"If the public health mission is to assure the conditions in which people can achieve the highest attributable state of physical, mental, and social well-being, and if these conditions are predominantly societal, then public health must work for social transformation."

— Dr. Jonathan Mann
The National Alliance of State & Territorial AIDS Directors (NASTAD) represents the nation’s chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis health care, prevention, education and support service programs funded by state and federal governments.

NASTAD’s mission is to strengthen state and territory-based leadership, expertise and advocacy and bring them to bear in reducing the incidence of HIV and viral hepatitis infections and on providing care and support to all who live with HIV/AIDS and viral hepatitis. NASTAD’s vision is a world free of HIV/AIDS and viral hepatitis.

For more information about NASTAD, please go to www.NASTAD.org.

Julie M. Scofield, Executive Director
H. Dawn Fukuda, Massachusetts, Chair
January 2014
NOTE FROM NASTAD’S CHAIR

As HIV/AIDS directors in state and territorial health departments, we are no strangers to the concept of strategic planning. Community engagement, consumer advisory, and evidence-based decision making are hallmarks of our approaches—as is the capacity for our systems to evolve and adapt in response to emerging trends and population needs. Our planning and program development methods have been soundly implemented and tested over years, in some cases over decades.

The infrastructure to deliver HIV/AIDS and viral hepatitis prevention and care services, while it may look and function differently across our individual jurisdictions, has been collaboratively designed to be maximally accessible, responsive, and effective in reaching local and national health promotion objectives. We have built a system that blends social welfare, medical care, and public health in an integrated services framework, and by all accounts we have been a success.

Now, we are being called to draw on our collective skills and experiences to think and plan strategically in an environment unlike any we have faced before in the history of the HIV/AIDS response. We are encountering a confluence of remarkable opportunities and unprecedented pressures—to advance prevention, care, and treatment approaches that can begin to end the HIV/AIDS epidemic, in the context of the most far-reaching transformation in our nation’s health care system in the last 50 years, and during an uncertain funding environment. This is no small task, and it demands we elevate the level of urgency we bring to the planning work before us.

We have a window of opportunity to define the essential roles of public health, communicable disease response, and HIV/AIDS services in the context of the evolving health care system. Our obligation is to ensure that we do not lose ground in our efforts to combat the HIV and viral hepatitis epidemics, and that we sustain what are today proven effective prevention, care, and treatment interventions for our most vulnerable residents. This is the essential mission of public health practice, and a moral obligation of responsible government.

At the same time, we must adapt existing systems to leverage the opportunities of national health care reform, modernize our disease surveillance approaches, coordinate communicable disease intervention efforts, and integrate HIV and viral hepatitis prevention and care responses. In collaboration with our community partners, we are responsible to redesign an HIV/AIDS service system that does not exist in protected siloes, but connects across all sectors of the medical care and public health environment. Only then can we assure a responsive service system that has a chance to survive, and that will assure persons living with and at risk for HIV and viral hepatitis will not be left behind.

— H. Dawn Fukuda, Massachusetts Department of Public Health
The number of individuals living with HIV in the United States increases each year, making new HIV infections ever more challenging to prevent, while the costs of providing HIV treatment and other vital preventive and care services continue to increase. We know that addressing the HIV epidemic requires decreasing new infections. Recent notable achievements provide promise for success, among them the release of the NHAS and the passage of the Affordable Care Act (ACA). Successful clinical trials demonstrating the effectiveness of treatment as prevention (TasP), combined with improved HIV testing and health information technologies contribute significant hope. Collectively, these achievements have catalyzed a transformative moment in healthcare systems for communities impacted by HIV. The time has come for state leadership to act on these achievements to get to zero, meaning minimal new HIV infections occurring in the U.S., with no new cases of advanced HIV disease, and all those who are living with HIV to be living healthy, productive lives free of stigma and discrimination. The future of HIV prevention, care, and treatment is now.

The release of the NHAS in July 2010 reinvigorated and unified domestic efforts to address the HIV epidemic. The NHAS challenges the U.S. to improve its response through commitment of government at all levels, and assigns shared responsibility to medical providers, people living with HIV (PLWH), researchers, faith communities, philanthropy, educational institutions, private industry, and others. The NHAS provides targets for stakeholders to achieve while encouraging local determination of the best path to do this. Health departments, as the cornerstone implementers of federal and state public health policy, are essential to leading local jurisdictions to meet the NHAS goals.

