NATIONAL HIV
PREVENTION INVENTORY

NHPI

NATIONAL HIV PREVENTION INVENTORY MODULE 3:

Analysis of Health Department HIV
Prevention Programming in the United States

NASTAD™
NATIONAL ALLIANCE OF STATE
& TERRITORIAL AIDS DIRECTORS

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Executive Summary

In 2009, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Kaiser Family Foundation released the National HIV Prevention Inventory (NHPI), a first-ever in-depth analysis of health department-led HIV prevention programs in the United States. The NHPI provided a baseline understanding of how HIV prevention was organized and delivered in the U.S. Policymakers, public health officials, community organizations and other stakeholders have used the NHPI to better understand domestic HIV prevention efforts and the role health departments play in these efforts.

Since 2009, the domestic HIV prevention landscape has changed significantly. Most notably the National HIV/AIDS Strategy (NHAS), the Affordable Care Act (ACA), and advances in the science of HIV treatment as prevention have led to new program priorities and approaches. In 2011, responding to these circumstances, the Centers for Disease Control and Prevention (CDC), the nation's leading funding agency for HIV prevention, released a new HIV prevention strategy, High-Impact Prevention, to increase the alignment of resources to geographic areas with highest HIV prevalence and to focus on combinations of interventions supported by scientific evidence that would yield the most preventive benefit for the populations most affected by HIV. State and local health departments were required to implement High-Impact Prevention through funding opportunity announcement (FOA) PS12-1201, focusing health department activities primarily on four core programs: HIV testing and linkage to care, prevention with persons with HIV[1], condom distribution, and policy initiatives.

To better understand HIV prevention programs in the current policy environment, including PS12-1201, NASTAD has updated the 2009 NHPI through a national survey of state and local health department HIV prevention programs. Using the 2009 NHPI as a baseline, the 2012-2014 NHPI update occurred in three modules. Previous modules of the NHPI, Module 1: HIV Testing, Module 2: HIV Funding, were released in 2012 and 2013 respectively.

This report, NHPI Module 3, presents findings on HIV prevention programs in the areas of HIV planning, evidence-based interventions, collaboration and integration, implementing the ACA and developing jurisdictional HIV continuums of care. NHPI Module 3 summarizes all activities supported by federal, state, and local HIV prevention funding with a focus on High-Impact Prevention.

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1   In this report, the phrase "prevention with persons with HIV" is used to refer to HIV prevention program activities for people living with HIV consistent with current CDC guidelines. The phrase "people living with HIV" is used to refer to the community of individuals living with HIV.

Key Findings

■ In 2014, a lack of adequate HIV prevention funding across all program areas examined presents a major challenge for health department programs as they strive to achieve the goals of the NHAS.

■ Health departments reported that funding requirements of CDC's PS12-1201 core prevention programs constrain their ability to support all program areas examined.

■ Between 2009 and 2014, health departments have increased their focus on prevention services for people living with HIV (PLWH).

■ Between 2009 and 2014, health departments have increased their focus on HIV prevention services for gay, bisexual, and other men who have sex with men (MSM).

■ The number of health departments who have integrated HIV prevention planning with HIV care and treatment planning has increased. Fifteen jurisdictions had integrated planning in 2009 while 27 reported it in 2014.

■ Findings suggest an increasing trend towards integration of HIV programs with other disease areas in client-level services as well as within the structure of health departments, particularly with sexually transmitted disease (STD) and viral hepatitis (VH) programs.

■ In 2014, community-based organizations (CBOs) were a key HIV prevention partner for health departments in implementing condom distribution programs (97% via distribution) and syringe services programs (94% as venue). CBOs are also key partners in providing evidence-based behavioral interventions.

■ Approximately 58% (33) of jurisdictions reported a syringe services program operating within their jurisdiction in 2014 compared to 42% (24) in 2009.

■ Health department HIV prevention programs lack access to data to help inform High-Impact Prevention programs, including complete HIV surveillance data and data showing antiretroviral medication prescriptions and use.

■ Fifty-five percent (30) of health department HIV prevention programs have focused ACA implementation efforts primarily on assessing readiness of contracted providers in their jurisdictions.

The HIV prevention landscape has changed significantly since the initial 2009 NHPI, including the release of the NHAS and the passage of the ACA. NHPI Module 3 highlights some of these differences while identifying factors that have held constant in the HIV response in the U.S. A lack of funding for HIV prevention remains a challenge for health department programs. CBOs are still key partners in HIV prevention, working with health departments to administer and implement prevention activities. HIV prevention programs continue to work with populations most vulnerable to HIV infection. However, to keep pace with change, health department HIV prevention programs have revised many of their prevention strategies and activities. The evolving science of treatment as prevention, alongside the July 2013 Executive Order on the HIV Care Continuum Initiative, will likely continue to lead HIV prevention programs to work with people living with HIV and HIV care and treatment programs. Raising the bars along the HIV continuum of care requires health department HIV prevention programs to invest in interventions that increase access to quality HIV care and treatment services. As ACA implementation continues and federal funding and priorities shift further, health departments will continue to adapt to a new era in HIV prevention and care.

Introduction

In 2009, NASTAD and the Kaiser Family Foundation released the National HIV Prevention Inventory (NHPI), the first-ever in-depth analysis of health-department-led HIV prevention programs in the United States. The NHPI examined how prevention services were organized and delivered and provided detailed information on how services were funded.

Since the release of the first NHPI, major shifts in the HIV policy landscape have occurred[2]. The President's National HIV/AIDS Strategy (NHAS), implementation of the Affordable Care Act (ACA), and new priorities set by the Centers for Disease Control and Prevention (CDC), such as funding opportunity announcement (FOA) PS 12-1201 HIV Prevention Activities for Health Departments, have impacted the programs and services supported by health departments. The success of treatment as prevention, working with those living with HIV to adhere to antiretroviral therapy (ART), has led HIV prevention to become as much a clinical activity as it once was a community-based activity. Another HIV prevention strategy emerged in 2012 as the U.S. Food and Drug Administration (FDA) approved Pre-Exposure Prophylaxis (PrEP), using HIV medications to prevent HIV infection among individuals vulnerable to HIV infection. HIV prevention in clinical and community settings can now be evaluated by the HIV care continuum by measuring the number of individuals living with HIV receiving the full benefits of quality care in a jurisdiction and demonstrating where improvements can be made.

CDC plays the central, federal role in the national HIV prevention response, providing a substantial amount of HIV prevention funds to state and local health departments to carry out local HIV prevention responses[3]. PS12-1201 Category A requires health departments to direct 75% of their prevention cooperative agreement funds to core programs, including HIV testing in community and clinical settings, comprehensive HIV prevention with persons with HIV, condom distribution, and policy initiatives. Twenty-five percent of cooperative agreement funds can be directed to evidence-based interventions for HIV-negative people at highest risk of acquiring HIV, community mobilization and social marketing, activities associated with PrEP and non-occupational post-exposure prophylaxis (nPEP), not including provision of medications, and jurisdictional planning. In addition to Category A, PS12-1201 expands the availability of HIV testing in a subset of eligible jurisdictions particularly in healthcare settings (Category B) and provides competitive funding to a subset of jurisdictions for innovative prevention projects (Category C).

The results presented in Module 3 illustrate how these shifts have impacted HIV prevention programs in the areas of HIV planning, evidence-based interventions, collaboration and integration, planning for ACA implementation and developing jurisdictional HIV continuums of care. These results summarize all activities supported by federal, state, and local prevention funding with emphasis on programs recommended by High-Impact Prevention.

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2   See "The Domestic HIV Prevention Landscape" in Module 2, Funding Report.

3   See "FY2012 CDC HIV Prevention Funding (PS12-1201)" in Module 2, Funding Report.

Methodology

I n December 2013, NASTAD distributed the NHPI Module 3 survey to all of the 67 CDC Division of HIV/AIDS Prevention (DHAP)-funded state, territorial and local health departments. The survey was developed by NASTAD in consultation with NASTAD's Prevention Advisory Committee (PAC), which consists of representatives from health departments around the country. The survey notification included background of the NHPI project and information for accessing the on-line survey, including the deadline and process for follow-up for incomplete surveys. Health departments were asked to complete the survey within a two-week period. Reminder emails and phone calls were conducted and the deadline was extended for health departments requesting additional time to complete the survey. A total of 57 health departments responded to the survey, including all 50 states, the District of Columbia, and six local health departments funded directly by the CDC for HIV prevention. The overall response rate was 85%.

The survey included 16 questions with sub-questions that addressed: HIV planning, evidence-based interventions (including condom distribution, behavioral interventions, syringe services programs, PrEP and PEP), integration, and collaboration between HIV prevention and other programs and service areas, implementation of the ACA, and the HIV care continuum. The survey data were analyzed in aggregate, identifying descriptive trends and qualitative themes. Comparisons were made, as appropriate, to the findings from the previous two NHPI modules, HIV Testing and HIV Funding, as well as the 2009 NHPI report.

