These notes reflect the discussion that took place during the 2011 HIV Prevention Contractor Summit held July 28-29, 2011. The content should not be interpreted as policy. DSHS has posted these materials for reference only.

2011 HIV Prevention Contractor Summit
Hyatt Regency Austin
July 28, 2011
Notes

WELCOME AND INTRODUCTIONS - Jeff Hitt

- Goals:
  - Continuation of last year's conversation on new directions
  - Discuss the future of HIV Prevention based on direction from ECHPP (Enhanced Comprehensive HIV Prevention Plan), the National Strategy for HIV/AIDS, and the CDC FOA for health departments.
  - New funding discussion for 2012 and 2013
- Participants were seated by regions and communities for round table discussions
- Hopes for meeting
  - Opportunity to shape the work that can bring new infections down
  - Common understanding of:
    - CDC language and requirements
    - What we are currently doing
    - Strategies for future
      - Possible activities

OVERVIEW AND PURPOSE - Jeff Hitt

- New ideas for prevention in the future; community mobilization
- Working together;
- Big picture/direction; How do projects fit into direction of future prevention
- Specific questions answered
- Funding
  - Learn about new funding opportunity and where to go with prevention efforts
  - What types of activities will be funded

HIV PREVENTION FOA - Jeff Hitt

- DSHS appreciates the level of involvement with funding agency as we move in this new direction
- Strategies to meet challenges of new contract year to share hope and prevention with communities served
- Share experience with community conversations and faith based orgs, school and HIV education
  - Innovative ideas for screening
- Continuity of programs - bring good things and history and knowledge with us

- National strategy and goals
  - Reducing undiagnosed infection

- Promoting behavior change through social and environmental interventions/strategies
- Jurisdictional plan
  - Over-arching plan
  - Comprehensive and coordinated response across many different levels
  - Agreeing to who is at risk (epidemiology)
  - Where we can have our highest impact

- Funding opportunity announcement
  - Funding for 2012 will be transition year with adjustments to explore how things might be done differently
- Organization of FOA is different
  - Review of 3 different categories (A,B,C)
  - Stated goals
    - Decrease the annual incidence rate
    - Decrease the rate of transmission by infected persons
    - Decrease the risky sexual and drug-using behaviors among persons at high-risk for acquiring
    - Increase the proportion of infected persons who are linked in prevention and care services
  - Formula allocation for funding
    - 75% required activities and 25% recommended activities

Category A, HIV Prevention:

- Required Activities:
  - Testing
  - Comprehensive prevention with positives
  - Condom distribution
  - Policy initiatives
    Other opportunities for local policy initiatives and schools
  - Other requirements
    - Jurisdictional prevention planning – system level ways
    - Capacity building and technical assistance to include training
    - Program planning, monitoring and evaluation, and quality assurance, to include data collection, management and reporting
- Recommended Activities
  - Evidence based prevention intervention for negative persons
  - Social marking, media, and mobilization
  - Pre-exposure prophylaxis (PrEP) and non-occupation post-exposure prophylaxis (nPEP) services
    - No medication can be purchased with funding

Category B: Expanded (Routine) HIV Testing

- Funding will be cut
  - Had large increase over previous years
- We will slow initiating new activities
- 150,000 tests through routine testing in clinical testing and is at .7% positive with continued positives identified
- Funds will be used to support integration of routine testing in clinical setting
  - 20% of funds can be used to support targeted testing in community based orgs
    - Must maintain a positivity rate of 2%
      - Creating new database to see how close to 2%
- 3 month extension of current funds will be given to accommodate for the shift in program period
  - Community based funds are still funded under category A

Category C: Demonstration Project

- Focuses
  - Structural, behavioral and or biomedical interventions or a combination
  - Innovative testing activities
  - Enhanced linkage to and retention in care
  - Advanced use of technology
  - Programmatic and epidemiological use of CD4, viral load and other surveillance data to assess and reduce transmission risk
    - Through electronic lab work
    - Making systems to allow flow of data
    - Working with couples who are both negative and positive
- New funding
  - Project period up to 4 years
  - Based on morbidity
  - Category C funding amounts
    - Up to 4 awards for 1m-2m
    - Up to 8 awards for 1/2m-1m
    - Look to slides for more info from Emma

New directions

- Community mobilization
- Encourage programs to begin integrating changes for new FOA without the need for amendments
- Looking at how prevention is packaged

- Encouraging social networking model for testing
    - Not partner notification but similar
    - Recruitment strategy for finding high-risk
    - Have found positives with this model
- Partner notification is reserved for Health departments by law
    - Community partner training around notification?
    - Regarding authority and protection
- Condom distribution
    - The prices for condoms is rising
    - DSHS is changing vendors
    - DSHS plans to continue to provide condoms in 2012
        - Lubricated condoms and female condom among others