The U.S. healthcare system is undergoing radical change. By significantly expanding access to Medicaid and private insurance, requiring that insurance be comprehensive and affordable, and investing in prevention and wellness, the ACA provides an opportunity to improve a very broken healthcare system – one that currently leaves approximately 30% of people living with HIV without any access to insurance. However, access to insurance alone does not replace public health programs that actively identify and locate persons at risk, nor does access to insurance ensure linkage to and retention in medical care in a manner that is responsive to the needs of PLWH.

Over the past decades, the Ryan White Program, the single largest federal program designed specifically for PLWH in the U.S., has established local systems of highly trained clinicians, case managers, adherence and outreach specialists, and other personnel who provide responsive, person-centered, and coordinat-ed medical care and other essential services. These systems of integrated care are located in disproportionately impacted areas, and serve clients with the highest level of psychosocial vulnerability and medical needs. In these settings, people living with HIV receive a full range of services that help them remain engaged in care, notably medical case management, care coordination, adherence support, benefits advocacy, and housing search and placement. As the ACA is implemented, PLWH may access medical care in an increasingly wider variety of care systems, for health services that are reimbursable by third party insurance, including Medicaid and Medicare. The Ryan White Program remains critical to address anticipated gaps in health services, and to continue to provide services that link, engage, and retain PLWH in care and treatment.

The demonstrated success of Treatment as Prevention (TasP) eliminates many of the divisions of prevention and care that have existed historically while encouraging a restructuring of HIV prevention programs to promote prevention through health care, particularly in those jurisdictions that may have limited resources for prevention services and programs. Strategies for prevention of transmission now include ensuring viral suppression in persons living with HIV. At the same time, strategies for care programming now extend to locating and testing persons living with HIV who have not yet been diagnosed, an activity previously limited to the realm of prevention programs. Providers of HIV prevention services must adapt to this shift, and become versed in both prevention science as well as the central role of HIV treatment to advance Prevention with Positives. At the individual level, PLWH will continue to rely on medical and community-based providers to deliver culturally appropriate care, inclusive of medical case management and adherence counseling, to achieve and sustain viral suppression long-term. For this reason, integrated prevention and care planning is now more important than ever. These efforts should continue to meaningfully involve PLWH.

The HIV care continuum provides a tool to measure progress towards increased access to and retention in medical care and antiretroviral treatment as a primary means to prevent new HIV infections. Prevention through health care can be achieved by implementing strategies that support the HIV care continuum. These strategies include an array of public health and clinical interventions that promote optimal individual health outcomes at the same time that they reduce transmissions. This encompasses diagnosing HIV and linkage to care, engagement, re-engagement, and retention in care, and successful treatment leading to viral suppression.

ACA implementation further reforms the delivery of HIV prevention by codifying the value of preventive health services, and incentivizing through payment reforms the delivery of timely
screening for a variety of health conditions and communicable infections. In 2014 as more individuals gain access to Medicaid coverage and private insurance, the likelihood of HIV screening and other prevention services occurring in healthcare settings, such as community health centers and private practices, greatly increases.

HIV testing technology has evolved such that evaluation for acute HIV infection can be a routine part of every diagnostic HIV test. The ability to identify acute infections and initiate partner services and HIV treatment earlier can improve overall health outcomes for individuals and create opportunities for prevention. As these testing technologies are deployed and new public health response protocols are implemented, further evidence of the health promotion and disease prevention potential will continue to emerge.

Increasingly sophisticated use of surveillance information, electronic health records, and laboratory data can enhance prevention and care planning, programming, and improve health outcomes. Effective HIV prevention, treatment, and care efforts must continue to be data-driven. Use of public health data for individual-level action is expanding in ways that were not imaginable just a few years ago. Health departments will be required to utilize data to direct client-level interventions, and monitor the impacts of prevention efforts on client-level health outcomes such as linkage to care and viral suppression while maintaining security and confidentiality. Effective and ethical use of data and technology enables health departments to more effectively target efforts and resources to where they will have the greatest impact in reducing new HIV infections, improving health outcomes for people living with HIV, and reducing HIV-related disparities. In tandem, health departments should leverage opportunities around health information to evaluate policies and practices that may perpetuate HIV-related stigma (i.e., forms, policies and procedures related to HIV).