The Module 3 survey was designed to require all respondents to answer 16 topic questions. Sub-questions were required of jurisdictions with programming relevant to the topic question. This pattern yielded varying response rates to sub-questions. The number of responding jurisdictions for topic and sub-questions is provided for specification throughout the report.
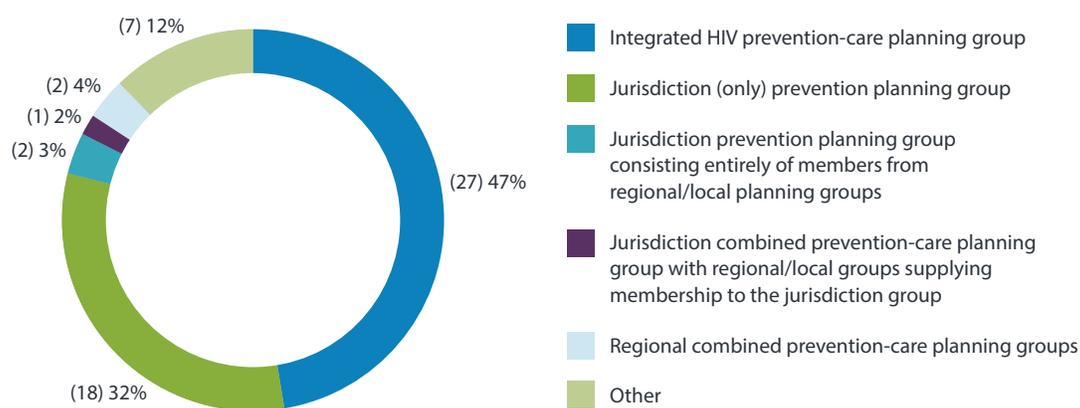
Findings

HIV Planning

CDC released its first HIV prevention community planning guidance in 1994, requiring as a condition of funding that health departments work with key stakeholders, members of affected communities and PLWH to develop jurisdictional plans describing the local epidemic and outlining a programmatic response. In July 2012, CDC released its latest guidance for HIV planning aligned with the goals of the NHAS and CDC's health department funding opportunity announcement (FOA), PS12-1201. The guidance offers jurisdictions flexibility in how they structure their HIV prevention planning bodies while encouraging collaboration across prevention, care and treatment. It emphasizes the importance of collaboration between health departments, planning groups, federal partners, community members, and other stakeholders in the development and implementation of HIV prevention plans. In 2014, the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and CDC issued a joint letter encouraging HIV care and treatment programs and HIV prevention programs to integrate planning activities at state and local levels.

Since the 2009 NHPI, many health departments have moved to integrate HIV prevention and care planning bodies. As displayed in Figure 1 below, 47% (27) of responding jurisdictions reported that their planning groups are integrated across prevention and care; only 15 reported integrated planning in 2009. Only five jurisdictions reported relying on some form of local or regional planning group, a decrease from 13 in 2009. Eighty percent (45) of health departments noted a change in their planning group or process structure since 2009.

Figure 1. **HIV Planning Group Structure (n=57)**

- Integrated HIV prevention-care planning group
- Jurisdiction (only) prevention planning group
- Jurisdiction prevention planning group consisting entirely of members from regional/local planning groups
- Jurisdiction combined prevention-care planning group with regional/local groups supplying membership to the jurisdiction group
- Regional combined prevention-care planning groups
- Other

Health department HIV planning in 2014 is resulting in more integrated products such as epidemiologic profiles, needs assessments and jurisdictional plans than in 2009. Five health departments reported developing integrated plans in 2009 while 21 did so in 2014. Over 98% of health departments no longer develop completely separate prevention and care planning products without some form of collaboration.

Health department HIV prevention planning groups increasingly integrate with other disease areas such as sexually transmitted diseases (STD), tuberculosis (TB) and viral hepatitis (VH). Forty-four percent (25) of groups have integrated with VH, 40% (23) with STD, and 12% (7) with TB. In a few jurisdictions, groups are integrating with addiction services, behavioral health, harm reduction, housing and HIV surveillance. Seventeen jurisdictions have not integrated their group with other disease areas; others are considering it or are actively planning for integration.

Figure 2 depicts the scope of current jurisdictional plans. In conjunction with integrating their groups, many jurisdictions have broadened the scope of their jurisdictional plans beyond HIV prevention, which speaks to the increasing level of collaboration and integration occurring across other infectious disease areas.

Figure 2. **Scope of Jurisdictional Plan (n=57)**
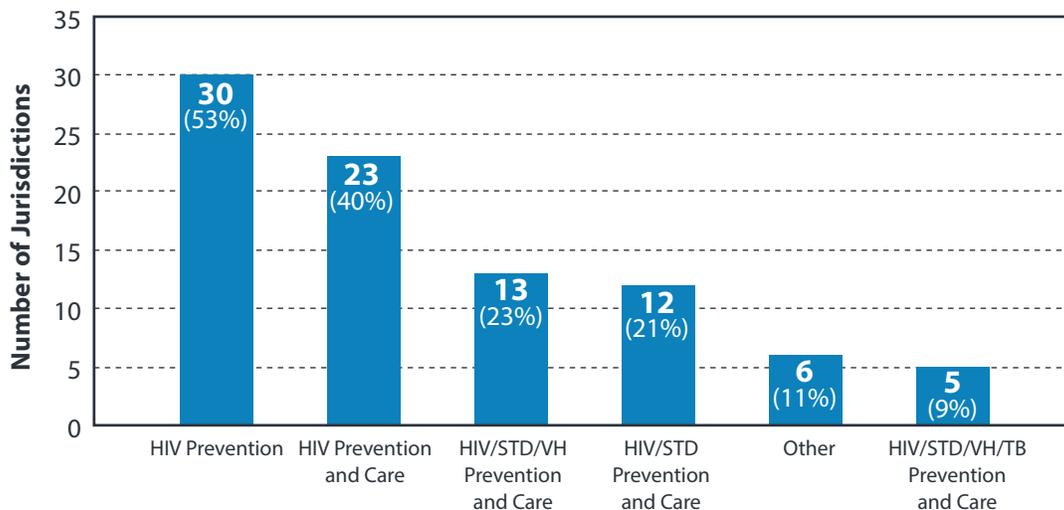
The average size of health department planning groups has remained fairly constant since 2009, though respondents reported a greater range in size in 2014. The average membership is comprised of 33 seats, up slightly from 30 in 2009, with a range that has expanded from 8 to 105 members versus 13 to 50 in 2009.

The most common challenge health departments reported related to planning is obtaining meaningful input from impacted populations (Table 1). Respondents shared a variety of other challenges including budget cuts for planning, lack of federal guidance for integrated planning, and the lack of clarity about the purpose of HIV planning in the current environment.

Table 1. Challenges for HIV Planning

Challenges for HIV Planning	Number and Percentage of Jurisdictions Reporting Challenge (n=57)
Obtaining meaningful input from impacted populations	39 (68%)
Determining best use of planning group input	24 (42%)
Membership skills	22 (39%)
Determining planning outcomes	21 (37%)
Membership retention	21 (37%)
Process of coordinating with other planning bodies	19 (33%)
Federal requirements	14 (25%)

Finally, health departments were asked to describe their methods of stakeholder engagement in addition to convening their planning group. While 19% (11) of jurisdictions do not have a formal mechanism for engagement, 67% (38) of respondents employ strategies such as focus group interviews or surveys with stakeholders, 42% (24) host town halls/forums and 32% (18) and 19% (11) have standing or ad hoc advisory bodies, respectively. Many jurisdictions reported having population-specific advisory groups such as gay men/MSM, youth and transgender advisory boards.

Policy/Structural Changes

Health departments are the cornerstone implementers of federal public health policy and are also leaders in defining and implementing state and local policies and structural change initiatives. PS12-1201 requires health departments to implement policy and structural changes as one of the four required core program activities. Health department HIV prevention programs were surveyed in Module 3 on policy and structural initiatives that include efforts to align structures, policies, and regulations to enable optimal HIV prevention and care and treatment (e.g., addressing structural barriers to routine opt-out testing, or updating policies to facilitate sharing of surveillance data across health department programs).

In 2014, 86% (49) of jurisdictions have initiated and/or completed policy changes related to HIV prevention. The types of policy changes vary. Sixty-three percent (31) of jurisdictions reported

policy and structural changes for HIV screening/routinizing HIV testing, 61% (30) for addressing data sharing and 59% (29) reported linkage/retention/reengagement in HIV-related medical care initiatives (Table 2). In contrast, only eight percent (4) of jurisdictions reported policy initiatives for comprehensive sexuality education for youth and six percent (3) of jurisdictions reported policy and structural changes for provision of HIV-related medical care/ART within the last year.

Table 2. Policy/Structural Initiative Changes

| Policy/Structural Initiative	Number and Percentage of Health Departments Reporting (n=49)
HIV screening (i.e., routinizing HIV testing)	31 (63%)
Data sharing	30 (61%)
Linkage/retention/reengagement in HIV-related medical care	29 (59%)
HIV testing	26 (53%)
Electronic lab reporting of CD4 and viral load	22 (45%)
Partner services	20 (41%)
Health reform (e.g., Medicaid expansion, billing & reimbursement, health insurance)	19 (39%)
Infectious disease integration - screening	16 (33%)
Expedited partner therapy (EPT)	15 (31%)
Condoms	14 (29%)
Viral hepatitis/access to integrated services	14 (29%)
Syringe access	13 (27%)
STD/access to integrated services	12 (25%)
Substance abuse/mental health/access to integrated services	11 (23%)
Infectious disease integration - treatment	8 (16%)
HIV surveillance	6 (12%)
HIV decriminalization/policy modernization	5 (10%)
PrEP	5 (10%)
nPEP	5 (10%)
Comprehensive sexuality education for youth	4 (8%)
Provision of HIV-related medical care/ART	3 (6%)

Community Mobilization

For NHPI Module 3, community mobilization activities include, but are not limited to: public health community mobilization models, social marketing campaigns, interventions involving communities (e.g., Community Promise) and models using community health workers and/or peers (e.g., *promotoras*, peer advocates).

Approximately 83% (47) of health departments reported some activity related to community mobilization. Ninety-four percent (44) of these health departments reported that their efforts focus

on gay, bisexual, and other MSM. Sixty-four percent (30) focus on people living with HIV. Figure 3 suggests a shift in HIV prevention from the 2009 NHPI, where the distribution of public information/ media campaigns was evenly distributed with a focus on gay and bisexual men, African Americans, and the general public, in comparison to the distribution of community mobilization in 2014.

Promoting HIV testing remains a key priority for health department HIV prevention programs. In 2009, this was the most often cited public information/media campaign message. In 2014, 98% (46) of community mobilization activities had the primary objective of identifying undiagnosed HIV infection and 81% (38) focused on linking newly diagnosed HIV-positive individuals to HIV-related medical care. Sixty-eight percent (32) reported promoting risk reduction strategies as a common mobilization theme.

