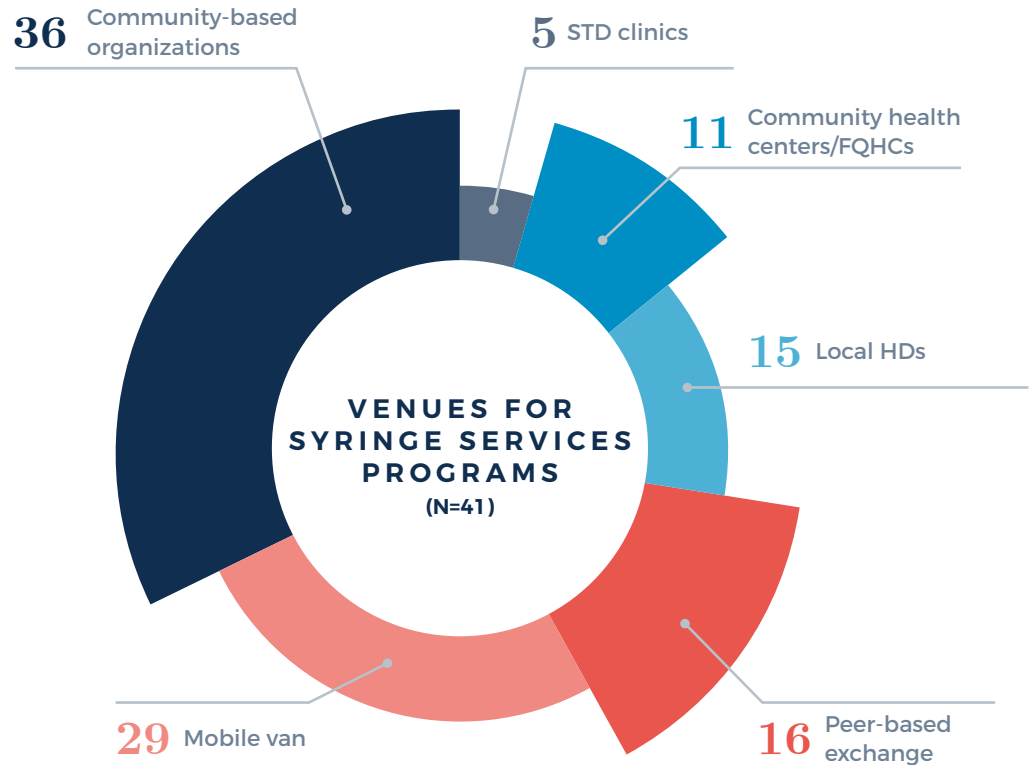
Seventy-five percent (41) of jurisdictions reported at least one SSP operating within their jurisdiction, up from 33 jurisdictions in 2013. This increase reflects recent increases in injection drug use, the expanding opioid crisis, and federal guidance released in 2016 that allows states, territories, and local jurisdictions, to use federal funds to support certain components of SSPs as long as they operate in compliance with local laws or ordinances.

- **Sixteen (16) jurisdictions reported using federal funding in 2017 to support SSPs, up from zero in 2013.**
- Of the 16 using federal funding for SSPs, 69% (11) received funds from CDC, 25% (4) from SAMHSA and 6% (1) from HRSA.
- Jurisdictions that have SSPs reported as few as one and as many as 42 SSPs in operation, with a median of five SSPs and an average of ten SSPs reported.
- In jurisdictions that have SSPs, CBOs administer SSP programs in 39% (16) of jurisdictions, while HD HIV programs administer in 27% (11), other HD agencies such as injury prevention administer in 12% (5), or a combination of agencies administer SSPs in (22%, 9) of jurisdictions.
- Thirty-four percent (14) of jurisdictions report that a combination of agencies fund SSPs, while 29% (12) report funding primarily from other sources like grants to local CBOs, 27% (11) report funding primarily through HD HIV programs, and 10% (4) through other HD programs outside of HIV prevention.
- SSPs are paying for syringes and injection supplies, which are prohibited to purchase with federal funds, through state funds (20 jurisdictions), non-profit partners (7), foundation grants (6), or a variety/combination of other sources (12).

SYRINGE SERVICES PROGRAMS (SSP)

Eighty-eight percent (36) of HDs reported that the **most common venue for operating SSPs is from CBOs**, consistent with the 2013 survey.

FIGURE 50:



SSPs offer a variety of services to the communities they serve. The most frequently-reported services were syringe disposal, syringe access, HIV testing, condoms, overdose prevention (e.g., Naloxone administration training and access), and linkage to substance use or medication assisted treatment.

SYRINGE SERVICES PROGRAMS (SSP)

TABLE 27:

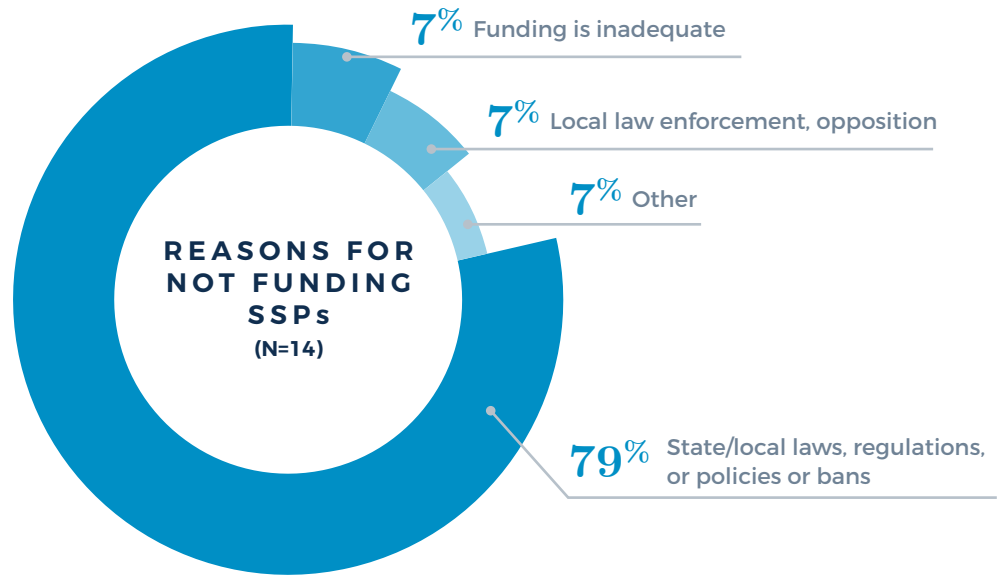
SERVICES OFFERED BY SYRINGE SERVICES PROGRAMS		
SSP Services	Jurisdictions (N=41)	%
Syringe disposal	41	100%
Syringe access	41	100%
HIV testing	39	95%
Condoms	38	93%
Overdose prevention (e.g., Naloxone administration training and access)	37	90%
Linkage to substance use/chemical dependency treatment	36	88%
HCV testing	35	85%
Linkage to HIV-related medical care	35	85%
Linkage to mental health services	30	73%
Linkage to other social and health services	29	71%
Wound and abscess care	29	71%
STD screening	25	61%
Linkage to housing, education, job training services	24	59%
Linkage to partner services	23	56%
PrEP	20	49%
Immunizations	17	42%
STD treatment	14	34%
Comprehensive case management	11	27%
Primary medical care	11	27%
Direct substance use/chemical dependency treatment including medication assisted therapy (MAT)	10	24%
nPEP	9	22%

Relatively few HDs market or advertise their SSPs (22%, 9 jurisdictions). The few that do publicize their SSPs do so through **websites** or **social media**.