Things that stood out for you during the FOA discussion

- Emphasis for prevention
    - Linkage and then breaking down the barriers
- 75/25 required vs recommended shift
- More condoms, more tests, fewer EBI's
- Policy on positivity rate:
    - 1% requirement for HIV programs jurisdictiosn for Texas
    - 1% does not apply to rountine testing programs except
        - 2% positivity rate for routine testing programs at CBO's
- Linkages of care expanding beyond referrals retaining and barriers
    - More coordination
- Inclusion of condom distribution in Category A
- Figuring out what we can do together
- Demonstration project
- Allocation of first time funding
- Policy initiatives focus
- Category C is shaped now by DSHS
- How far into the future will these programs (HIV) with the new affordable care act
    - Looking forward to 2014 or 2015 possible but unknown
    - Funding could change quite a bit
    - Feels they will still use clinics regardless of health insurance

<u>COMMUNITY PLAN</u> – Greg Beets

- The landscape
    - 6 regional CPGs to 1 statewide CPG
    - National Strategy then came out
    - ECHPP/12 Cities Project
    - CDC HIV Prevention FOA
- National themes

        - Reduce new infections
    - Framework
        - Behavior does not take place in a vacuum
        - Blow up prevention to speak to every one of these levels for nodes of opportunity
            - Build upon the individual
- Priority population
    - HIV positive especially those who do not know their status
    - Black gay MSM
    - All other gay and MSM
    - Black Heterosexual Woman
    - IDU
    - Black Heterosexual Men
    - High risk Heterosexual Hispanics
    - Youth
    - Special Populations
        - Transgender
        - Partner of HIV positive persons
        - Homeless
        - Incarcerated/recently released
        - Sex professionals
        - Individuals with STD/Hepatitis C
        - Mental health issues
        - Substance use issues
- Universal prevention strategies
    - Expanded testing
    - Linkage to care/treatment
    - Access to condoms/clean needles
    - Partner service/public health
    - Perinatal care
    - Community mobilization
- Population/Intervention Matching
    - TxCPG reviewed interventions on the current CDC compendium
    - Population/intervention match list included in Plan
    - Decreased role of EBI

- Action Briefs
    - Identified key settings where HIV testing is critical
    - Contain recommendation at all levels from the socio-ecological framework
    - Is not meant to be an exhaustive list for planning an intervention strategy
    - Template to develop prevention strategies
- 7 objectives of plan

- Address entire population instead of individuals
  - 1 in 3 diagnosed with AIDS after diagnosed with HIV in 1 year
  - Promote behavior change through condoms, clean needles
  - Those reported being tested is 1 in 5, same as in 1997
  - Leverage traditional and non-traditional resources
  - Focus prevention on populations most at risk
    - Not everyone has same risk
  - Design scalable, cost effective prevention strategies
- Growing population of positive persons in Texas disproportionately on marginalized populations
- Enhancing goes beyond small scale intervention to embed prevention strategies at levels of society
- Limited resources must be prioritized, targeted and coordinated to maximize compact
- Community Viral load - term to describe and characterize community risk
  - How is it expressed is not clear yet, working on it for the next year or so

HIV INVESTMENTS AND EPIDEMIC – Liza Hinojosa and Jeff Hitt

- DSHS accessed the investments/funding landscape to see were changes needed to be made based on the morbidity
- We know what tools are needed but don't know what the picture will look like; we are putting the pieces of the puzzle together without knowing what the end product will be
- Programs need to understand what is going on in their communities
- DSHS looked at current prevention investments and how that matched up to the epidemic
- Agencies can no longer depend on one funding source, must diversify and look for alternative resources
- Where is the money?
- Regional investments
  - Morbidity minus Houston and Dallas morbidity
  - Can we see price per case
    - Different for rural vs urban
    - Take in to account scope and scale of projects
  - Ryan White Money?
    - Pulling it together
- Targeted testing and the epidemic
  - Only targeted testing DSHS funded in 2010
  - National Strategy and FOA have raised the issue of focus within our programs
  - Over half of diagnosis are MSM but heterosexual are tested at over 60%
  - How do we focus testing on a big scale

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July 29, 2011
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QUESTIONS/THOUGHTS FROM FIRST DAY

- Corrections:
  - CDC conceptualizes funding in very specific way
  - DSHS uses STD funds to provides a portion of partner services
    - Positives are located in other categories
    - Jeff will edit or create new slides before posting to website