Figure 3. HIV Prevention Programs and Community Mobilization Populations (n=47)
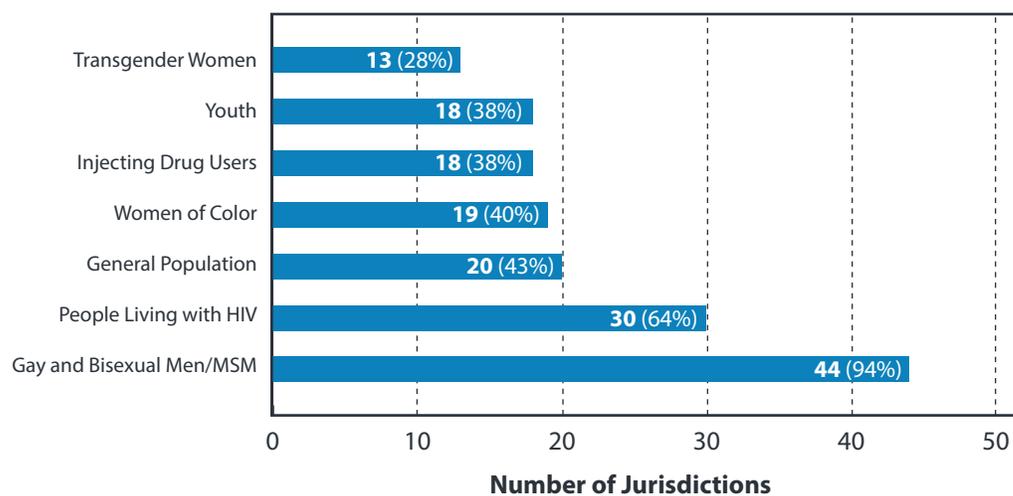
Eighty-one percent (38) of health departments reported using social media sites such as Facebook and Twitter to promote their community mobilization objectives. Seventy-five percent (35) reported public information media campaigns and programming at community events as community mobilization activities. Sixty-two percent (29) reported the use of social marketing campaigns such as those supported by CDC's *ACT Against AIDS* and the Kaiser Family Foundation's *Greater Than AIDS* to advance community mobilization objectives. Text messaging was reported as a tool for 17% (8) of health departments.

Inadequate funding for community mobilization is a clear challenge for all NHPI Module 3 responding health departments, reported by 69% (39) of respondents. Thirty-nine percent (22) reported that challenges include the lack of staff, 33% (19) reported the funding requirement restrictions of PS12-1201 and 33% (19) cite the procurement processes of the health department.

Condom Distribution

Most health departments partner with community-based organizations (CBOs) and other partners to make condoms available to people living with HIV and to those vulnerable to HIV infection. Forty-six percent (26) of health departments reported implementing condom distribution programs while another 40% (23) support CBOs and AIDS service organizations (ASOs) to implement programs. Fourteen percent (8) of health departments share implementation responsibility between the health department and CBOs and ASOs.

Fifty percent (13) of the 26 health departments directly implementing condom distribution actively market and/or publicize their condom distribution programs. Of the 23 health departments that contract with CBOs or ASOs for condom distribution, only 35% (8) require contractors to implement condom marketing or publicizing. Some of the marketing mechanisms frequently reported include websites, posters, condom dispensers, flyers, billboards and social media.

Condoms must reach individuals living with HIV and those vulnerable to HIV infection to be effective HIV prevention tools. Figure 4 illustrates the type of venues health departments use most frequently to distribute condoms.

Figure 4. **Venues Health Departments Use to Distribute Condoms to PLWH (n=57)**
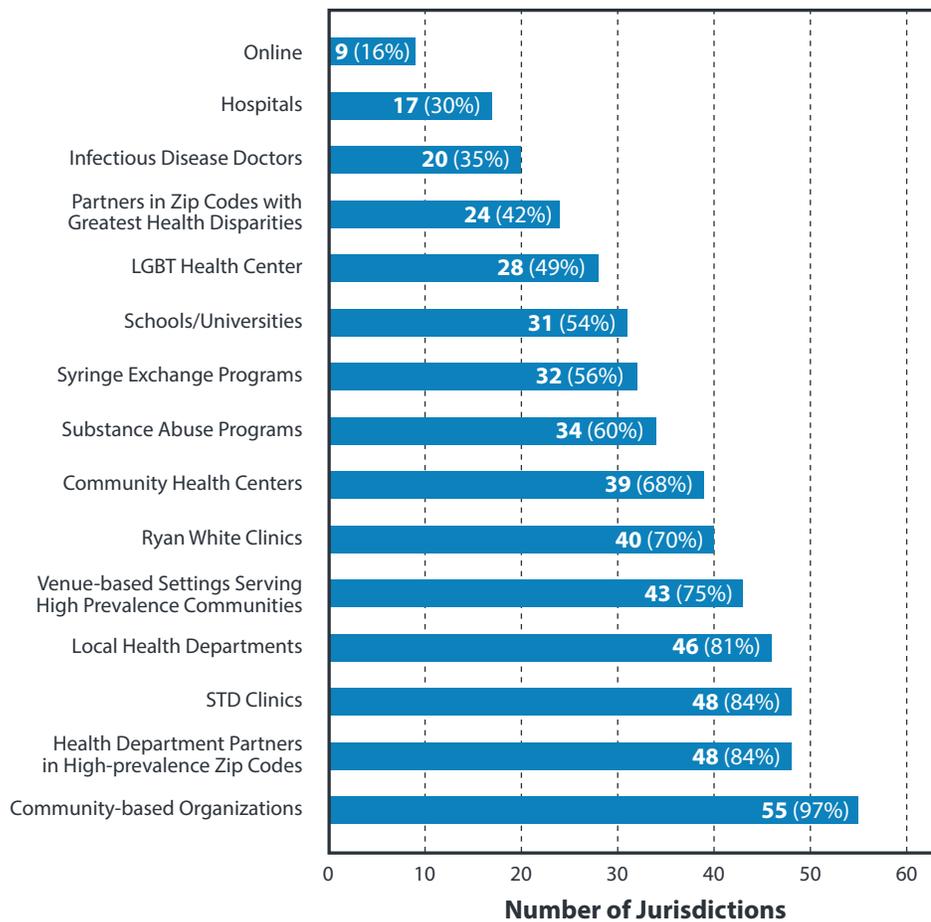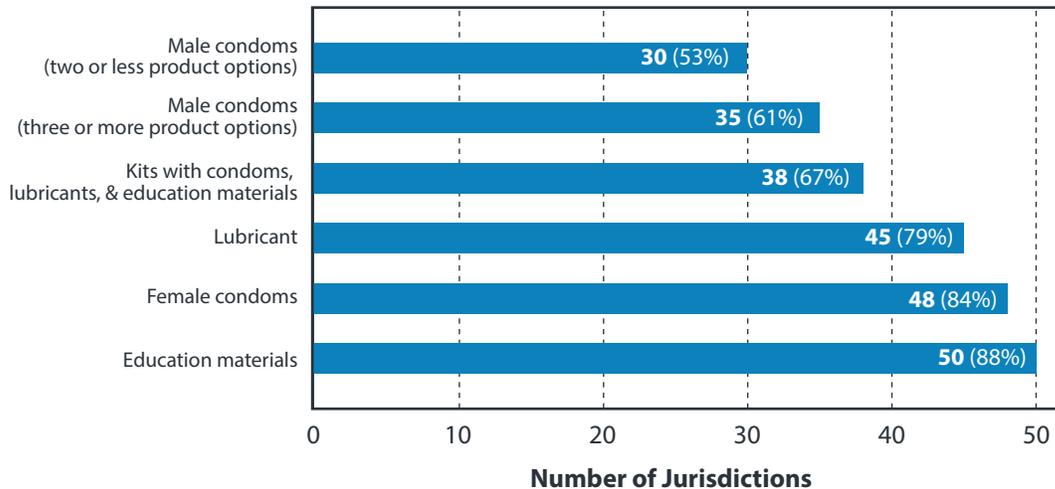

When asked about venues health departments use to ensure that condoms reach individuals vulnerable to HIV infection, responses were similar, though 83% (47) jurisdictions reported working with high risk venues[4] and 72% (41) with community health centers (CHCs)/federally qualified health centers (FQHCs).

Health departments provide a variety of products beyond male condoms through their condom distribution programs. They also provide consumers with preferred choices of products to help

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4   High risk venues refer to physical and/or virtual places where overall HIV prevalence is high combined with behaviors that have a higher probability to transmit HIV.

ensure use. Seventy-nine percent of programs (45) reported distributing personal lubricants which are critical to reducing risk of transmission among gay men/MSM. Figure 5 illustrates what products health departments include in their condom distribution programs.

Figure 5. **Condom Distribution Products (n=57)**

When asked about challenges encountered with condom distribution programs, 46% (26) of health departments responding reported that funding is inadequate to fully support condom distribution programs, 54% (31) reported monitoring and evaluation challenges and 44% (25) face barriers due to their political environments or venue restrictions. Approximately 30% (17) reported procurement and distribution challenges.

Behavioral Interventions

Health departments were asked to separately report on behavioral interventions with persons with HIV and on behavioral interventions with HIV-negative persons. PS12-1201 differentially prioritized these activities. Jurisdictions must spend 75% of their funding on interventions with persons with HIV as one of the four required activities. Interventions with HIV-negative persons vulnerable to HIV infection are one of many recommended activities which are allowable with the remaining 25% of funding.

Prevention with Persons with HIV

Prevention with Persons with HIV programs are a core required component of current health department HIV prevention programs. Ninety-seven percent (55) of health department HIV prevention programs reported partner services[5] (PS) as a component of their Prevention with Persons with HIV program. Ninety-three percent (53) of the responding jurisdictions indicated linkage-to-care activities were an important component of their Prevention with Persons with HIV program (Table 3).