Of the 14 HDs that reported that they **do not have SSPs** within their jurisdiction, 79% (11) indicated that **state/local laws, regulations, or policies or bans** (e.g., on funding, paraphernalia, etc.) were the reasons.

SYRINGE SERVICES PROGRAMS (SSP)

FIGURE 51:



Determination of Need

Under the [Consolidated Appropriation Act of 2016](#), federal law permits use of funds from the Department of Health and Human Services (DHHS) to support SSPs with the exception that funds may not be used to purchase needles or syringes. In order to use DHHS funds for this purpose, eligible state, local, tribal, and territorial HDs must first consult with the CDC and provide evidence – a **Determination of Need (DON)** – that their jurisdiction is experiencing, or at risk for, significant increases in hepatitis infections or an HIV or hepatitis outbreak related to injection drug use.

At the time of the 2017 survey, sixty-two percent (34) of the jurisdictions had submitted Determination of Need requests to CDC, with 31 approved, 1 request pending, and 2 requests rejected. An up-to-date record of DON requests can be found on the CDC [SSP DON website](#).

BIOMEDICAL PREVENTION

Non-Occupational Post Exposure Prophylaxis (nPEP)

nPEP is the provision of antiretroviral therapy to prevent HIV infection after exposure to HIV.

HD HIV prevention nPEP programs may include planning, education, personnel, and other support for providers and/or vulnerable individuals using federal funds, and can be supplemented with other local or private funding sources. CDC HIV prevention funds to HDs cannot be used to support provision of medications.

FIGURE 52:



of HDs provide support for nPEP programs

This is an increase from 12 HDs in 2014 (21%) and 10 HDs (17%) in 2009.

Of the 22 HDs with nPEP programs, the majority (64%, 14) provide nPEP outreach and education through CBOs and through STD clinics.

TABLE 28:

VENUES FOR PROVIDING nPEP OUTREACH AND EDUCATION

Venue	Jurisdiction (N=22)	%
Community-based organizations	14	64%
STD clinics	14	64%
Community health centers/FQHCs	10	45%
Local HDs	9	41%
Online web sites, including HD and social media	8	36%
LGBT health centers	7	32%
Emergency departments	6	27%
Family planning clinics	5	23%
Mobile dating applications	4	18%
Community pharmacies	3	14%
Outpatient clinics	3	14%
Primary care clinics	3	14%
Rape crisis centers	2	9%
Specialty clinics	1	5%
Substance use clinics	1	5%
Consultation line	1	5%
DIS	1	5%

BIOMEDICAL PREVENTION

Biggest challenges to implementation of nPEP programs:

- Lack of funding (61%, 33)
- Provider willingness to provide nPEP (41%, 22)
- Community awareness of nPEP (39%, 21)

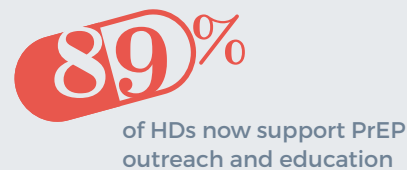
Pre-exposure Prophylaxis (PrEP) Programs

PrEP is the provision of antiretroviral therapy in combination with frequent HIV and STD testing and counseling to individuals at high-risk for HIV infection.

HD PrEP programs may include planning, education, personnel and other support for PrEP provision by a licensed physician. Federal HIV funds cannot be used to pay for provision of medication for PrEP.

Among the most significant changes in the 2017 NHPI is the notable increase in HD support of PrEP programs.

FIGURE 53:



This is a significant increase from only 15% (8) of HDs in 2013. This most likely reflects the increased acceptance of PrEP as a standard of care following the May 2014 release of U.S. Public Health Service clinical practice guidelines for PrEP.

PrEP referrals were the most frequently-cited components of HD PrEP programming reported by 90% (44) of the 49 jurisdictions, followed by PrEP navigation (76%, 37) and PrEP awareness campaigns (76%, 37).

FIGURE 54:



MAJOR COMPONENTS OF HD PrEP PROGRAMS

(N=49)

NUMBER OF JURISDICTIONS

44 PrEP Referrals

37 PrEP Navigation

37 PrEP Marketing or Awareness Campaigns

28 PrEP Academic Detailing (including any provider education)

26 PrEP Working Group to support collaboration

BIOMEDICAL PREVENTION

Ninety percent of the jurisdictions with HD PrEP programs **plan to conduct PrEP outreach and engagement** to their communities in the next year. In addition, HDs are planning to conduct provider outreach and education in the next year to **primary care clinicians** (88%, 43), **HIV/infectious disease specialists** (67%, 33), **pharmacists** (39%, 19) and **gynecologists** (31%, 15).

HDs with PrEP programming focus attention on reaching gay and bisexual men/MSM, with 78% (38) of the 49 jurisdictions most frequently reporting that **Black MSM, gay/bisexual male couples, and Latinx MSM are the focus of PrEP programs**. These populations are **followed closely by serodiscordant couples** (76%, 37) and **transgender women** (76%, 37).

FIGURE 55:

POPULATIONS OF FOCUS FOR HD PrEP PROGRAMS

Population	Jurisdictions (N=49)	%	Population	Jurisdictions (N=49)	%
Black MSM	38	78%	Substance users/IDUs	26	51%
Gay/Bisexual male couples	38	78%	Sex workers	25	53%
Latino/Hispanic MSM	38	78%	Black WSM	22	45%
Serodiscordant couples	37	76%	Black MSW	20	41%
Trans women	37	76%	Latina/Hispanic WSM	19	39%
White MSM	35	71%	Youth	19	39%

BIOMEDICAL PREVENTION

Similar to nPEP, the top five venues that HDs rely on for PrEP outreach and education in the community are CBOs, STD clinics, local HDs, websites and social media, and Community Health Centers (CHCs)/Federally Qualified Health Centers (FQHCs).

FIGURE 56:

VENUES FOR PROVIDING PrEP SERVICES

Venue	Jurisdictions (N=49)	%	Venue	Jurisdictions (N=49)	%
Community-based organizations	43	88%	Family planning clinics	21	43%
STD clinics	39	80%	Other primary care clinics	15	31%
Local HDs	34	69%	Bathhouses	13	27%
Online websites, including HD and social media	34	69%	Hospitals	12	25%
Community health centers/FQHCs	33	67%	Pharmacies	12	25%
Bars and clubs	25	51%	Substance use clinics	11	23%
LGBT health centers	22	45%	Specialty clinics	9	18%
Mobile dating applications	22	45%			

The six HDs that do not provide support for PrEP services cited a variety of barriers, including inadequacy of funding, cost-effectiveness, provider willingness to provide PrEP, and difficulty bringing PrEP to scale.

