Division of HIV/AIDS Prevention Program Monitoring Update

Progress Towards National HIV/AIDS Strategy Goals: Success Stories from the Enhanced Comprehensive HIV Prevention Planning Project

June 2015

ECHPP Success Story Highlights

Dallas

- Number of HIV tests among MSM increased by 214%
- Number of HIV tests among Black MSM increased by 573%

Miami

- Number of newly diagnosed, HIV-positive people interviewed through partner services increased by 206%

Los Angeles

- Percentage of HIV-diagnosed patients enrolled in the new Medical Care Coordination program who were virally suppressed increased from 30% to 60%

Chicago

- Chicago's new integrated prevention and care council was instrumental in implementing a citywide HIV Unified Plan

In this Update, we describe four success stories from CDC's Enhanced Comprehensive HIV Prevention Planning Project (ECHPP). This 3-year (2010-2013) demonstration project was the Division of HIV/AIDS Prevention's first response to the National HIV/AIDS Strategy (NHAS). Through ECHPP, health departments in twelve jurisdictions enhanced local HIV prevention planning and coordination and developed strategies to increase local program impact using all available funding. These success stories showcase health department progress toward achieving the following NHAS goals:

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV infection
- Reduce HIV-related health disparities
- Achieve a more coordinated national response to the HIV epidemic

All success story content was provided by ECHPP grantees and is based on local data sources.

Success in Dallas: Increasing HIV Testing among MSM and Black MSM

The Texas Department of State Health Services (DSHS) refocused its HIV prevention activities in Dallas to reduce new HIV infections and HIV-related health disparities.

In 2010, at the start of ECHPP, the Texas DSHS conducted a situation analysis in Dallas that showed:

- 40% of health department counseling and testing efforts were directed towards MSM but only 5% focused on Black/African American MSM
- MSM accounted for 67% of people living with HIV in the Dallas area and 70% of all new HIV diagnoses
- 25% of MSM who tested HIV-positive were new diagnoses and over half of them (54%) were unaware of their infection

To address these disparities, the Texas DSHS strategically selected Dallas providers in high morbidity areas who could reach MSM through HIV testing and linkage to care activities. Over time, providers identified additional testing opportunities throughout Dallas County. Additionally, the use of nucleic acid amplification testing (NAAT) at the Dallas County Health Department Laboratory enabled the early identification of infections.

As a result of these efforts, there was an increase in CDC-funded HIV testing among MSM overall and among Black MSM in Dallas during ECHPP (Table 1). From 2010 to 2013:

- The number of tests increased by 214% for all MSM and by 573% for Black MSM
- The number of newly diagnosed MSM also increased 99% for all MSM and 183% for Black MSM

The Texas DSHS reports that these testing trends were largely driven by local ECHPP objectives to improve targeting of MSM in non-clinical settings and increase the emphasis on reaching MSM through health department-supported funding announcements. As testing increased, large pools of undiagnosed individuals were reached and, once those individuals had been diagnosed, HIV-positivity rates began to decline.

Table 1. Number of HIV tests, number of newly diagnosed people, and HIV-positivity in Dallas among all populations, MSM, and Black MSM, 2010-2013

	2010	2011	2012	2013
		All People		
Total tests	5,913	6,763	9,904	14,349
Newly diagnosed	114 (1.9%)	130 (1.9%)	204 (2.1%)	188 (1.3%)
		MSM		
Total tests	1,781	2,248	4,218	5,584
Newly diagnosed	85 (4.8%)	108 (4.8%)	175 (4.1%)	169 (3.0%)
		Black MSM		
Total tests	312	377	1,421	2,100
Newly diagnosed	24 (7.7%)	28 (7.4%)	91 (6.4%)	68 (3.2%)

Success in Miami: Expanding the Reach of Partner Services

Miami-Dade County Health Department, in collaboration with the Florida Department of Health, greatly improved the reach of the HIV/STD partner services program in Miami during ECHPP. This success helped public health officials in Miami make progress toward the NHAS goals of reducing new HIV infections and increasing access to care, improving health outcomes for people living with HIV infection.

Trends in partner services indicators in Miami, 2010-2013:

- **206%** increase in newly diagnosed, HIV-positive people interviewed through partner services
- **142%** increase in partners tested for HIV
- **411%** increase in tested partners who were newly diagnosed, HIV-positive
- **820%** increase in newly diagnosed, HIV-positive partners who received their test results

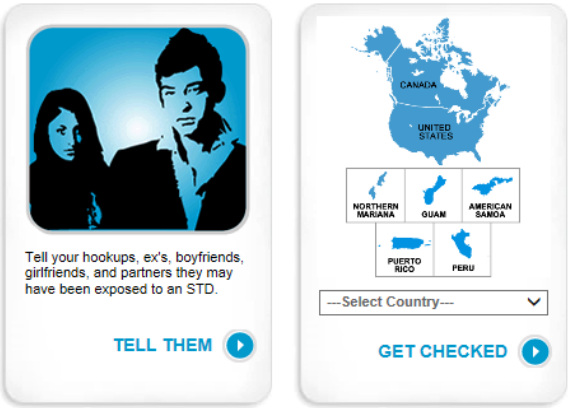
County and state health department staff used a variety of strategies to boost the partner services program in Miami:

- Trained Ryan White linkage coordinators to conduct partner services
- Conducted informant interviews with community providers and listening sessions with Ryan

White case managers to identify challenges with service delivery

- Prioritized partner service interviews for persons newly diagnosed with HIV infection
- Distributed educational materials to community providers about the partner services program and its importance for stopping HIV transmission
- Updated memoranda of understanding to increase the number of venues where partner services could be accessed
- Provided inSPOT e-cards (Figure 1) to persons newly diagnosed with HIV infection to anonymously or confidentially inform their sex or drug-injecting partners of potential exposure to HIV.
- Worked with faith-based leaders in Haitian neighborhoods to develop educational materials to be distributed at church services after learning that stigma was preventing Haitian community members from providing information about their sex and drug-injecting partners.

Figure 1. InSPOT e-card



Improvements in partner services activities in the Miami metropolitan area were the result of significant efforts by both HIV and STD prevention staff at the Miami-Dade County Health Department. Health department staff characterize these improvements as the product of two separate historical processes: ECHPP (including the work of ECHPP STD champions and community partners) and state-level policy changes (including a de-emphasis on lower priority field investigations, such as non-HIV, non-Syphilis cases).

Success in Los Angeles: Improving Continuum of Care Outcomes using the Medical Care Coordination Model

MCC team members assess patient needs in various domains:

- Health status
- Social support
- Mental health
- Substance use
- Adherence to antiretroviral therapy
- Housing access
- Transportation access
- Medical care access
- Financial support

The Los Angeles County Department of Public Health's Division of HIV and STD Programs implemented a Medical Care Coordination (MCC) model in 2011 as a complement to the ECHPP project. Early evidence indicates that improved coordination has resulted in better health outcomes for program participants, suggesting progress toward the NHAS goal of increasing access to care and improving health outcomes for people living with HIV infection.

In the MCC model, a multidisciplinary team consisting of a nurse, a social worker, and a case worker provide coordinated, patient-centered care to people living with HIV. At enrollment, the MCC team assesses the patient's needs for specific services. The team works directly with patients using evidence-based, brief interventions and counseling techniques to empower them to adhere to treatment, manage their illness, and ultimately extend their lives.

Preliminary evaluation data[1] show improvements in retention in HIV medical care and viral suppression among MCC enrollees (January 2012 – December 2014) (Figure 1).

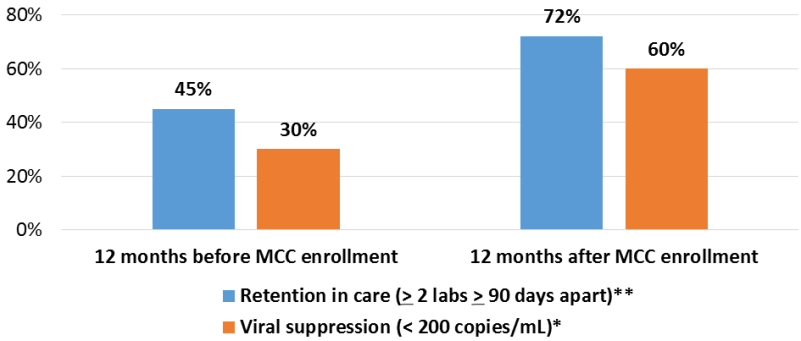
There were 1,204 patients enrolled in MCC in 2013. In 2012:

- 537 patients (45%) were retained in care
- 367 (30%) were virally suppressed

At 12 months after enrollment, in 2014, the two outcomes improved:

- The number of patients retained in care increased to 872 (72%)
- The number who were virally suppressed increased to 719 (60%)

Figure 1. Percentages of Patients Retained in Care, Virally Suppressed Before and After Medical Care Coordination Enrollment, Jan. 2012-Dec. 2014



Outcomes computed from data in the LAC HIV/AIDS Reporting System as of January 12, 2015 and in the Ryan White Care Services database (Casewatch) from January 2012-December 2014 as of January 31, 2015.
*Most recent viral load in the last 6 months of the 12m period; if no viral load reported in period, then considered unsuppressed (≥ 200 copies/mL)
**Estimated using ≥ 2 CD4, viral load or genotype tests ≥ 90 days apart within the time period

The MCC model required a paradigm shift among medical and non-medical staff who historically had provided their services separately to patients. Over time, clinic staff adapted to the new emphasis on integrated service delivery and successfully integrated the MCC model into the clinic flow at clinical sites. The Division of HIV and STD Programs put considerable effort into educating staff about the importance of MCC, providing technical assistance regularly and conducting routine evaluations to get feedback from providers. Although not the primary funding source, ECHPP funding helped support the rollout of the MCC model and increased the likelihood of model success.