Table 3. Prevention with Persons with HIV Program Activities

Prevention with Persons with HIV Program Activity	Number and Percentage of Jurisdictions Reporting Activity (n=57)
Partner services	55 (97%)
Linkage-to-care activities	53 (93%)
STD screening	41 (72%)
Risk screening	38 (67%)
Counseling & Comprehensive Risk Reduction Services (CRCS)	37 (65%)
STD treatment	30 (53%)
Retention-in-care activities	28 (49%)
Viral hepatitis screening	27 (47%)
Antiretroviral Treatment and Access to Services (ARTAS)	26 (46%)
Patient navigation	25 (44%)
Antiretroviral medication adherence counseling	24 (42%)
Couples' HIV testing and counseling	19 (33%)
Viral hepatitis treatment	13 (23%)
Antiretroviral medication adherence, other strategies (e.g., text message reminders)	11 (19%)
Other intensive prevention counseling models	10 (18%)
Reproductive health care	5 (9%)

Thirty-seven percent (21) of health department HIV prevention programs reported coordination among local providers as the most frequent barrier to engaging PLWH in care. Thirty-five percent (20) of jurisdictions indicated provider staff capacity to engage PLWH in care and 33% (19) reported use of HIV surveillance data to target prevention interventions with PLWH as barriers in supporting the Prevention with Persons with HIV program activities (Figure 6).

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5   Partner Services are a broad array of services offered mostly to people living with HIV or infected with syphilis and to individuals infected with gonorrhea or chlamydia. Services include partner elicitation and notification and partner counseling.

Figure 6. Reported Challenges in Supporting Prevention with Persons with HIV Program Activities (n=57)
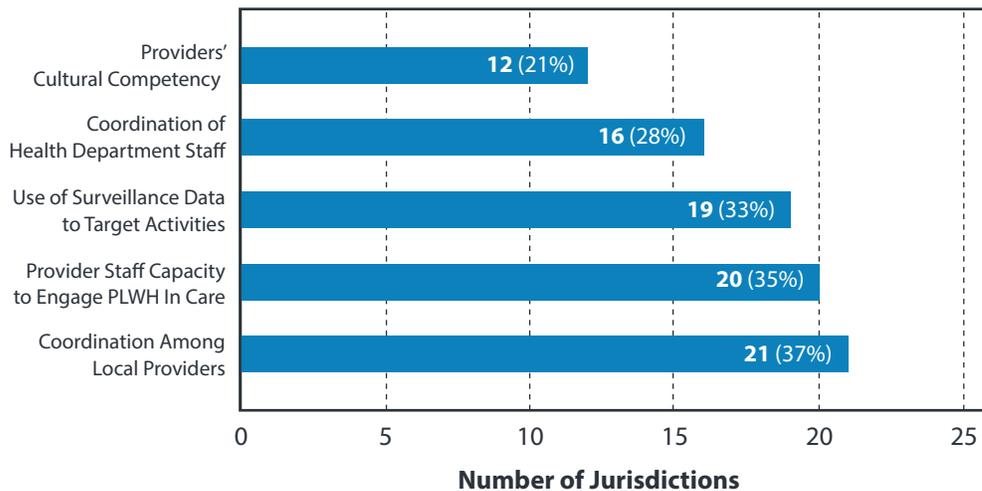
Behavioral Interventions with HIV-Negative Individuals

Seventy-two percent (41) of the responding jurisdictions support behavioral interventions for individuals who are vulnerable to HIV infection. Gay and bisexual men are the most frequent population(s) for whom health departments support behavioral interventions at 90% (37) of the 41 implementing these interventions. Seventy-one percent (29) support behavioral interventions for youth ages 13-29. MPowerment, the most frequently reported intervention for youth and for gay and bisexual men is supported by 55% (16) for youth and 60% (22) for gay and bisexual men. MPowerment creates a safe-space for young gay and bisexual men to receive sexual health and HIV risk-reduction information. Sixty-one percent (25) of the 41 jurisdictions support behavioral interventions for women of color. Of these, 64% (16) reported SISTA as the most frequent intervention supported for women of color. Forty-four percent (18) of the 41 jurisdictions support interventions for transgender women and for people who inject drugs (PWID). Thirty-three percent (6) of these 18 health departments support Safety Counts for PWID while health departments support homegrown and adapted interventions for transgender women due to a lack of interventions rigorously tested through scientific methods.

It is important to highlight that under PS12-1201, the CDC de-emphasized behavioral interventions for individuals who are vulnerable to HIV infection. In 2009, 34% of prevention funding across the U.S. was allocated to investments in health education/risk reduction activities and behavioral

interventions compared to 11% in 2014[6]. Twenty-eight percent (16) of the responding health departments reported not supporting these interventions. Eighty-one percent of these 16 health departments reported their reason for not supporting behavioral interventions in 2014 as inadequate funding while 44% reported the funding requirements of PS12-1201.

Syringe Services Programs

According to PS12-1201, the term Syringe Services Programs (SSPs) is inclusive of syringe access (including pharmacy sales), disposal, and needle exchange programs, as well as referral and linkage to HIV prevention services, substance abuse treatment, and medical and mental health care. Currently, by law, the use of federal funds to support the distribution of sterile syringes (i.e., needle exchange) is prohibited[7]. Programs distributing sterile syringes must be supported by other means, such as state, local or private funding.
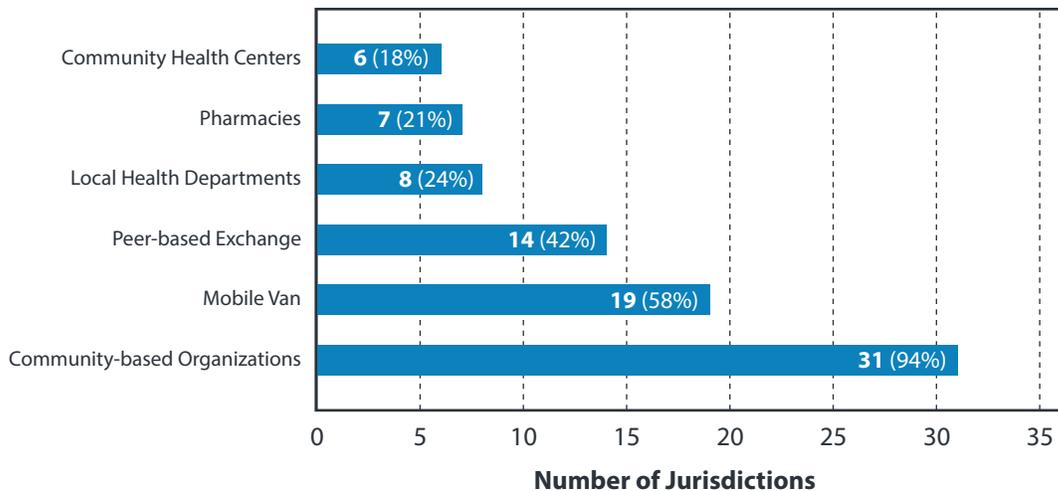
Approximately 58% (33) of jurisdictions reported operating at least one SSP within their jurisdiction. This represents an increase from 24 jurisdictions reporting SSPs in 2009. Of these programs, CBOs administer approximately 55% (18), while health department HIV programs administer 42% (14). The remaining programs are operated mostly by health department programs outside of HIV prevention or through a local health department.

Figure 7 demonstrates that 94% (31) of health departments reported that the most common venue for operating syringe services programs is within CBOs. Fifty-eight percent (19) reported mobile vans and 42% (14) peer-based exchange as venues for SSPs.

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6   Finding from NHPI Module 2, Funding Report.

7   Consolidated Appropriations Act, 2012. Public law 112-74. Section 523. Date accessed: March 26, 2014.

Figure 7. Venues for Syringe Services Programs (n=33)

Community Health Centers: **6** (18%)
Pharmacies: **7** (21%)
Local Health Departments: **8** (24%)
Peer-based Exchange: **14** (42%)
Mobile Van: **19** (58%)
Community-based Organizations: **31** (94%)

Number of Jurisdictions (0, 5, 10, 15, 20, 25, 30, 35)

SSPs offer a variety of services to the communities they serve (Table 4). Health department HIV prevention programs reported the following services being offered most frequently: syringe disposal, syringe exchange, condom distribution, and HIV testing.

Table 4. Syringe Services Program Activities

Syringe Services Program Activities	Number and Percentage of Jurisdictions Reporting (n=33)
Syringe disposal	30 (91%)
Syringe exchange	30 (91%)
Condoms	30 (91%)
HIV testing	28 (85%)
Linkage to substance use treatment	27 (82%)
Linkage to HIV medical care	26 (79%)
HCV testing	25 (76%)
Overdose prevention	21 (64%)
Wound/abscess care	19 (58%)
STD screening	16 (49%)
Linkage to mental health services	16 (49%)
Linkage to housing, education, job training services	13 (39%)
STD treatment	12 (36%)
Primary medical care	11 (33%)
Immunizations	10 (30%)
Direct substance abuse/chemical dependency treatment	8 (24%)
Drug substitution	6 (18%)
nPEP	2 (6%)
PrEP	1 (3%)

Twenty-four percent (8) of health departments with SSPs actively market or advertise those operating in their jurisdiction. These health departments use methods such as information published online or paper brochures for advertising.

Of the 40% (23) of health departments that do not have SSPs operating in their jurisdiction, 74% (17) reported that both state and local policies and 48% (11) reported the federal ban on the use of funding for syringe exchange were barriers to supporting a program.

Non-occupational Post Exposure Prophylaxis (nPEP) Programs

Non-occupational Post Exposure Prophylaxis (nPEP) is the provision of ART to prevent HIV infection after exposure to HIV. Health department 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. PS12-1201 funds cannot be used to support provision of medications. In 2009, 10 health departments reported operating an nPEP program. In 2014, 12 health departments reported supporting nPEP programs.

Of the 12 health departments with nPEP programs, 58% (7) provide nPEP outreach and education through CBOs (58%), 42% (5) through CHCs/FQHCs, 42% (5) through emergency departments and 42% (5) through lesbian, gay, bisexual and transgender (LGBT) health centers. Eight of the 12 health departments who do support nPEP programs focus on specific populations. Six health departments direct these services toward gay and bisexual men/MSM and four toward people who have been sexually assaulted. Transgender women are also included in three of the health department programs that provide nPEP outreach.