FIGURE 57:

STATUS OF WHETHER HDs HAVE A DATA COLLECTION

Method in Place for Tracking PrEP Referrals (N=55)



44%

Yes



29%

No



27%

In progress

PROGRAM INTEGRATION

HD HIV prevention programs reported a high degree of collaboration with a variety of HIV care and treatment services and other infectious disease programs within HDs, including many with direct oversight by NASTAD members.

Top Ten Program Areas Overseen by NASTAD members:

- 1) HIV prevention
- 2) HIV testing
- 3) RWHAP care and treatment services
- 4) Linkage to HIV-related medical care
- 5) Partner Services
- 6) ADAP
- 7) STD screening
- 8) Perinatal HIV prevention
- 9) HIV Surveillance
- 10) STD Surveillance.

These areas corresponded with the areas with the highest levels of collaboration.

Sixty percent (33) of HIV surveillance programs receive direct oversight from the NASTAD member, and 75% (41) of HIV prevention programs reported collaborating with HIV surveillance.

Many NASTAD members' purview includes direct oversight of other programs within NCHHSTP, particularly **STD screening** (64%, 35), **STD surveillance** (55%, 30), and **viral hepatitis testing and activities** (51%, 28).

The majority of jurisdictions reported **relatively high levels of collaboration with other key program areas**, despite the fact that many NASTAD members do not have direct programmatic oversight of these programs. These **other program areas include STD surveillance, viral hepatitis testing, viral hepatitis activities, HOPWA, drug user health, LGBT health, chronic viral hepatitis surveillance, and acute viral hepatitis surveillance.**

PROGRAM INTEGRATION

TABLE 29:

**INTEGRATION BETWEEN HIV PREVENTION AND
OTHER HD PROGRAMS
(N=55)**

Programs	None	AIDS Director* oversees staff	AIDS Director* oversees budget	Inter-program meetings are held	Programs collaborate on projects
HIV prevention ex. testing	0%	82%	76%	75%	82%
HIV testing	0%	78%	76%	75%	80%
RWHAP	4%	75%	67%	67%	78%
Linkage to HIV care	0%	75%	69%	76%	75%
Partner services	0%	71%	62%	82%	78%
RWHAP - ADAP	11%	69%	58%	58%	64%
STD screening	5%	64%	58%	75%	78%
Perinatal HIV prevention	5%	60%	47%	62%	69%
HIV surveillance	0%	60%	56%	80%	75%
STD surveillance	4%	55%	51%	76%	75%
Viral hepatitis testing	15%	51%	42%	67%	71%
Viral hepatitis activities	11%	51%	44%	69%	69%
HOPWA	5%	42%	31%	55%	60%
Drug user health	31%	27%	22%	53%	55%
LGBT health	27%	25%	20%	44%	58%
Chronic viral hepatitis surveillance	27%	25%	24%	58%	60%
Acute viral hepatitis surveillance	31%	24%	20%	56%	56%
TB testing	47%	22%	18%	35%	42%
TB surveillance	47%	18%	18%	36%	40%
Perinatal hepatitis B	51%	13%	11%	33%	40%
Refugee health	65%	7%	5%	22%	29%
Minority health	42%	7%	5%	31%	47%
Immunization	53%	5%	4%	29%	36%
Medical marijuana	89%	4%	2%	4%	5%
Maternal and child health	38%	4%	2%	35%	53%
Peer worker certification	84%	4%	4%	15%	16%
Reproductive health	44%	2%	2%	36%	44%
Adolescent health	44%	2%	2%	38%	38%

* Many "AIDS Directors" oversee programmatic and/or budgetary portfolios including hepatitis, tuberculosis, STDs, and more. As such, NASTAD now refers to this leadership position as the "NASTAD Member."

PROGRAM INTEGRATION

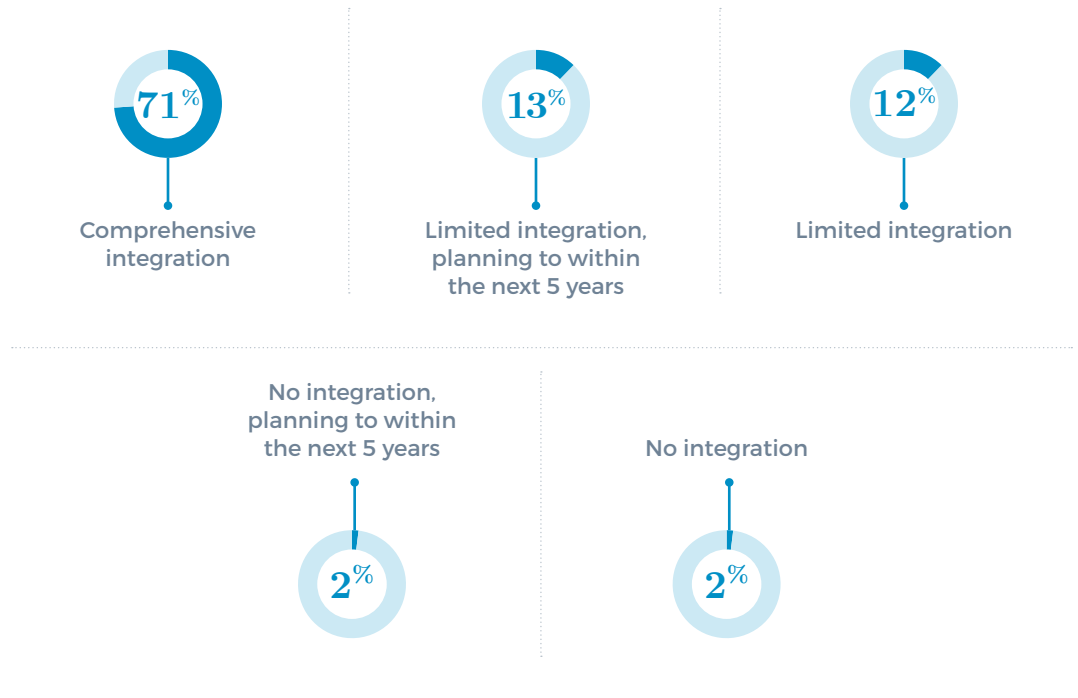
HIV Prevention and Surveillance Integration

In 2017, prior to the combined CDC core funding for HD HIV prevention and surveillance programs, 71% of HDs (39) had comprehensively integrated programs, while the remaining jurisdictions had limited or no integration, with most planning to integrate programs within the next five years.

FIGURE 58:

INTEGRATION BETWEEN HIV PREVENTION AND SURVEILLANCE

(N=55)



Health Equity

Health equity is defined as efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Seventy-six percent of HD HIV prevention programs work with external partners to support health equity.