Success in Chicago: Dismantling HIV Service Silos and Improving Local Coordination through a Citywide Unified HIV Plan

In 2012, the Chicago Department of Public Health established the Chicago Area HIV Integrated Services Council as part of ECHPP. Through this Council, the health department developed a citywide HIV Unified Plan and effectively dismantled HIV service "silos" to support the NHAS goal of achieving a more coordinated local response to the HIV epidemic.

Chicago's HIV Unified Plan is Based on Four Strategies:

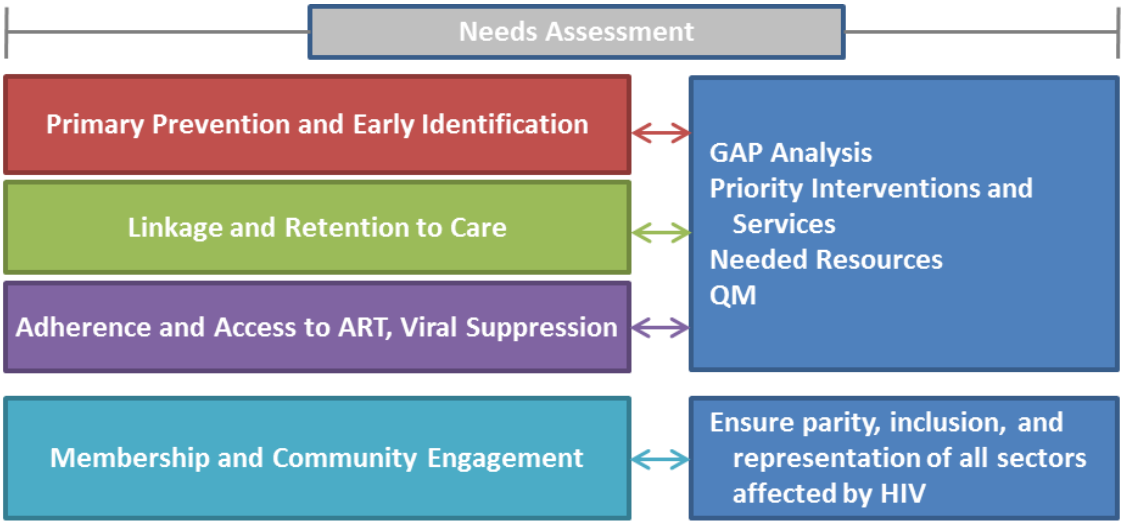
- Improve administrative systems to support coordination of planning and implementation of integrated services
- Develop a holistic HIV High Impact Prevention approach that helps both HIV-negative and HIV-positive individuals prevent HIV transmission
- Fully integrate the system of Early Intervention and Linkage and Retention
- Closely monitor progress across the continuum of care toward decreasing community-level viral load

The HIV Unified Plan represents a new approach for Chicago that leverages services spanning multiple stages of the HIV care continuum – driving a new process to determine how services are resourced and delivered. The Plan emphasizes a single *continuous* plan that follows individuals as they

progress along the continuum to meet evolving prevention, care, housing, and essential service needs.

The formation of the Chicago Area HIV Integrated Services Council was critical for creating and implementing the Unified Plan. Council development began in 2010 based on input from community stakeholders and a review of already-integrated HIV community planning models. In 2012, the Chicago HIV Prevention and Ryan White Care planning groups were dissolved at a joint meeting and the Council was officially approved with a unanimous vote. At the end of the first year of planning, Council members decided that a new Council structure was needed to fully achieve integrated planning and avoid silos of the past (Figure 1). The HIV continuum of care model provides a helpful framework for service delivery

Figure 1. Chicago Area HIV Integrated Services Council Committee Model



and client outcomes and helps public health officials identify service gaps and areas of unmet need. The Council viewed the HIV continuum of care model as an effective guide for to structuring Council Committees and redesigned its structure into three working committees that focused on specific continuum of care areas (plus a Membership and Community Engagement Committee).

The citywide HIV Unified Plan was a milestone for the Council, making recommendations for HIV services along the continuum, reviewing service utilization, and using resource allocation modeling to prioritize service delivery. The Unified Plan serves as a model for other health departments who need to integrate their own HIV prevention and care activities.

Contributors

The Update was prepared by Holly Fisher[a], Steve Flores[a], Tamika Hoyte[a], and Amanda Jones[b]. Corresponding contributor: Tamika Hoyte (imb5@cdc.gov, 404-639-6029). Success story content was provided by the Texas Department of State Health Services, the Florida Department of Health, the Los Angeles County Department of Public Health, and the Chicago Department of Public Health.

[a] Program Evaluation Branch, Division of HIV/AIDS Prevention, CDC; [b] Manila Consulting Group

References

1. Garland WH, Kulkarni SP. *Improvements in Retention in Care and Viral Suppression: Results from the First Year of the Medical Care Coordination Program in Los Angeles County.* Presentation at the 10th International Conference on HIV Treatment and Prevention Adherence, June 28-30, 2015, Miami, FL.