As with behavioral interventions, funding is the biggest challenge to proper implementation of nPEP programs for all 57 responding health departments. Seventy-seven percent (44) reported that funding is inadequate while 33% (19) reported the funding requirements of PS12-1201 hinder supporting nPEP programs. Twenty-six percent (15) reported provider willingness to prescribe nPEP as a challenge. In 2012, health departments reported allocating less than one percent of funding to nPEP[8] activities.

Pre-exposure Prophylaxis (PrEP) Programs

PrEP is the provision of ART in combination with frequent HIV and STD testing and counseling to individuals at high-risk for HIV infection. Health department PrEP programs may include planning, education, personnel and other support for PrEP provision by a licensed physician. PS12-1201 funds cannot be used to pay for provision of medication for PrEP. Eight of the 55 health departments who responded to the survey reported they currently support a PrEP program. Four health departments indicated they are conducting or plan to conduct community outreach or engagement for PrEP in the next 12 months. Five health departments reported they are conducting or plan to conduct provider outreach/education for PrEP in the next 12 months.

All health departments with PrEP programming focus on gay and bisexual men/MSM. Three health departments reported PrEP programs that focus on gay or heterosexual couples where one partner is living with HIV. Similar to nPEP, three health departments rely equally on CBOs, CHCs/FQHCs, local health departments, and STD clinics as venues for PrEP outreach and education in the community. Looking forward, of the eight health departments with PrEP programs, 50% (4) will engage HIV/infectious disease specialists and 38% (3) primary care physicians to increase awareness and promote uptake of PrEP.

Seventy-six percent (43) of all responding health departments reported inadequate funding as a reason for not supporting PrEP programs, 28% (15) reported funding requirements of PS 12-1201, 25% (14) reported provider willingness to provide PrEP and 25% (14) reported difficulty bringing PrEP to scale.

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8   Finding from NHPI Module 2, Funding Report.

Integration

The 2009 NHPI demonstrated that health department HIV prevention programs have relationships with or are integrated with other disease areas. Integration can occur at the program level with central oversight and/or at the client level in the direct delivery of services. The ultimate aim of integration at either level is to optimize service delivery to ensure that the entire array of client needs is addressed.

As demonstrated in Table 5 below, HIV prevention programs reported high levels of integration with HIV care and treatment services, including services supported by Ryan White funding. Out of 56 responding health departments, approximately 40% (23) of HIV surveillance programs remain outside of the purview of the AIDS director, yet 86% (48) of HIV prevention programs reported collaborating with HIV surveillance. In addition to HIV programs, health departments reported integration with STD, VH and TB programs in descending order. Sixty-eight percent (38) of jurisdictions reported that the AIDS director oversees partner services, with levels of integration for STD screening, treatment, and surveillance not far behind. Across each of these disease areas, surveillance was the least likely to be integrated with HIV prevention. Furthermore, over 30% (17) of health departments reported that they are not at all integrated with TB testing, treatment or surveillance.

Table 5. Integration between HIV Prevention Programs and Other Health Department Programs (n=56)

	None	AIDS director oversees budget	Inter-program meetings are held	Programs collaborate
HIV testing	0%	84%	79%	86%
Linkage to HIV-related medical care	0%	75%	82%	84%
HIV-related care and treatment	0%	77%	86%	80%
HIV support services (includes ADAP and medicine)	9%	70%	75%	66%
HIV surveillance	0%	59%	86%	86%
Viral hepatitis testing	9%	48%	70%	79%
Viral hepatitis activities (training, other services)	5%	46%	71%	80%
Viral hepatitis surveillance	25%	16%	54%	61%
STD screening (excluding partner services)	5%	57%	84%	86%
STD treatment (excluding partner services)	5%	54%	77%	75%
Partner services	4%	68%	75%	84%
STD surveillance	4%	54%	79%	86%
TB testing	30%	16%	52%	43%
TB treatment	34%	18%	46%	39%
TB surveillance	36%	18%	46%	38%

On the client level, health department HIV prevention services are being integrated with STD, viral hepatitis and TB services in health care clinics and CBOs. As shown in Figure 8, the level of integration is greater in health care clinics, possibly due to the broader spectrum of health services and billing infrastructure available. Across all venues, HIV prevention services are more likely to be integrated with STD services than viral hepatitis and are least likely to be integrated with TB. This mirrors the picture of integration across public health programs within health departments. While there is a long-standing awareness of co-infection between HIV and STDs, health departments are more recently merging with viral hepatitis and TB as resources decrease and vulnerable populations continue to overlap.

Figure 8. Integration with STD, VH, and TB in Health Care Clinics and CBOs (n=56)

HIV/STD Integration in Public Clinics (n=56)

(5) 9%
(21) 37%
(30) 54%

- Limited Integration
- Expanded Integration
- Comprehensive Integration

HIV/STD Integration in CBOs (n=56)

(2) 4%
(7) 12%
(24) 43%
(21) 37%

- No Integration
- Limited Integration
- Expanded Integration
- Comprehensive Integration

HIV/VH Integration in Public Clinics (n=56)

(3) 5%
(13) 23%
(16) 29%
(24) 43%

- No Integration
- Limited Integration
- Expanded Integration
- Comprehensive Integration

HIV/VH Integration in CBOs (n=56)

(5) 9%
(4) 7%
(14) 25%
(33) 59%

- No Integration
- Limited Integration
- Expanded Integration
- Comprehensive Integration

HIV/TB Integration in Public Clinics (n=56)

(3) 5%
(7) 13%
(15) 27%
(31) 12%

- No Integration
- Limited Integration
- Expanded Integration
- Comprehensive Integration

HIV/TB Integration in CBOs (n=56)

(1) 2%
(6) 11%
(26) 46%
(23) 41%

- No Integration
- Limited Integration
- Expanded Integration
- Comprehensive Integration

Collaboration

Health department HIV prevention programs must work well with other state and local programs in order to best meet the needs of people living with and vulnerable to HIV and to achieve the goals of the NHAS. Collaboration with other programs can be measured via a continuum. For the NHPI, we measured collaborative relationships at three points along a continuum: cooperation, coordination, and collaboration (Figure 9).

Figure 9. Collaborative Relationships with Other State and Local Programs

Cooperation → Coordination → Collaboration

Cooperation

For the NHPI, cooperation with other programs is defined as fully autonomous entities sharing information to allow each to independently maximize its effectiveness, in awareness of the other's activities and goals. Of the 55 health departments responding for cooperation, 46% (25) of health department HIV prevention programs indicated cooperative relationships with mental health, 44% (24) with substance abuse, 44% (24) with family planning, 44% (24) with maternal and child health, 42% (23) with immunization, and 42% (23) with state Medicaid. Educational agencies cooperate with HIV prevention programs at various levels, including 36% (20) with local middle and high schools, 36% (20) with universities (37%), and 29% (16) with the state education agency.

Coordination

For the NHPI, coordination with other programs is defined as fully autonomous entities willingly aligning activities, sponsoring particular events or delivering targeted services in support of compatible goals. Of the 55 health department HIV prevention programs responding, 46% (25) indicated coordination with other programs such as state corrections and 35% (19) with local and county corrections. Thirty-six percent (20) of health department HIV prevention programs reported coordination with Ryan White Part A and 42% (23) with Part C programs[9]. Coordination between TB programs and HIV prevention programs was 40% (22).

---

9   Ryan White Part A provides grants to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) to provide HIV-related care and treatment services. Ryan White Part C directly funds outpatient HIV services and ambulatory care.

Collaboration

For the NHPI, collaboration is defined as entities actively sharing decision-making, planning efforts and resources to achieve common goals. Accountability and rewards are shared. Of the 55 health department HIV prevention programs responding, 46% (25) reported their most collaborative relationships to be with the various parts of the state and local Ryan White Program, particularly Parts B, D and F[10].

Relationships with other programs and external partners to address racial/ethnic health disparities are a key aspect of HIV prevention programs in most jurisdictions. Fifty-five percent (30) of health department HIV prevention programs indicated having these relationships.

HIV Care Continuum

Figure 10. HIV Care Continuum in the U.S.[11]

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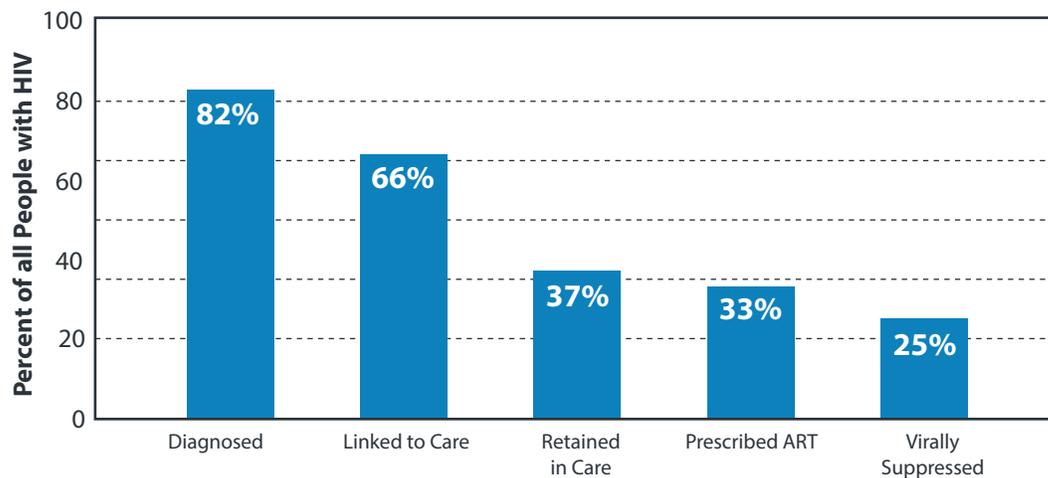
10   Ryan White Part B provides grants to U.S. states and territories to improve the quality, availability and organization of HIV/AIDS health care and support services, including AIDS Drug Assistance Programs (ADAPs), which provide medications to under and uninsured clients. Ryan White Part D includes services for women, infants, children and youth. Ryan White Part F comprises Special Projects of National Significance (SPNS), AIDS Education & Training Centers (AETCs), Dental Programs and the Minority AIDS Initiative (MAI).