Among the most frequently referenced collaborations to support health equity was with HD offices of minority health or health equity branches within HDs.

PROGRAM INTEGRATION

HIV Prevention Research

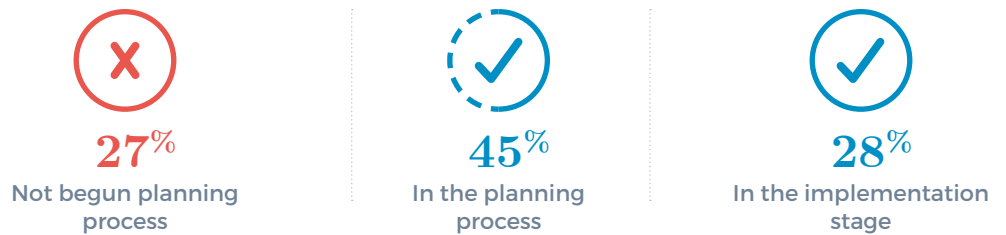
There are 19 Centers for AIDS Research CfARs located at academic and research institutions throughout the United States. 38% (21) of HDs collaborate with HIV prevention researchers, with most reporting work with CfARs.

Plans

At the time of the 2017 NHPI survey, jurisdictions were at varying stages of developing ending the HIV epidemic plans. **Most of the jurisdictions (73%) were in the planning or implementation stages.** An updated record can be found through NASTAD's [ending the HIV epidemic plans online resource](#).

FIGURE 59:

JURISDICTIONS' DEVELOPMENT OF ENDING THE HIV EPIDEMIC PLANS (N=53)



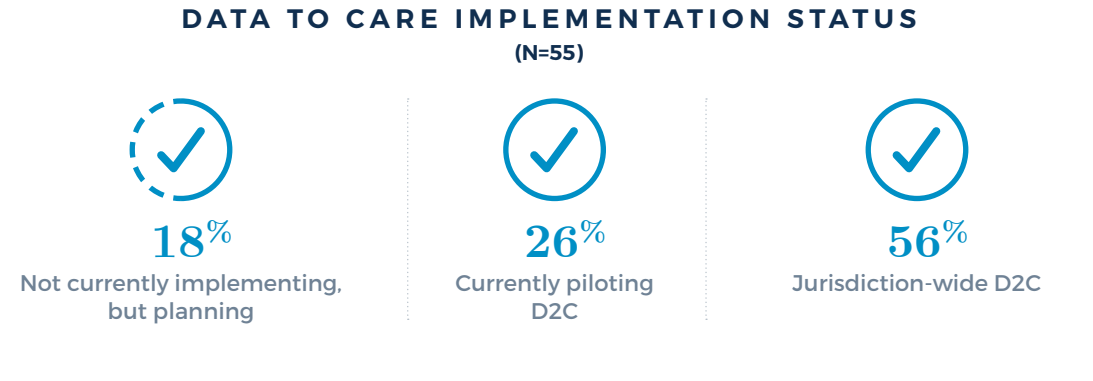
DATA TO CARE & SURVEILLANCE

The CDC defines **Data to Care (D2C)** as a public health strategy that uses HIV surveillance and other data to support the HIV Care Continuum by identifying PLWH who are in need of HIV medical care or other services and facilitating linkage to these services.

The primary goals of D2C are to increase the number of persons diagnosed with HIV who are engaged in HIV medical care and to increase the number of HIV-diagnosed persons who are virally suppressed. CDC encourages jurisdictions to include the active use of HIV surveillance data as part of their comprehensive strategy for linkage to and re-engagement in care activities.

Though most (56%, 30) U.S. state and CDC-directly funded HDs are currently implementing D2C, 26% are currently piloting D2C programs (14) and 19% are planning to implement D2C in the future (10).

FIGURE 60:



Data Sharing Agreements

For the 44 jurisdictions currently piloting or implementing D2C, 73% (32) reported **data sharing agreements** in place with internal HD programs such as **RWHAP, ADAP, and surveillance**.

Fewer data sharing agreements were noted with health systems and payers, including state Medicaid programs (11%, 5) and Health Information Exchanges (2%, 1).

DATA TO CARE & SURVEILLANCE

TABLE 30:

ENTITIES WITH DATA SHARING AGREEMENTS IN PLACE WITH HDs FOR D2C

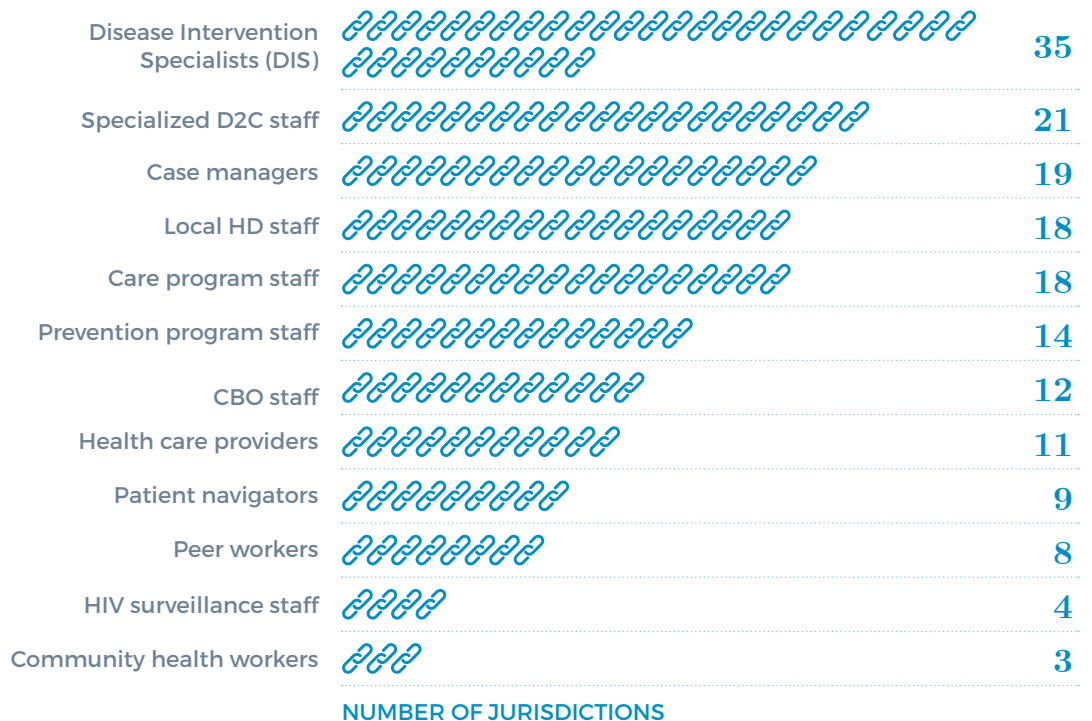
Entities	Jurisdictions (N=44)	%
Internal HD programs	32	73%
Local HDs	21	48%
Community based organizations (CBOs)	14	32%
Health care providers	13	30%
Hospitals	8	18%
Health care plans (public and/or private)	5	11%
Department of Veteran's Affairs (VA)	3	7%
Tribal governments and/or tribally designated organizations	1	2%
Health Information Exchange	1	2%

Linkage to Care for D2C

Forty-four jurisdictions have staff or entities responsible for investigating and re-linking individuals who appear to be not in care based on HD surveillance data. DIS staff are the most common, with **80% (35) of jurisdictions using DIS for D2C investigation and re-linkage**. Many jurisdictions reported using various combinations staff in different roles to perform D2C-related linkage work.