What stood out for you yesterday

- Allocation of funds with 75/25 split
- Other funding sources and how that will play out
- With multiple funding sources for programs how will that play out
  - Looking at it more as a community instead of an organization
  - Responding to the epidemic appropriately
- Morbidity percentages and who is receiving funding
  - Should it match, what is acceptable
- The ratio of those that are positive with routine testing funds
  - Less money available for that across the country
  - Resources and being asked to do more
  - National strategy is asking to do more
  - Just not significantly seeing more funding
  - Not supposed to fund research but the CDC has certain expectations
- The difference between rural and urban and the way it looks
  - Black MSM vs White MSM
  - Reconnecting those with care – linkage and networks
- The Plan is not a broad stroke for all communities
  - Responses differ in different areas
- Distribution of routine testing affect the distribution of prevention
  - Diffusion process and giving that away without external support
  - CDC has not required to look at the distribution
- Policy focus to benefit the program services
  - How can get more involved and unify will other orgs
    - DIS in some areas are our main resources for those populations
    - Engage in local health department is a great idea, how do we do that and further those conversations
  - Develop policy with partner orgs, who gets the credit
    - You all do
    - Data system right now does not recognize collaboration
      - Need to figure out how to share that information

FOCUS & RE-DIRECTION – Jeff Hitt

Resource application

- How have you decided to allocate funding to specific areas
  - Does matter where you start
    - Geography
    - Narrow or broad populations
    - Haven't figured out yet
    - Focus of MSM
      - Need to look at where in the state
      - Not thinking of just regional distribution but also by those most affected

Group and Community Level Interventions

- Community Level Data
  - hard to capture and not completely accurate
- Group Level
  - Data easier to capture

- All are funded at different levels
- Data is hard to gather
  - There are concerns about the accuracy of the data provided today
    - Data does not reflect working with positives for some activities
    - How are numbers of people through an intervention interpreted
    - Capturing data on positives moving through multiple systems can be problematic (e.g. solely in private care)
    - How can positivity rate for a geographic area accurately reflect the epi?
    - DSHS wants to share the data so everyone understands what they are looking at when they understand DSHS work on the epidemic
    - Consultants use the data in deciding how to work with contractors
    - Contractors need to check semiannual report data accuracy

Where are we headed:

EBI's

- EBIs may become packaged with condom distribution etc. to achieve a more comprehensive approach
- EBI work needs to be integrated into a community approach that involves the total programming in the community
- Between now and 2013 we want to talk about how we can support engaging communities in collaborative efforts
  - This includes engaging institutions such as schools in prevention programming

- A goal would be to reduce undiagnosed infections at the community level

CRCS

- Has problems achieving scale
- If it is focused on HIV+ then we can have an acceptable level of scale
- We need to think about the need for CRCS referrals with respect to adherence to care

Testing

- See power point
  - Giving negative results over the phone will be allowed
  - Finding positives and then linking them to care
  - Targeted testing better at finding people early in the course of disease
  - Partner services from public health side provides a larger picture of how the linkage works
  - Revisited testing/proportions by population
  - It can be hard to accurately assess risk behavior because of unwillingness to report MSM behavior, IDU, etc – does TWOC reduce ability to assess risk behaviors & influence behavior?
  - White and Latino epi vs. testing are similar
  - How do you become relevant for most influenced communities if that is not your mission
  - Why reduction in IDU infections
    - We are doing a good job
    - Different drugs; less shooting
    - Underground syringe exchanges
  - Why discrepancy between testing and positivity rates with heterosexuals?
  - 1.5×10^6 tests required to find all estimated positives with 1% positivity rate
  - With only 450,000 msm in texas, the task is not so daunting
  - 1.2×10^6 Adolescent/adult black females
  - DSHS does not have reports on negative tests and on other funding streams

Linkage to Care

- Testers need to engage more with DIS, and those doing CRCS & case management
- We are working on data systems to capture success in linkage to care
- National Strategy has a goal of having people attend medical care apt within three months of diagnosis

In summary

- Move toward number of tests correlated with positivity
- EBIs need to increase scope
- Differentiate between positives and negatives
    - Negatives might be in greater need of scope expansion
        - SISTA promotion by minister
        - PIP WE focus groups to identify community engagement opportunities
    - Positives – example Healthy Relationships (HR)
        - Make HR an organizational level org
            - Case managers could reinforce disclosure messages if their org promoted that idea.
        - Interpersonal level
            - Bring partner to last session
            - Couples counseling
    - Collaborations – how to do it?
        - Having care providers refer to behavioral supports
        - Return to care collaborative
            - Local FQHC – checks data regularly for those out of care
    - Other ideas (see posters)
        - Negative results over phone
        - Enhanced linkage to care
        - Testing flexibility
        - Technology for testing
        - Type of encounter
        - Linkage = medical care event
        - Longer engagement with newly diagnosed clients
        - Outreach and peer support as supports for linkage
    - Group activity to process morning's work