11   Source: http://aids.gov/federal-resources/policies/care-continuum/ last accessed on 4/25/2014.

The HIV care continuum, also known as the HIV treatment cascade, is a model that identifies issues and opportunities related to improving the delivery of services to people living with HIV from diagnosis of HIV infection and linkage to care to initiation of retroviral therapy, retention in care, and eventual viral suppression. The HIV care continuum provides a tool to measure progress toward increased access to and retention in medical care and antiretroviral treatment as a primary means to prevent new HIV infections. Since 2011 the HIV care continuum has become an important tool to represent progress towards achieving the goals of the NHAS. In July 2013, the White House released an Executive Order for all federal agencies with delineated responsibilities under the NHAS to mobilize and coordinate federal efforts to improve outcomes along the HIV care continuum.

Eighty percent (44) of the 55 responding health departments reported creating a local HIV care continuum. Of the 44 jurisdiction-specific HIV continuums of care, 77% (34) have data for all "bars." Of 10 health departments reporting missing "bar" data, 80% (8) reported missing data among individuals who were prescribed ART and 40% (4) reported missing data among those who are estimated to be HIV-infected but have not been identified through HIV surveillance.

Of the 44 jurisdiction-specific HIV continuums of care created, 48% (21) have created population-specific continuums based on risk behaviors and 56% (19) of jurisdictions have created population specific continuums based on race/ethnicity.

Ninety-one percent (40) of the 44 responding health departments reported that creating jurisdiction-specific continuums have been most useful in framing planning conversations and 84% (37) for framing conversations with prevention partners. Health departments less frequently reported using jurisdiction-specific continuums to make changes to programming, including 32% (18) in the focus of interventions or 23% (10) to which interventions were being funded.

Access to data is the largest barrier for jurisdictions that created a jurisdiction-specific care continuum and for those jurisdictions that have not yet created a care continuum (Figure 11). For example, of the 55 health departments responding, 45% (25) of health departments noted that incomplete HIV surveillance data, including electronic lab reporting, hindered the creation of a care continuum. In addition, 33% (18) of health departments noted access to sources of data outside of HIV prevention programs and 31% (17) cited quality of data as barriers. A quarter (14) of health departments reported staff time and expertise as an additional challenge in creating continuums.

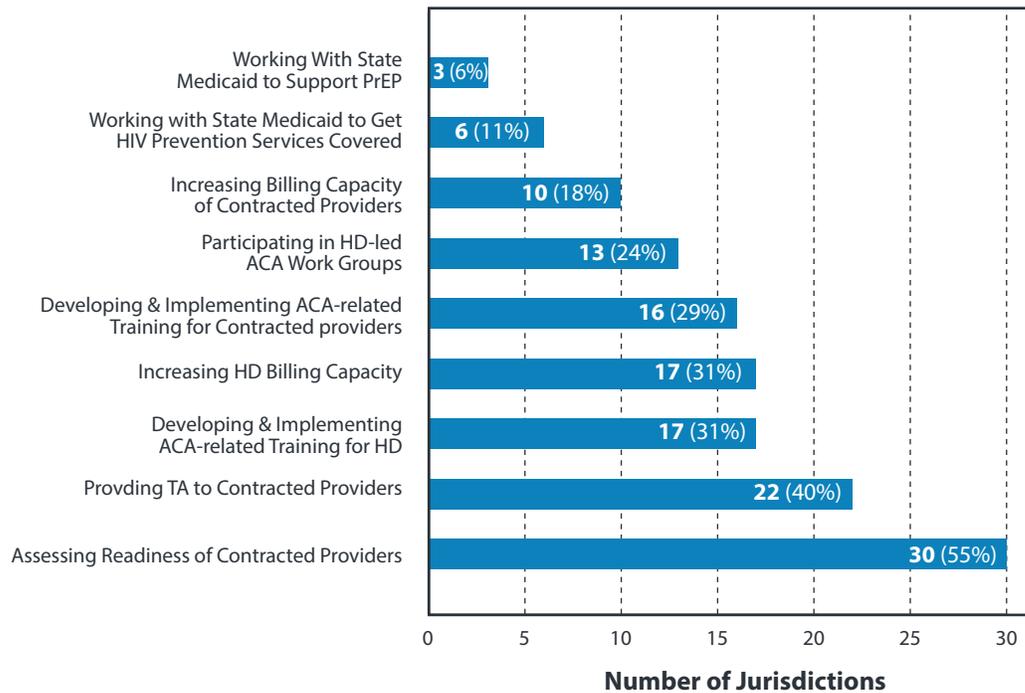**Figure 11.** **Barriers to Creating Continuums of Care (n=55)**
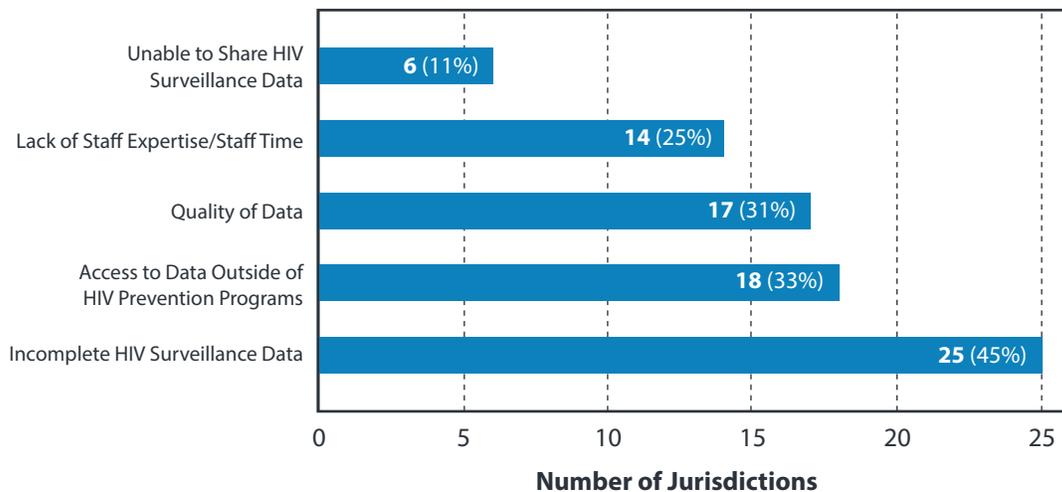
HIV Prevention and ACA Implementation

Alongside the NHAS, the ACA has ushered in significant health systems changes for HIV prevention programs to navigate. The NHPI examined three areas of HIV prevention program activities associated with the ACA, including planning and implementation, outreach and enrollment, and billing capacities. Fifty-five health department HIV prevention programs responded to the ACA section of the survey.

Planning and Implementation

Health department HIV prevention programs are planning for ACA implementation primarily by supporting the capacity of their contracted providers (Figure 12). Fifty-five percent (30) of health department prevention programs reported assessing the readiness of contracted prevention providers. Health departments are assessing if providers can bill for services, enroll clients and interact with public/private insurance. Forty percent (22) have provided technical assistance to their contracted service providers in this area. Eleven percent (6) of health department prevention programs reported working with state Medicaid programs to obtain coverage for HIV prevention services and 6% (3) to support PrEP. Fifty-one percent (28) of health department HIV prevention programs indicated that prevention managers and HIV planning group members are participating in ACA implementation activities. Some health departments reported that they have experienced restrictions on ACA-related activities due to local political environments.

Figure 12. ACA Implementation & Planning Activities in HIV
Prevention Programs (n=55)

Activity	Value
Working With State Medicaid to Support PrEP	3 (6%)
Working with State Medicaid to Get HIV Prevention Services Covered	6 (11%)
Increasing Billing Capacity of Contracted Providers	10 (18%)
Participating in HD-led ACA Work Groups	13 (24%)
Developing & Implementing ACA-related Training for Contracted providers	16 (29%)
Increasing HD Billing Capacity	17 (31%)
Developing & Implementing ACA-related Training for HD	17 (31%)
Provding TA to Contracted Providers	22 (40%)
Assessing Readiness of Contracted Providers	30 (55%)

Number of Jurisdictions

Sixty-four percent (35) of health departments indicated that their HIV prevention program was working with other health department programs on ACA implementation. Of the 35 responding health department HIV prevention programs, 80% (28) indicated they were collaborating with HIV care and treatment, 74% (26) with ADAP and 66% (23) with STD programs. Thirty-one percent (11) of the 35 HIV prevention programs reported working with state Medicaid offices.

Outreach and Enrollment

Seven health departments indicated that HIV prevention program staff are engaged in ACA outreach and enrollment activities. HIV prevention programs engaging in ACA outreach and enrollment reported developing ACA outreach and enrollment training for prevention program staff and contracted providers, incorporating ACA outreach and enrollment into linkage-to-care activities, and receiving ACA certified application counselor training.

HIV Prevention Programs Increasing Billing Capacity

Thirty-eight percent (21) of health department HIV prevention programs indicated that they have undertaken activities to increase billing capacity within the last year. Of those efforts occurring in health departments to increase billing capacity regarding HIV prevention, 57% (12) are assessing third-party billing practices and capacity of contracted providers of prevention services, 48% (10) are identifying billing technical assistance resources for contracted providers and 43% (9) are identifying billing technical assistance resources for the health department.

Conclusion

C ompared to 2009 findings, key findings of the NHPI Module 3 demonstrate a shift in state and local health department HIV prevention programs, responding to the NHAS, the ACA, CDC's High-Impact Prevention, and uncertain economic circumstances for the U.S. A lack of funding for HIV prevention remains the one constant in the domestic HIV prevention response, as health departments reported in 2009 and again in 2014. Recent federal policies, such as the July 2013 Executive Order on the HIV Care Continuum, further move federal efforts and those of state and local partners toward HIV prevention programs that directly influence health outcomes along the HIV care continuum for PLWH, including increased integration between HIV prevention and care and treatment. As the nation strives to "raise the bars" of the HIV care continuum, health departments will increasingly invest in interventions improving population outcomes along their specific jurisdictional HIV continuums of care. As ACA implementation continues, federal funding and priorities shift and roles change for CBOs and clinical partners, health departments will continue to restructure their partnerships to effectively and efficiently meet NHAS goals.