FIGURE 61:

STAFF RESPONSIBLE FOR D2C OUTREACH AND LINKAGE TO CARE (N=44)



DATA TO CARE & SURVEILLANCE

Staff capacity (63%, 27), and **difficulty locating individuals on the “not in care” lists** (58%, 25), prove to be the greatest **challenges in implementing D2C**.

TABLE 31:

DATA TO CARE CHALLENGES		
D2C Challenges	Jurisdictions (N=43)	%
Staff capacity.....	27	63%
Difficulty locating individuals on the “not in care” lists.....	25	58%
Completeness and/or timeliness of lab reporting.....	17	40%
Issues determining whether an individual has moved out of the jurisdiction.....	17	40%
Issues with data sharing with surveillance or external partners.....	12	28%
Data quality.....	11	26%

HIV Cluster and Outbreak Detection and Response

For decades, HIV genetic sequencing data have been used to establish a baseline of antiretroviral (ARV) drug resistance, evaluate the mutations associated with ARV resistance, and monitor the prevalence and spread of drug resistant strains of HIV in jurisdictions. More recently, HIV genetic sequencing data have been used to investigate and respond to clusters of HIV transmission among individuals with closely related virus genetic sequences, and CDC now requires network and molecular analysis for PS18-1802 grantees.

Forty-seven percent of jurisdictions use HIV network and molecular analysis data to identify or respond to clusters.

Fifty-eight percent of jurisdictions reported that their surveillance programs receive HIV nucleotide sequence data.

Perinatal HIV Prevention and Surveillance

Perinatal HIV testing of all pregnant women remains the most common strategy for preventing perinatal HIV transmission among jurisdictions (79%, 42).

DATA TO CARE & SURVEILLANCE
TABLE 32:
PERINATAL HIV PREVENTION ACTIVITIES IMPLEMENTED

Perinatal HIV Prevention Activities	Jurisdictions (N=53)	%
Promote routine, perinatal HIV testing of all pregnant women	42	79%
Perinatal HIV Exposure Reporting for follow-up of perinatally HIV-exposed infants	37	70%
Use surveillance and epidemiological data to guide perinatal prevention and care efforts	35	66%
Perinatal HIV services coordination	23	43%
Conduct annual matching of HIV-infected women reported to surveillance from the state/tribal birth registry	21	40%
Fetal Infant Mortality Review (FIMR)-HIV Prevention	18	34%

Outbreak Detection and Response

One-third of jurisdictions have a general outbreak detection and response plan in place for all communicable diseases in their jurisdiction. **Fifty-two percent (28) have a specific outbreak response plan in place for one or more communicable diseases (HIV, viral hepatitis, and/or syphilis).** At the time these data were collected, fifteen percent (8) had no outbreak plan in place.

TABLE 33:
STATUS OF OUTBREAK DETECTION AND RESPONSE PLANS

Outbreak Plans	Jurisdictions (N=54)	%
General plan for all communicable diseases	18	33%
For all three: HIV, viral hepatitis, and syphilis	12	22%
No	8	15%
Only for HIV and syphilis	7	13%
Only for syphilis	4	7%
Only for HIV	3	6%
Only for viral hepatitis	1	2%
Only for HIV and viral hepatitis	1	2%
Only for viral hepatitis and syphilis	0	0%

Geocoding for HIV Surveillance

Of HDs that use **geocoding**, 47% (25) produce maps to determine priority testing and treatment activities, 36% (19) collect and submit data to CDC, and/or 32% (17) analyze data to detect transmission clusters. Nearly one-third (32%, 17) of HDs reported that they do not use geocoding.

WORKFORCE DEVELOPMENT

Priority Population Representation in HIV Prevention Staff

Black/African American women are the most strongly represented in jurisdictions' HIV prevention staff among priority populations. Thirty-seven percent of jurisdictions (19) reported that Black/African American women comprise 25% or more of their HIV Prevention staff.

PLWH are the next most represented priority population group, with 6% of jurisdictions (3) reporting that PLWH represent more than 25% of HIV Prevention staff.

Jurisdictions have been **least able to attract trans-identified individuals** to serve as HIV prevention staff; 81% of jurisdictions (39) had no trans-identified HIV Prevention staff.

TABLE 34: HIV PREVENTION STAFF IDENTIFYING AS MEMBERS OF PRIORITY POPULATIONS (N=51)

	0%	1-25%	26-50%	51-75%	76-100%
	NUMBER OF JURISDICTIONS				
Black/African American women	15	17	11	6	2
Black/African American gay and bisexual men	26	21	0	0	0
Latino/Hispanic gay and bisexual men	30	16	2	0	0
People living with HIV	26	20	2	1	0
Trans-identified individuals	39	9	0	0	0
Youth (ages 18-26)	30	17	1	1	0

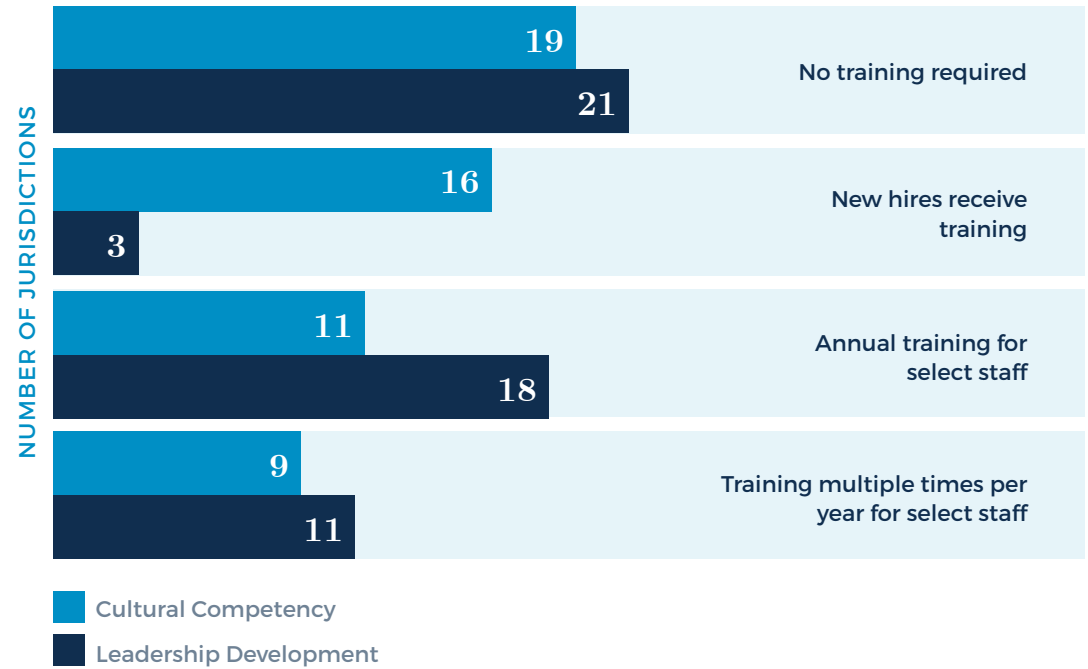
Requirements vary for training HIV prevention staff in cultural competency and leadership development, with reporting jurisdictions somewhat more likely to require cultural competency training. Overall, 40% of jurisdictions (21) impose no requirements for leadership training, compared to 35% of jurisdictions (19) that require no cultural competency training. New hires in 29% of jurisdictions (16) receive cultural competency training as part of the onboarding process. In contrast, jurisdictions more frequently require leadership training on an annual (34%, 18) or more frequent (21%, 11) basis for selected staff.