ARIES DEMONSTRATION – Jonathon Poe

- Possibility of sharing client information
- Possibility of updating client information without reentering client info from the beginning
- With the possibility of sharing the system you could also monitor client and ensure follow through with referrals and appointments
- Possibility of extracting your own data
    - Maybe try to plan for… exporter/importer functions
    - In the future, if not a funded program, could you still have access
- Opportunity for others outside of pilot site to make comments on the system
    - The code is owned by DSHS

- Shaped data around old limitations of the system, might not exists in the new system
- Laptop availability of the system
  - Hopefully sometime next year at least for Aries prevention
- Issues surrounding confidentiality

NEW DIRECTION – Jeff Hitt

- Intentionality
- Work with regional and local health departments
- Think of new possible resources

EXAMPLES from FUNDED CONTRACTORS

- AIDS Foundation Houston Presentation: Dwayne Morros
  - The Truth Project
  - Splash Houston testing

- Valley AIDS Council: Chris Salinas
  - Created special position, case finder, because of those dropping out of care
    - Role of the case finder is to engage in positive case
    - Shadowing the client to the next session
    - Explains services from the many resources
    - Layout of the intake lengthy process
    - Other possible referral (substance abuse or mental)
    - HIV 101 for the client and family
    - Provides transportation for clients if necessary
    - Presents info to doctors, clinics, including WIC
    - Will also go to the clients home in search if necessary
  - Lupe card in area for those without some form of identification
    - Case finder ensure client has card for service
  - Case workers work closely with DIS
  - Training for that position
    - Case finder is trained in PBC PRS
    - Trained with HIV case manager role
  - Length of time to engage and go through the system with clients
    - Does impact the amount of time spent with each client
    - No real dead time for the case manager
    - Real helpful with linkage of care
  - When do the case finders first meet
    - Risk reduction specialist refers from first positive to enroll them in the correct follow up care
    - Case finder also does outreach with rapid testing
      - Eve taking back for counseling

        - Case managers with try to reach client for 60-90 days and then turn over to case finder
    - Others refer because only AIDS program in the valley
    - How is this position funded
        - Ryan White, HERSA?, CDPG?, and other funding sources
    - The position has been filled for about 3 years
    - Success rate is very high
    - Has volunteer coordinator helps to provide info on services
        - Link peers to new HIV patients to provide a sense of understanding (peer navigators)

- Black Women Initiative Presentation: Michelle Durham
    - 3 years ago introduced to group of 30 churches called San Antonio Fighting Back
    - Saw linkage between substance use and STD/HIV
    - Pastor asked to come test at church and educate nurses
    - With funding educated pastors through CHIPP process
    - Pillow Talk, Joy in our Town, Girl Worth
    - Tons of support from the faith community
    - Churches and other orgs were taught SISTA
    - Lots of community level collaboration
    - Mini Conference October 2
    - How do you fund these events
        - Ryan White funds and other resources

- Legacy Presentation: Amy Leonard
    - Next Step Health Educator
        - Group level around for 10 years originally funded through Ryan White
            - Now takes place over the course of a couple of evenings with about 10 individuals newly diagnosed
        - She meets with them immediately after positive diagnosis introducing them to system
    - Electronic medical record
        - Centricity
- Social Networks Strategies Presentations: Brian Barron, Tarrant Co HD
    - Program focusing on individuals with a network of people to get tested
    - Position that uses referral sources, including intervention sites, to find these individuals.
        - Those he recruits engage their social networks to get tested
            - High success rate (7%)
            - Given gift card to become recruiter
            - Recruiter is also given gift card when someone test as well as the person who tests

        - $10 gift card from Target
    - Looking at testing "parties"

<u>WHAT DOES ALL THIS MEAN? Thoughts and Questions</u>

- Dream big thinking about the future newsprint
    - Awareness
    - Peer navigators and case finders
    - Educating the private sector
    - Community assessment regarding condom distribution
    - Condom blast messages
    - Nat testing more available
    - Community resource coordinator

- Pluses
    - Regional seating
    - Social networking here was fantastic
    - Good timing to prepare
    - Projections of future direction and progress from last year
    - Hearing the work of contractors
    - Approach of treating everyone as equal partners in moving this forward
    - Honesty of staff and says what they don't know
    - Individualized creativity

- Wishes
    - Wish for more agencies beyond DSHS
    - Wish for quarterly regional meetings