Acknowledgements

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Appendix One: Survey Instrument

National HIV Prevention Inventory Module 3

General Information

Jurisdiction's name _____

Name of jurisdiction's contact person for this survey _____

Phone number _____

Email address _____

URL for jurisdiction's health department HIV/AIDS program website _____

HIV Planning

For this section we are asking about planning efforts for HIV only. We will ask about other integrated public health program planning (i.e., STD, TB, VH) in a specific question later in this section.

1. What is the current HIV planning structure in your jurisdiction? **[CHECK ONE]**

    ☐ Integrated HIV prevention-care planning group [IF YES, GO TO 1a.]

    ☐ Jurisdiction (only) prevention planning group

    ☐ Jurisdiction prevention planning group consisting entirely of members from regional/local planning groups

    ☐ Jurisdiction combined prevention-care planning group with regional/local groups supplying membership to the jurisdiction group

    ☐ Regional/local prevention (only) planning groups

    ☐ Regional combined prevention-care planning groups

    ☐ Other: Please describe:

1a. What products have your HIV integrated prevention-care planning group used or created? **[CHECK ALL THAT APPLY]**

    ☐ Integrated epidemiologic profile including demographics of HIV infection and estimates of HIV care outcomes

    ☐ Integrated HIV needs assessment tool(s)

    ☐ Integrated HIV prevention-care jurisdiction plan and/or recommendations to address gaps along the HIV continuum

    ☐ None, prevention and care planning products remain separate

    ☐ Other: Please describe:

    _____

2. Have you changed the structure of your planning group and/or planning process since 2009? **[CHECK ONE]**

    ☐ Yes   ☐ No

3. How many voting members are on the HIV planning body responsible for developing your HIV prevention plan in your jurisdiction, including any currently vacant seats?

    _____

    _____

    _____

4. Does your planning group responsible for developing your HIV prevention plan use other strategies to complete work as a group between in-person meetings? **[CHECK ONE]**

    ☐ Yes   ☐ No **[IF YES, GO TO 4a. IF NO, GO TO 5.]**

4a. Which of the following tools does your planning group responsible for developing your HIV prevention plan use? **[CHECK ALL THAT APPLY]**

    ☐ Conference calling

    ☐ Group email

    ☐ Group website

    ☐ Webinars/Web meetings

    ☐ Other: Please describe:

    _____

5. What is the scope of your current HIV Jurisdictional Plan (as required through 12-1201)? **[CHECK ALL THAT APPLY]**

    ☐ HIV prevention

    ☐ HIV prevention and care

    ☐ HIV/sexually transmitted disease (STD) prevention and care

    ☐ HIV/STD/viral hepatitis prevention and care

    ☐ HIV/STD/viral hepatitis/tuberculosis (TB) prevention and care

    ☐ Other: Please describe:

    _____

6. With which other public health disease areas has your HIV planning group integrated?
   [CHECK ALL THAT APPLY]

   ☐ STD

   ☐ TB

   ☐ Viral Hepatitis

   ☐ Other: Please Describe:

   _____

7. What about your current HIV prevention planning process is challenging for health department HIV planners? **[CHECK ALL THAT APPLY]**

   ☐ Determining best use of planning group input

   ☐ Determining planning outcomes

   ☐ Federal requirements

   ☐ Membership retention

   ☐ Membership skills

   ☐ Obtaining meaningful input from impacted populations

   ☐ Process of coordinating with other planning bodies

   ☐ Other: Please describe:

   _____

8. In addition to HIV planning, what other methods of stakeholder engagement does your health department use? **[CHECK ALL THAT APPLY]**

   ☐ Focus groups, interviews, surveys with stakeholders

   ☐ Town Halls/Forums with stakeholders

   ☐ We currently do not have a formal mechanism for stakeholder engagement

   ☐ Other ad hoc advisory bodies: Please describe:

   ☐ Other standing advisory bodies: Please describe:

   ☐ Other: Please describe:

   _____

   _____

Policy & Structural Initiatives

For the purpose of the NHPI, policy and structural initiatives include efforts to align structures, policies, and regulations to enable optimal HIV prevention, care, and treatment (e.g., addressing structural barriers to routine opt-out testing, or updating policies to facilitate sharing of surveillance data across health department programs).

9.   Since 2009, has your jurisdiction initiated and/or completed any policy changes related to HIV prevention? **[CHECK ONE]**

☐ Yes   ☐ No   ☐ I don't know **[IF YES, GO TO 9a. IF NO or I DON'T KNOW, GO TO 10.]**

9a.   On which of the following areas did your jurisdiction's policy change efforts focus?
[CHECK ALL THAT APPLY]

☐   Condoms

☐   Comprehensive sexuality education for youth

☐   Data sharing

☐   Electronic lab reporting of CD4 and viral load

☐   Expedited partner therapy (EPT)

☐   Health reform (e.g., Medicaid expansion, billing & reimbursement, health insurance)

☐   HIV decriminalization/policy modernization

☐   HIV screening (routinizing HIV testing)

☐   HIV testing

☐   Infectious disease integration - screening

☐   Infectious disease integration - treatment

☐   Linkage/retention/reengagement in HIV-related medical care

☐   nPEP

☐   PrEP

☐   Partner services

☐   Provision of HIV-related medical care/ART

☐   STD/access to integrated services

☐   Substance abuse/mental health/access to integrated services

☐   Syringe access

☐   Viral hepatitis/access to integrated services

☐   Other: Please describe:

_____

_____

Community Mobilization

For the purpose of the NHPI, mobilization activities include , but are not limited to: Public Health Community Mobilization Models, Social Marketing Campaigns, interventions involving communities (e.g., Community Promise) and models using Community Health Workers and/or peers (e.g., promotoras, peer advocates).

10. Does your health department currently support[12] any community mobilization activities? **[CHECK ONE]**

☐ Yes   ☐ No   ☐ I don't know **[IF YES, GO TO 10a. IF NO or I DON'T KNOW, GO TO 11.]**

10a. Which populations do your efforts target? **[CHECK ALL THAT APPLY]**

☐ Gay and bisexual men/MSM

☐ General population

☐ Injecting drug users

☐ People living with HIV

☐ Providers

☐ Transgender women

☐ Women of color

☐ Youth

☐ Other: Please describe:

_____

---

12 "Support" refers to programming that the health department supports through staffing grant, reimbursement or indirect means such as provision of materials, training, HIV test kits, etc.

10b. What are your community mobilization objectives? **[CHECK ALL THAT APPLY]**

☐ To educate communities about health reform

☐ To educate communities about incidence and prevalence among disproportionately impacted populations

☐ To identify undiagnosed HIV infection/promote HIV testing

☐ To link newly diagnosed HIV-positive persons to HIV-related medical care

☐ To promote adherence to HIV treatment

☐ To promote disclosure of HIV status

☐ To promote risk reduction strategies (e.g., use of condoms, sterile injection equipment

☐ To promote knowledge, awareness of nPEP and/or PrEP

☐ To promote knowledge and HIV testing opportunities with other STDs and viral hepatitis

☐ To promote reengagement for individuals who have fallen out of/never engaged in care

☐ To promote use of partner services

☐ To retain HIV-positive persons in HIV-related medical care

☐ Other: Please describe:

_____

10c. What activities do you support that you consider to be a part of your community mobilization efforts? **[CHECK ALL THAT APPLY] [GO TO 11]**

☐ Campaign website

☐ Community health workers

☐ Community level interventions

☐ HIV prevention programming at community events

☐ Local/jurisdiction-wide telephone information/referral line

☐ Meetings/town halls with community stakeholders

☐ Peer advocates/support

☐ Public information media campaigns (e.g., radio, billboards, palm cards)

☐ Social media outlets (e.g., Facebook, Twitter)

☐ Social marketing campaigns (e.g., Greater than, Testing Makes Us Stronger)

☐ Text messaging (e.g., reminders of testing, medical appointments)

☐ Other: Please describe:

_____

_____

11. Which reasons best describe challenges in supporting community mobilization activities?
[CHECK ALL THAT APPLY] [GO TO 12]

☐ Funding is inadequate

☐ Funding requirements of 12-1201

☐ Lack number of staff to implement

☐ Lack of sufficient expertise to implement

☐ Procurement requirements of health department

☐ Other: Please describe:

Condom Distribution Programs

12. Does your health department currently support a condom distribution program(s)?
[CHECK ONE]

☐ Yes, HD implements **[IF YES, GO TO 12a.]**

☐ Yes, HD supports community-based organizations (CBOs) and AIDS service organizations (ASOs) to implement **[IF YES, GO TO 12b.]**

☐ Yes, other: Please describe: **[IF YES, GO TO 12c.]**

☐ No **[IF NO, GO TO 13.]**

☐ I don't know **[IF DON'T KNOW, GO TO 13.]**

12a. Does your health department actively market and/or publicize your condom distribution program (e.g., through advertising)? **[CHECK ONE]**

☐ Yes   ☐ No **[IF YES, GO TO 12c. IF NO, GO TO 12d.]**

12b. Does your health department require contractors to implement condom marketing and/or publicizing (e.g., through advertising)? **[CHECK ONE]**

☐ Yes   ☐ No **[IF YES, GO TO 12c. IF NO, GO TO 12d.]**

12c. Please briefly describe your marketing and publicity activities: **[GO TO 12d]**

_____

_____

_____

_____

_____

12d. Who do you distribute condoms to in order to reach individuals living with HIV?
[CHECK ALL THAT APPLY]

☐ Community based organizations working with PLWH/A

☐ Community health centers/federally-qualified health centers serving high # of PLWH/A