WORKFORCE DEVELOPMENT

FIGURE 62:

REQUIRED FREQUENCY OF CULTURAL COMPETENCY AND LEADERSHIP DEVELOPMENT TRAINING

(N=51)



Seventy-one percent of responding jurisdictions (31) reported that **their teams have expertise in matching surveillance and health system data**. Claims data analysis and electronic health record analysis were each identified as areas of expertise by 25% of jurisdictions (11). HIV prevention teams in 16% of jurisdictions (7) do not have expertise in any of the three areas, while teams in 11% (5) have other expertise.

FIGURE 63:

HIV PREVENTION STAFF DATA ANALYSIS EXPERTISE

(N=44)

NUMBER OF JURISDICTIONS

- 31 Matching surveillance and health systems data
- 11 Electronic health record data analyses (e.g. Health Information Exchanges)
- 11 Claims data analyses (e.g. Medicaid or all-payer claims databases)
- 7 None
- 5 Other

WORKFORCE DEVELOPMENT

Data analysis and cultural responsiveness training topped the list of needed training, selected as beneficial training topics by 56% (28) and 50% (25) of jurisdictions. Jurisdictions selecting cultural responsiveness as a desired training topic most frequently cited **transgender** and **LGBT populations** as the **needed training focus**.

Jurisdictions were also interested in training related to **health IT** (42%, 21) and **Passport to Partner Services** (28%, 14).

Eighty-five percent of jurisdictions reported that **more than 75% of HIV prevention staff positions were currently filled**.

FIGURE 64:

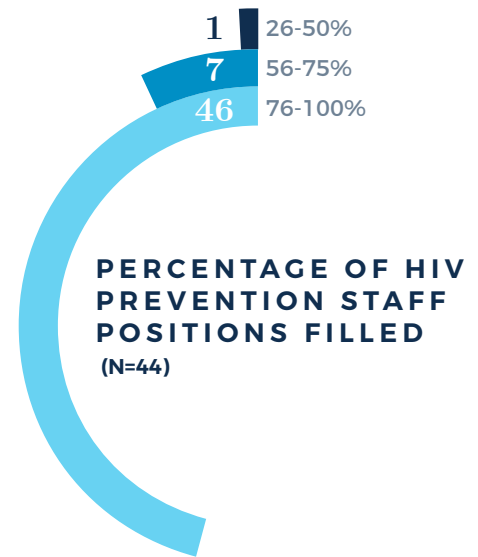
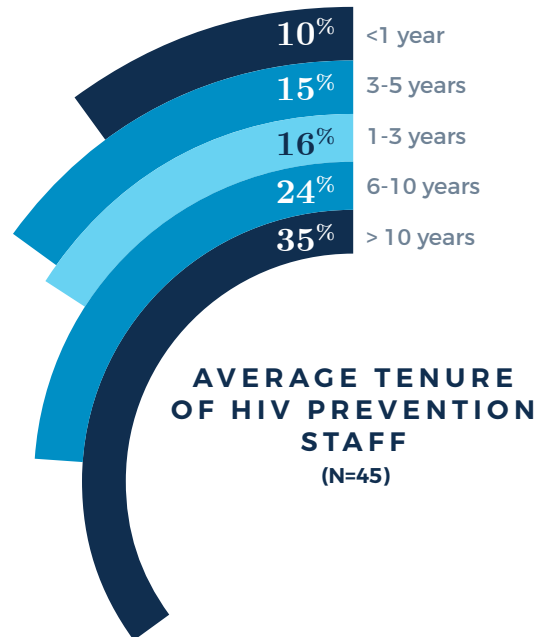


FIGURE 65:



HIV prevention staff are highly tenured, with jurisdictions reporting an average of 35% of staff with more than 10 years of experience and an average of 24% of staff with between six and 10 years of experience. On average, only 10% of staff in responding jurisdictions had been on the job less than one year.

DISCUSSION

Resources

In 2017, HIV prevention programs nationwide generally benefitted from increased funding compared to recent years. Funding increases allowed for more concentrated efforts around continued projects and new initiatives, including PrEP, SSPs, and D2C, all of which contribute to preventing new HIV infections, particularly in priority populations. Overall, CDC funding accounted for over half of all HIV prevention funds, aligning jurisdiction-level programmatic efforts with established national priorities. In addition to CDC funds, HRSA/HAB proved to be a valuable resource in terms of RWHAP support and ADAP rebate funding for prevention-related activities. Many HDs use creative strategies to maximize funding, identifying ways to support staffing and programmatic activities through the integration of programs. Some jurisdictions report allocating rebate funding for DIS and surveillance support, as well as linkage services. HDs find rebates are advantageous for activities because of funding availability and flexibility.

In response to increases in HIV and hepatitis cases related to injection drug use, the creation, implementation, and support of SSPs has increased rapidly. In 2013, state, local, and territorial HDs were unable to use federal funds to support SSP programs. Since that time, federal statute that allows for the use of federal funds to support certain elements of SSPs has been enacted, and in 2017, sixteen jurisdictions were doing so. The majority of federal funds used for SSPs were from the CDC, followed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA. At the time of the survey, three-fourths of the HDs reported at least one SSP (regardless of who administered the program) in operation within their jurisdiction, up from 58% of jurisdictions in 2013. This is likely in response to the opioid crisis, an increase in injection drug use behavior, and to the 2016 federal guidance allowing states and local communities, under limited circumstances, the opportunity to use federal funds to support certain components of SSPs. Updated DoN requests are tracked through CDC.

Among the most significant changes in the 2017 NHPI is the notable (74%) increase in HD support of PrEP programs. PrEP is changing the face of HIV prevention as the only proactive biomedical intervention for HIV prevention. Funding allocations also reflected this change, with a 56% increase in jurisdictions supporting PrEP services through their HIV prevention funds.