Despite significant progress in the HIV response over the past 30 years, multiple patterns of injustice persist which anchor and sustain health inequities for minority communities in the U.S. Social determinants such as poverty, homelessness, racial and gender inequalities, homophobia, transphobia, and the stigmatization of disease fuel the spread of HIV. Economic hardship in the U.S. is significant, with many communities of color experiencing a growth in child poverty, high unemployment and underemployment, along with dismantlement of public education and mass incarceration.

This web of complex social determinants makes it possible for HIV to continue to thrive in communities where it first took hold: gay, bisexual, and other men who have sex with men (MSM) of all races and ethnicities; communities of color, thus disproportionately affecting Black and Latina women and young people; persons who inject drugs; and transgender women. HIV-related stigma has impeded even the best program efforts throughout the epidemic and remains a barrier to successful engagement in prevention and care efforts. Untreated substance use and mental illness pose challenges across the HIV care continuum. Political inaction to address structural drivers of HIV, or in some cases, political initiatives to suppress science-based action to achieve NHAS goals are real challenges to overcome.

The ACA may be a force to address HIV-related health inequities provided the health care system is enabled to meet the needs of communities impacted by HIV. Access to healthcare systems will not be simple. Many communities will be interacting with a healthcare system not always perceived as safe. Health department HIV programs will play a key role in ensuring access to health care through the ACA. As ACA implementation will vary by state, health departments must form a local plan to enroll community members and help build the capacity of communities to manage their own health.

Raising the bars is complex because the factors that contribute to HIV infection and transmission are varied, individuals, communities, and populations present with different levels of need for prevention and care services, and systems-level capacities are uneven. Raising the bars will require us to build on past achievements while maintaining flexible, dynamic systems open to change. Federal, state, and local governments and public health authorities must work in partnership with all sectors of society, to achieve and sustain an effective response.

How can your jurisdiction raise the bars?
CALL TO ACTION:
STATE HEALTH DEPARTMENTS RAISING THE BARS OF PREVENTION AND CARE

Health departments are uniquely situated to lead a jurisdictional response to HIV/AIDS. Entrusted by the U.S. Constitution to be accountable for public health, health department HIV/AIDS programs have both administrative and strategic responsibilities to ensure a continuum of HIV services that meet the needs of local communities, while coordinating and leveraging funding streams and programs (federal, state, and local) efficiently and effectively. In the context of ACA implementation, now is the ideal time for state health departments to chart a course for the future of public health. In some jurisdictions, health department leadership has already revised the approach to deliver HIV prevention and care programs, while recommitting to core principles: sound public health policy, fiscal efficiency, partnership and collaboration, and meaningful consumer involvement and engagement with communities impacted by HIV infection.

Health departments must guide the direction of HIV prevention and care within their jurisdictions, informing policy and determining and executing state strategy that best fits jurisdictional needs. Health departments must assert the perspective of public health particularly within often-times divisive political contexts. Examples of effective leadership efforts include actions undertaken in New York State and Iowa, where health departments identified barriers to successful HIV prevention and care efforts that were grounded in unjust policies, and proactively implemented processes to modify the policy environment.

SHAPING THE FUTURE: ADAPTING PUBLIC HEALTH POLICY TO MATCH CURRENT CONTEXT IN NEW YORK AND IOWA

Public health policies must reflect current HIV science and public health practice, while actively working to decrease stigma associated with HIV infection. State health department HIV programs in New York and Iowa have demonstrated leadership on this issue, resulting in:

- A New York State Health Department Guide specifically outlining a public health approach to address ongoing risk behavior by HIV infected persons, providing guidance, sample tools and opportunities to access one-to-one assistance for difficult cases
- An Iowa-specific fact sheet used as an educational tool to support revision of laws that criminalize HIV transmission in Iowa to be compatible with scientific evidence, and reduce stigma associated with HIV infection

Engaging in state implementation of the ACA is essential to assure continued coverage for people living with HIV. Decisions made in state insurance and Medicaid divisions will impact the ability to deliver HIV-related services to those in need. Health departments must advocate for people living with HIV and provide information to consumers, advisory bodies, and other stakeholders regarding state-level implementation. In Arizona, the health department ensured continued access to care by enrolling clients in the Pre-existing Condition Insurance Plan (PCIP), a component of the ACA.