Though most jurisdictions benefitted from federal HIV prevention funding increases, HDs identified funding decreases as their greatest challenge. As noted in Figure 1, HDs received funding from numerous sources including federal, state, local, and private sectors. For HDs that rely on non-federal entities for the majority of HIV prevention program support, federal funding increases may not have been significant enough to absorb the impact from non-federal source decreases. Additionally, while funding for

DISCUSSION

priority populations and innovative strategies were indeed increased, HDs faced difficult decisions in scaling back existing programs that were deemed less effective. These decreases affected HD staffing, as well as the ability to maintain clinical and community-based providers in disproportionately affected areas. Staffing shortages have major implications on the success of an HIV prevention program. HDs are tasked with ensuring that services do not wane, and existing staff do not experience fatigue during periods of shortage. Additionally, much of the HIV prevention workforce is seasoned, with more than ten years of work experience in the HIV field. Though this shows a dedication to the work, it also presents a potential challenge in terms of anticipating a generation of the workforce that is retiring. In preparation, HDs should prepare to cross-train current staff and enforce succession plans to ease in future staff transition. As new generations enter the workforce, they may benefit from leadership training early and often instead of reserving this privilege for senior employees.

HDs allocate funding through a variety of sources to best serve jurisdictions. One source, which is often underutilized, is third-party billing. HD-supported providers (including community health centers, STD clinics, hospitals, etc.) commonly bill Medicare, Medicaid, or private insurers for HIV prevention services, but HDs rarely do so for activities other than PrEP initiation and counseling. By pursuing reimbursement through Medicare, Medicaid, or other third-party entities, HDs may free up funding for monies to be used for populations most in need. Though utilizing this opportunity can be financially practical, many jurisdictions assert that the barriers outweigh the benefit. For a quarter of jurisdictions, the revenue generated from third-party billing is not returned to the HIV programming budget. Considering that many HDs report challenges related to staff capacity, including accessing the education needed to train staff on effective implementation, technology capabilities, and support for providers, it can be difficult to provide the resources necessary to effectively implement third-party billing. Particularly, for jurisdictions who serve large populations of uninsured patients, the effort to implement third-party billing may be difficult to justify.

Additionally, HDs are increasing staff capacity to ensure that individuals seeking HIV prevention services understand their public and private insurance coverage options and how to enroll. Since the Patient Protection and Affordable Care Act (ACA) was initiated in 2010, expanded access to Medicaid and private insurance, insurance education, outreach, referral, and enrollment services have become important HIV prevention interventions. Ensuring that consumers understand their benefits as it relates to HIV prevention has been particularly important for PrEP access.

DISCUSSION

Strategic Integration

HIV prevention is moving in the direction of program integration. In June 2015, CDC and HRSA released their [Integrated HIV Prevention and Care Planning Implementation Guidance](#), which served as the impetus for many HDs to embark upon integrated planning processes. January 2018 marked the kick-off for PS18-1802, the first integrated HIV prevention and surveillance program announcement. While many HDs were already progressing in the direction of program integration through a variety of facets (60% of HIV surveillance programs were already overseen by NASTAD members), directives outlined by federal funding sources further accelerated this process of integration.

D2C is one recent initiative that requires collaboration between HD prevention, care, and surveillance programs to be effective. While most HD prevention programs have internal data sharing for D2C (e.g., with RWHAP, ADAP, and surveillance programs), fewer have data sharing agreements in place with programs and partners external to the HD (e.g., CBOs, health care providers, or the VA). Data sharing agreements help ensure that D2C programs have access to the data needed to effectively locate and re-link individuals to HIV care, and also ensure that client-level data is shared securely and confidentially between collaborating programs and partners.

Currently, almost all jurisdictions integrate their prevention and care programs, many of whom utilize these plans as key components of their ending the epidemics campaigns. This further reinforces the benefit of breaking down “silos” and working collaboratively to monitor outcomes across the HIV Care Continuum. In addition to the challenges noted in this report, HDs discuss strategies for creating plans that represent unique needs within their own jurisdictions, and determining what communication needs to take place before, during, and after integration. HDs work towards including a diverse cadre of stakeholders to ensure successful implementation and impact of the integrated plans.

Tools of the Trade

SSPs continue to operate most commonly out of CBOs, which is consistent with 2013 NHPI findings, though the number of local HD-operated SSPs is increasing. SSPs operating out of mobile vans, community health centers, and via peer networks are also popular, allowing SSPs to better engage with priority populations in a variety of settings and on the SSP participants' terms. SSPs offer numerous services beyond syringe access, including safe syringe disposal, HIV and hepatitis testing, condoms, overdose prevention (e.g., Naloxone administration training and access), and linkage to medication assisted treatment, and are often described as a ‘hub’ for services to improve the health of people who use drugs. SSPs aim to provide nonjudgmental, low threshold, access to services for PWIDs and are a vital link to engage these individuals in care and prevent HIV, hepatitis, and overdose death.

DISCUSSION

PrEP implementation requires robust programs featuring referrals, financing, navigation, and awareness campaigns. Of those eligible for PrEP, HDs overwhelmingly focus programmatic attention on gay and bisexual men/MSM, Black MSM, gay/bisexual male couples, and Latinx MSM. Transgender women and serodiscordant couples make up the next cohort of priority populations. Though these populations represent those who face the greatest burden of the epidemic, HDs may consider catering additional outreach and educational methods to youth and Black heterosexual women as well. While important, campaigning to priority populations is not enough. Provider willingness to prescribe PrEP is a looming hindrance for HDs, particularly in high prevalence regions, mainly driven by stigma. HDs must use strategic methods to increase partnerships with willing providers and equip consumers with the knowledge and skills to demand access to this medication.

As PrEP becomes increasingly accessible, the utility of condoms continues to be a point of conversation and concern in the public health arena. This “tried and true” method of HIV prevention remains a primary component of HD HIV programs and indicates that it is indeed possible to focus on more than one method of HIV prevention. Other common challenges HDs face include difficulty in monitoring and evaluating (M&E) the condom distribution and HD procurement processes. In terms of M&E, simply because condoms are provided to a population does not ensure that they are truly being used, that they are being used correctly, or that they are being used by the priority population. Thus, the number of condoms distributed to the community is not a reliable indicator of condom efficacy within that community.

Though HIV testing supported through HDs remains at a fairly steady state, modest downward trends were observed after the implementation of PS12-1201. This is likely a result of funding shifts and reprioritization of program activities under PS12-1201 as HDs adapted from CDC’s expanded testing initiatives to targeting testing in both clinical and non-clinical settings. NASTAD will continue to track potential changes in trends as HDs implement PS18-1802 to determine the impact of changes in federal funding.

HDs seek ways to increase the impact of testing through strategies to: co-test for other infections (including HCV and STDs), test in previously untapped settings (including SSP sites, substance use treatment centers, and corrections settings), and utilize conventional testing to identify acute infection, and promote integrated testing services and sustainability.