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ACTION ITEM

REGULARLY ANALYZE STATE HEALTH POLICIES TO ASSURE THEY PROMOTE PUBLIC HEALTH GOALS IN THE CURRENT CONTEXT. IDENTIFY OPPORTUNITIES TO EDUCATE STAKEHOLDERS, AND DESCRIBE THE SUCCESS OF LOCAL HIV PREVENTION AND CARE EFFORTS.
EXPANDING CARE OPTIONS: GAINING COMMUNITY SUPPORT FOR INCREASED CLIENT ACCESS IN ARIZONA

The Arizona AIDS Drug Assistance Program (ADAP) capitalized on the opportunity to enroll clients in the federally-run Pre-existing Condition Insurance Plan (PCIP), a component of early implementation of the Affordable Care Act. This work has resulted in:

- Outreach to the entire HIV/AIDS provider system in Arizona to ensure that clients being enrolled would have comprehensive access to physicians specializing in HIV who were already partnered with the Arizona Ryan White Program
- Enrolling over 672 clients in PCIP as of December 2012

Health departments share analyses needed to inform planning and public health action through collection of surveillance and program data. Surveillance data play a central role to strategically target public health action along the care continuum, and to more effectively locate and reach individuals and communities in need. Due to the sensitivity of the data, public health action must occur in partnership with local health department and medical providers, with sufficient transparency and opportunities to share information and respond to questions and concerns. HIV Planning Groups (HPG), Scientific Advisory Committees (SAC), and Consumer Advisory Boards (CAB) may be instrumental in this regard. In Louisiana, the health department carefully planned and implemented a health information technology system improving health care access and outcomes for people living with HIV, TB, and syphilis.

USING SURVEILLANCE DATA TO IMPROVE HEALTH: ENGAGING INDIVIDUALS IN CARE SERVICES IN LOUISIANA

The Louisiana Office of Public Health (OPH) partnered with Louisiana State University (LSU) Hospitals to create the Louisiana Public Health Information Exchange (LaPHIE). LaPHIE is an electronic health information exchange that uses surveillance data housed at OPH to alert clinicians at LSU when a hospital or clinic patient may need care or treatment for HIV, TB, or syphilis. This initiative has resulted in:

- A secure mechanism to place patient-specific public health information in the hands of the clinician at the point of care
- Identification of over 900 out-of-care individuals in need of HIV treatment services

Health departments are capitalizing on innovations in information and communication technologies to improve services along the HIV care continuum. Digital technologies, including mobile devices, social media and Internet-based interventions, are fundamentally transforming healthcare systems and have implications for how both prevention and care services can be accessed and delivered. We are at a critical moment in the HIV epidemic and health department programs need to use the best tools available. For example, in Illinois, the state health department utilized available state data to improve access to care for people living with HIV.

ACTION ITEM

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USE RESOURCES TO MOBILIZE HIGHLY-ImpACTED COMMUNITIES TO ADDRESS SYSTEMS-LEVEL BARRIERS TO HIV PREVENTION AND CARE.

ASSURE INCREASED PARTNERSHIP BETWEEN HIV SURVEILLANCE, HIV PROGRAMS, AND HIV CARE PROVIDERS TO USE SURVEILLANCE DATA TO IMPROVE HEALTH OUTCOMES.
INCREASING CLIENT ACCESS: USING HEALTH INFORMATION TECHNOLOGY (IT) TO EXPEDITE ACCESS TO CARE IN ILLINOIS

The Illinois AIDS Drug Assistance Program (ADAP) maximized available state data to streamline its application processes, resulting in:

- A web-based common application for ADAP, leading to an entire web-based Ryan White Program eligibility determination application in the near future
- A reduced burden on clients and case managers
- Greater transparency of the ADAP application review and approval process
- Faster application review and eligibility determination of approximately 10 minutes
- A single online application increased staff efficiency and improved the quality of application review
- Enhanced the security of the application review process involving multiple confidential documents

State leadership has identified key strategies to decrease new HIV infections through expanded access to syringes, condoms, medications, and targeted prevention services. For example, New York prioritized meaningful community engagement and consumer participation in expanding access to care and prevention services.

EXPANDING ACCESS TO CARE AND PREVENTION SERVICES: DECREASING NEW INFECTIONS OF HIV IN NEW YORK STATE

In response to an epidemic that was driven by substance use in the 1980s and 1990s, New York State adopted a comprehensive approach to drug user health, involving access to syringes through syringe exchange programs. This approach resulted in:

- Nearly three million sterile syringes distributed per year
- The Expanded Syringe Access Program, through which syringes are available from more than 3,200 registered providers

The proportion of injection drug users among newly diagnosed cases has dropped dramatically, from 54% in 1992 to just 4% in 2011.

As part of its approach to preventing sexual transmission of HIV and other diseases, New York State provides free condoms to organizations serving persons with or at risk for HIV and STDs through the online New York State Condom program (NYSCondom). This program has resulted in:

- NYSCondom distributing approximately 12 million condoms per year at no cost to eligible organizations requesting them
New York State’s HIV Uninsured Care Programs provide medications and health care to persons with HIV/AIDS (PWHA) who are not eligible for Medicaid and who do not have private insurance. The Programs:

- Provide assistance in paying health insurance premiums to support access to comprehensive health care coverage for PWHA who have insurance but cannot afford to pay their premiums
- Bridge the gap between Medicaid coverage and private insurance, providing universal access to medications and care for New York’s residents living with HIV/AIDS

Raising the bars demands innovative partnerships. It is clear that separate, siloed programming does not address co-occurring epidemics associated with HIV, including substance use, mental health, other sexually transmitted infections, and viral hepatitis. Logical overlap of these services has catalyzed states to maximize limited financial and human resources through program collaboration and services integration via strategic partnerships, redirecting traditional partnerships, and realignment of programs. Challenges must be overcome, such as identifying a common ground in the face of multiple ideological approaches to disease intervention, coordinating work with common partners outside of the governmental public health system, and assuring culturally relevant approaches to working with communities. In Washington State, integrating across infectious disease prevention programs and building capacity to develop partnerships with other systems allow for a more comprehensive response to the myriad health issues of individuals who inject drugs (IDU).

**MAXIMIZING LIMITED RESOURCES: INTEGRATION AND PARTNERSHIP IN WASHINGTON STATE**

In order to best address co-occurring issues for persons at risk for and living with HIV, and to best leverage opportunities to address public health needs through the health care delivery system, the Washington State Department of Health has realigned its prevention programs. Work in the areas of HIV, adult viral hepatitis (AVH), and sexually transmitted diseases (STD) is now conducted by an integrated Infectious Disease Prevention Section. The realignment resulted in a new functional structure which includes:

- The Public Health Systems program, which has a focus on strengthening the governmental public health system in the areas of diagnosis of disease, and linkage to and retention in care
- The Business Development program, which has a focus on building opportunities for delivery of public health services through the health care delivery system and getting them paid for through this system
- Ability to build capacity to leverage multiple systems to deliver better integrated services at the client level

**ACTION ITEM**

**IDENTIFY ALL OPPORTUNITIES TO EXPAND ACCESS TO MEDICATIONS, CONDOMS, AND SYRINGES TO INDIVIDUALS AND COMMUNITIES MOST IN-NEED.**

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**ACTION ITEM**

**IDENTIFY OPPORTUNITIES TO ADDRESS THE MULTIPLE NEEDS OF PEOPLE AT RISK FOR OR LIVING WITH HIV BY INCREASING POSSIBILITIES FOR SERVICE DELIVERY THROUGH PUBLIC AND PRIVATE SYSTEMS.**
As the proportion of persons living with HIV who are diagnosed increases relative to the proportion who are not yet diagnosed, the importance of focusing prevention efforts on those who have been diagnosed increases. Hall, Holtgrave, et al. estimate that 55% of transmissions now come from a relatively small number of persons who have been diagnosed but who engage in risk behaviors with discordant partners. Recent resource allocation models also indicate that prevention efforts will be most cost effective if they place a strong emphasis on so-called Prevention for Positives strategies. These will require collaborative efforts between prevention and care providers, and will involve focusing both on reducing risk behaviors and increasing treatment adherence. Iowa restructured its HIV prevention program in response to these changes.