Though convenient, rapid point-of-care HIV tests are less sensitive and more expensive. Depending on rapid tests instead of conventional testing may represent a missed opportunity for HDs relative to identification of acute HIV infection, timeliness and completion of surveillance data, as well as revenue generation through third-party billing. HDs may benefit from continued training on how to implement third-party billing as a standard operating procedure, and how to encourage or require providers they fund and programs they support to do the same.

DISCUSSION

As a recent initiative, some jurisdictions began implementing rapid start testing programs in which individuals start antiretroviral therapy (ART) the same day as receiving a reactive rapid test. Rapid ART initiation began in 2017 and may serve as another avenue to integrate HIV prevention and care.

For those jurisdictions implementing D2C, staff capacity and difficulty locating individuals on the “not in care” lists prove to be the greatest challenges. Reported issues with the basic necessary data infrastructure may be the underlying cause of these primary concerns, as other common barriers included completeness and/or timeliness of lab reporting, data quality, and data sharing issues. Incomplete or outdated client-level data can lead to inefficient use of staff time investigating or performing outreach to individuals presumed to be “not in care”. As D2C programs continue to scale up, HDs require continued support to ensure their data systems and infrastructure can keep up with the rapid growth of this prevention strategy, and funding that aligns with the significant staff time investment necessary to implement D2C. Over time the role of DIS has continued to evolve beyond their traditional partner services function. In many jurisdictions, DIS are also responsible for facilitating linkage to care as well as referring HIV-negative individuals to prevention services such as PrEP.

Heretofore, many HDs have had limited technological and personnel capacity to respond to potential HIV outbreaks or “clusters”. Given new requirements under PS18-1802 to have plans in place to identify and respond to HIV transmission clusters and outbreaks, many jurisdictions may need additional support to expand these activities.

Advances in HIV network and molecular analysis allow HDs to mitigate new HIV infections through data sharing and the detection of clusters and acute infections. Because of the sensitive nature of HIV genetic sequencing data and the presence of HIV criminal transmission statutes in the majority of jurisdictions, HDs are reviewing data privacy protections for surveillance data to ensure adequate policies to safeguard data are in place. In light of the current political climate, a history of mistrust between community and governmental public health, and drastic increases in immigrant deportations, HDs are also meaningfully engaging communities in conversations about surveillance activities more broadly and how states are using HIV network and molecular analysis data in particular.

Representation

Representation matters. HDs prioritize specific populations and cater services to their needs by creating outreach materials that reflect the likeness of the population being served. Social marketing campaigns that visually and culturally represent the prioritized audience are more effective and are perceived as promoting respect and decreasing stigma. This effort can be a difficult balance for some, as HDs navigate showcasing the faces of priority populations in their outreach materials without promoting the

DISCUSSION

assumption that all people of a specific population are living with HIV, or at high risk of contracting HIV. HDs seek a balance of promoting awareness and access within a specific audience without making them feel ostracized.

In addition to health campaigns, HDs may be able to better serve priority populations by cultivating a workforce that is derived from the priority population. Consumers who are in need of services, and who face stigma, may be more receptive to stepping outside their comfort zone to seek preventive services or to remain in care if they feel that their journey is understood. One way of achieving this is by hiring staff who can speak to the lived experience of those whom HDs are most trying to reach. In addition to hiring from the priority populations, existing staff should be tasked with understanding that cultural competency, or cultural responsiveness (as one can never be fully competent on another person's culture), is of the utmost importance. Health equity cannot be understood or achieved without respecting the socioeconomic factors that contribute to the overall health of a population.

Limitations

There are several limitations to these findings. Though the survey completion rate indicated a high yield of responses (83%), the results may not be generalizable across the entirety of NASTAD's membership. Unique perspectives of specific HDs may not be represented by the overall experiences of the survey participants. Further, of the 83% of jurisdictions who completed the survey, some jurisdictions did not have available data for all survey items. All data were self-reported and therefore subject to the knowledge and biases of the individual(s) who completed the survey.

The survey included questions that asked respondents to quantify funding levels as well as test volume by test type and specimen. Several HDs were not able to provide these data, therefore hindering the ability to interpret longitudinal trend analysis for these categories. While selected questions were analyzed compared to previous surveys, there are some cases where there was slight variation in the question being asked. Lastly, the survey inquires about practices around routine testing. It should be noted that there may be substantial variability in how routine testing is deployed among HDs. Comparison should be made with some caution.

Conclusion

For the first time in the history of HIV in the United States, HDs and partners have the tools within reach to effectively end the national HIV epidemic. Through the alignment of policies, partnerships, and practices, this common goal is attainable.

DISCUSSION

National HIV prevention efforts continue to gain momentum as increasingly more jurisdictions adopt Medicaid expansion and promote ACA coverage, affording millions of Americans (including those living with or most at risk for HIV) increased access to better healthcare coverage and insurance options. Additionally, in 2018 HHS indicated an intention to update the goals of NHAS beyond its current end date of 2020, and during the State of the Union address on February 5, 2019, President Donald Trump announced an initiative to end the HIV epidemic by 2030. The new initiative intends to reduce new infections by 75% in the next five years, and by 90% in the next ten years by supporting 48 counties, Washington, DC, and San Juan, Puerto Rico, as well as seven states with high rates of HIV in rural geographic regions. Health departments in jurisdictions who face the greatest burden of the epidemic were previously allocated resources comparable to their jurisdiction's HIV prevalence through PS18-1802; the president's proposed initiative is projected to supplement these resources. In the spirit of aligning efforts to end the HIV epidemic, jurisdictions are creatively and resourcefully operating under integrated HIV prevention and care plans as well as the first integrated HIV prevention and surveillance program announcement, and engagement between community and governmental public health continues with jurisdiction-level and national alliances such as the Presidential Advisory Council on HIV/AIDS (PACHA).

Perhaps the most exciting development in the quest to end the HIV epidemic is the evidence-based confirmation that a person living with HIV who adheres to their ART and is durably virally suppressed does not sexually transmit HIV. In an environment where stigma fuels much of the disparities related to HIV prevention, this declaration that undetectable equals untransmittable (U=U) is paramount. As of February 14, 2019, 17 NASTAD member jurisdictions have embraced this messaging, spearheaded by the [Prevention Access Campaign](#), as a part of their efforts to reduce stigma and increase awareness of the benefit of getting tested, engaging in care, and remaining compliant to ART.

The NHPI was disseminated at a key point in time – during the final year of CDC PS12-1201 funding. The results tell less of a story of the specifics of this particular funding announcement, and more details about the current status of the HIV landscape including which populations were prioritized and standards of care that were emphasized. The growing opioid crisis and relaxed restrictions on federal funding allowed for jurisdictions to ramp up SSPs. PrEP became a standard of care. HIV incidence trends caused scaling up of programs for Black and Latinx MSM and other high priority populations, including the deployment of interventions such as Mpowerment which speaks to a growth of awareness and emphasis on addressing needs of this population.

As HDs operate under the first integrated HIV prevention and surveillance program announcement, myriad opportunities avail themselves to focus on the policies, partnerships, and practices needed to push the needle forward in ending the HIV epidemic.

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