**RETARGETING PREVENTION SERVICES: PREVENTION WITH POSITIVES PROGRAM IN IOWA**

In response to the significantly reduced funding for low-morbidity areas that was associated with the HIV prevention funding opportunity announcement PS12-1201, Iowa restructured its prevention and care portfolios based upon the factors just discussed. Components included:

- A prevention-for-positives focus across HIV prevention and care programs that facilitates shared use of federal funds from CDC and HRSA
- Resource allocation modeling that recommended a strong investment in behavioral prevention programs for the relatively small pool of persons living with HIV who have detectable viral loads and continue to engage in risk behaviors with partners of negative or unknown status
- Other programmatic efforts narrowly focused on the steps in the HIV care continuum, including testing, linkage, retention, and re-engagement in care
- A single, integrated state plan and a reorganized community planning process, both of which are framed around the HIV care continuum
- A revision of state statutes and regulations to promote use of surveillance data for client-level action, including uploading of surveillance data into the case management system (CAREWare), development of a real-time out-of-care database to identify persons who might benefit from public health services, and the assignment of cases to DIS for re-engagement in care

Based on approximately 20 years of health planning with communities impacted by HIV and viral hepatitis, health departments have necessary relationships to foster a strong understanding of a jurisdiction’s needs and how best to meet those needs. Established relationships with communities allow a meaningful exchange of information and increased participation in public health matters. Engaging with impacted communities in public health programs provides critical insight into solutions to health problems while providing a base for advocacy efforts to assure availability of necessary resources. In Florida, the Gay Men’s work group has actively participated in health department initiatives to address the HIV epidemic among Florida’s gay, bisexual and other MSM population.

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MEANINGFUL COMMUNITY ENGAGEMENT: DIVERSE, PARTICIPATORY WORK GROUPS IN FLORIDA

The membership of Florida’s Gay Men’s work group continues to grow, representing the diversity of Florida’s gay, bisexual, and MSM communities. The work group is heavily invested in health department projects through participation in regular conference calls and workgroup meetings. This work has resulted in:

- Advising the development of culturally relevant health department materials and campaigns
- A cultural competency training for Disease Investigation Specialists (DIS)

Health departments must adapt to foster the infrastructure that can meet the demands of a new, ever-changing healthcare system. After 30 years of implementing HIV prevention and care programs, raising the bars requires informed and at times uncomfortable re-positioning and re-purposing of staff, planning bodies, community, and resources. The role, scope and job descriptions of HIV program staff will change as new skill sets are needed, including data analysis and evaluation, active surveillance and disease intervention, and understanding of integrated communicable disease response efforts. Long-time staff must be encouraged to take on new tasks while building on the lessons learned from previous work.

Health department capacity to collaborate and coordinate as resources shift is essential to sustain effective HIV prevention and care services for at-risk populations. Innovative, savvy partnership-building to address longstanding social problems, promoting informed policy, and managing and communicating the knowledge that informs prevention and care programs are vital components of raising the bars.

Achieving the goals of the NHAS is only the beginning. Health departments will be increasingly relied upon for leadership in framing strategies to address local epidemics, identifying innovative partnerships to advance health promotion goals, and maintaining meaningful relationships with impacted communities to inform and implement a dynamic response. These leadership lessons are far-reaching, not only impacting domestic programs but also programs administered by ministries of health across the globe. Beyond offering a menu of services, health departments are being called upon to enhance and improve the capacity of the health care system to effectively implement HIV prevention and care activities, while simultaneously defining the components of the HIV/AIDS response that will remain in the purview of the jurisdictional public health authority. Moving ahead, it will be the combination of an accessible and responsive medical care system, alongside community-based organizations, and in partnership with a vigorous and data-driven public health response that will make it possible for the U.S. to raise the bars along the HIV care continuum.