☐ Health department partners in high-prevalence zip codes

☐ Venue-based settings likely to service high prevalence communities

☐ Hospitals

☐ Infectious disease doctors

☐ LGBT health centers

☐ Local health departments

☐ Online

☐ Partners in zip codes with greatest health disparities

☐ Ryan White clinics

☐ Schools/universities

☐ STD clinics

☐ Substance abuse programs

☐ Syringe exchange programs

☐ Other: Please describe:

_____

12e. Who do you distribute condoms to in order to reach high-risk HIV negative individuals?
[CHECK ALL THAT APPLY]

☐ Community based organizations working with target populations

☐ Community health centers/federally-qualified health centers

☐ Health department partners in high-risk zip codes

☐ High-risk venues (e.g., gay bars, bathhouses)

☐ HIV clinics (for use with HIV-unknown and negative status partners)

☐ LGBT health centers

☐ Local health departments

☐ Online

☐ Partners in zip codes with greatest health disparities

☐ Schools/universities

☐ STD clinics

☐ Substance abuse programs

☐ Syringe exchange programs

☐ Other: Please describe:

_____

12f. What products are available through your condom distribution program?
[CHECK ALL THAT APPLY]

☐ Educational/risk reduction materials

☐ Female condoms

☐ Kits with condoms, lubricants, and education materials

☐ Lubricant

☐ Male condoms (two or less product options)

☐ Male condoms (three or more product options)

☐ Other: Please describe:

_____

12g. Which factors best describe challenges in condom distribution programs?
[CHECK ALL THAT APPLY]

☐   Target community buy-in

☐   Distribution challenges

☐   Funding is inadequate

☐   Health department procurement processes

☐   Monitoring and evaluation

☐   Political environment/restrictions based on venue

☐   Political environment/restrictions based on geography

☐   Other: Please describe:

---

13. Which reasons best describe challenges in supporting condom distribution activities?
[CHECK ALL THAT APPLY] [GO TO 14]

☐   Funding requirements of 12-1201

☐   Funding is inadequate

☐   Lack the number of staff to support condom distribution

☐   Lack of sufficient expertise to support condom distribution

☐   Political environment/policy restrictions

☐   Other: Please describe:

Behavioral Interventions
Prevention with Positives

14. Which activities are components of your Prevention with Positives program?
     [CHECK ALL THAT APPLY]
     ☐ Antiretroviral medication adherence counseling
     ☐ Antiretroviral medication adherence, other strategies (e.g., text message reminders)
     ☐ Antiretroviral Treatment and Access to Services (ARTAS)
     ☐ Counseling & Comprehensive Risk Reduction Services (CRCS)
     ☐ Couples' HIV testing and counseling
     ☐ Linkage-to-care activities
     ☐ Partner services
     ☐ Patient navigation
     ☐ Reproductive health care
     ☐ Retention-in-care activities
     ☐ Risk screening
     ☐ STD screening
     ☐ STD treatment
     ☐ Viral hepatitis screening
     ☐ Viral hepatitis treatment
     ☐ Other care coordination models: Please describe:
     ☐ Other intensive prevention counseling models: Please describe:
     ☐ Other: Please describe:

     _____

15. Which challenges are you experiencing in supporting Prevention with Positives activities?
     [CHECK ALL THAT APPLY]
     ☐ Use of surveillance data to target PWP activities
     ☐ Coordination among local providers (including ASOs, CBOs, clinical providers)
     ☐ Coordination of health department staff to engage PLWH in care
     ☐ Cultural competency of providers to engage PLWH in care
     ☐ Provider staff capacity to engage PLWH in care
     ☐ Other: Please describe:

     _____

Prevention with High-Risk Negatives

16.   Are you supporting behavioral interventions for high-risk HIV negative individuals?
      [CHECK ONE]

      ☐ Yes   ☐ No   ☐ I don't know **[IF YES, GO TO 16a. IF NO or I DON'T KNOW, GO TO 16k.]**

16a. If yes to 16, are you supporting behavioral interventions for youth (ages 13-29)?

      ☐ Yes   ☐ No **[IF YES, GO TO 16b. IF NO, GO TO 16c.]**

16b. If yes to 16a., which behavioral interventions do you support for youth?
      [CHECK ALL THAT APPLY]

      ☐   Focus on the Future

      ☐   Focus on Youth

      ☐   MPowerment

      ☐   Popular Opinion Leader

      ☐   Street Smart

      ☐   Other: Please describe:

      _____

16c. If yes to 16, are you supporting interventions for gay and bisexual men?

      ☐ Yes   ☐ No **[IF YES, GO TO 16d. IF NO, GO TO 16e.]**

16d. If yes to 16c., which behavioral interventions do you support for gay and bisexual men?
      [CHECK ALL THAT APPLY]

      ☐   D-up

      ☐   MPowerment

      ☐   Many Men, Many Voices

      ☐   Popular Opinion Leader

      ☐   Other: Please describe:

      _____

16e. If yes to 16, are you supporting interventions for transgender women?

      ☐ Yes   ☐ No **[IF YES, GO TO 16f. IF NO, GO TO 16g.]**

16f.   If yes to 16e., please list and describe briefly the behavioral interventions you support for transgender women.

List: _____

Describe: _____

16g.   If yes to 16, are you supporting behavioral interventions for women of color?

☐ Yes   ☐ No **[IF YES, GO TO 16h. IF NO, GO TO 16i.]**

16h.   If yes to 16g., which behavioral interventions do you support for women of color?
[CHECK ALL THAT APPLY]

☐   Community Promise

☐   Popular Opinion Leader

☐   SIHLE

☐   SISTA

☐   VOICES/VOCES

☐   Other: Please describe:

_____

16i.   If yes to 16, are you supporting behavioral interventions for injection drug users?

☐ Yes   ☐ No **[IF YES, GO TO 16j. IF NO, GO TO 18.]**

16j.   If yes to 16i., which behavioral interventions do you support for injection drug users?
[CHECK ALL THAT APPLY]

☐   Safety Counts

☐   Holistic Health Recovery Program

☐   Street Smart

☐   Other: Please describe:

_____

16k. If no to 16, what are the reasons for not supporting behavioral interventions?
[CHECK ALL THAT APPLY]

☐ Access to/availability of training

☐ Funding is inadequate

☐ Funding requirements of 12-1201

☐ Difficulty bringing to scale

Evidence from modeling/assessment indicates behavioral interventions for HIV-negative individuals are not cost-effective

☐ Expertise to adapt/tailor interventions

☐ HIV planning group recommendation to not support behavioral interventions

☐ The interventions are not responsive to the identified needs of the priority population(s)

☐ There are no interventions available for the priority population(s)

☐ Other: Please describe:

_____

Syringe Services Programs

According to the CDC, the term Syringe Services Programs (SSP) is inclusive of syringe access (including pharmacy sales), disposal, and needle exchange programs, as well as referral and linkage to HIV prevention services, substance abuse treatment, and medical and mental health care.

17. Is there a syringe service program (SSP) in your jurisdiction? **[CHECK ONE]**

☐ Yes   ☐ No   ☐ I don't know **[IF YES, GO TO 17a. IF NO, GO TO 17g. IF I DON'T KNOW, GO TO 18.]**

17a. Which entity administers the program? **[CHECK ALL THAT APPLY]**

☐ Health department HIV/AIDS program

☐ Other health department program (non-HIV/AIDS) Please describe:

_____

☐ Other: Please describe:

_____

17b.   Which entity funds the program? **[CHECK ALL THAT APPLY]**

☐   Health department HIV/AIDS program

☐   Other health department program (non-HIV/AIDS) Please describe:

☐   Other: Please describe:

_____

17c.   Through which venues does your SSP operate? **[CHECK ALL THAT APPLY]**

☐   Community-based organizations

☐   Community health centers/federally-qualified health centers

☐   Hospitals

☐   LGBT health centers

☐   Local health departments

☐   Mobile van

☐   Peer-based exchange

☐   Pharmacies

☐   Specialty clinics

☐   STD clinics

☐   Tribal organizations

☐   Other: Please describe:

_____

17d. Which of the following services are available through your jurisdiction's SSPs?
[CHECK ALL THAT APPLY]

☐ Condoms

☐ Direct substance abuse/chemical dependency treatment

☐ Drug substitution

☐ HCV testing

☐ HIV testing

☐ Immunizations

☐ Linkage to HIV-related medical care

☐ Linkage to housing, education, job training services

☐ Linkage to mental health services

☐ Linkage to substance abuse/chemical dependency treatment

☐ Linkage to other social and health services

☐ Overdose prevention

☐ Primary medical care

☐ nPEP

☐ PrEP

☐ STD screening

☐ STD treatment

☐ Syringe disposal

☐ Syringe exchange

☐ Wound abscess care

☐ Other: Please describe:

_____

17e. Does your health department market and/or publicize your SSP (e.g., through advertising)?
[CHECK ONE]

☐ Yes   ☐ No   ☐ I don't know **[IF YES THEN GO TO 17f. IF NO or I DON'T KNOW, GO TO 18.]**

17f. Please briefly describe your marketing and publicity activities: **[GO TO 18]**

_____
_____
_____

17g. If no to 17, what are the reasons for not funding SSP? **[CHECK ALL THAT APPLY]**

- ☐ Community opposition
- ☐ Evidence from modeling/assessment indicate SSPs is not cost-effective
- ☐ Federal ban on funding
- ☐ Funding requirements of 12-1201
- ☐ Funding is inadequate
- ☐ Local law enforcement opposition
- ☐ State/local policies
- ☐ Other: Please describe:

_____

Non-Occupational Post-Exposure Prophylaxis

A non-occupational post-exposure prophylaxis (nPEP) program may include planning, education, personnel, and other support for providers and/or high-risk populations.

18. Does your health department currently support a non-occupational post-exposure prophylaxis (nPEP) program(s)? **[CHECK ONE]**

☐ Yes ☐ No ☐ I don't know **[IF YES, GO TO 18a. IF NO or I DON'T KNOW, GO TO 19.]**

18a. Through which venues does your health department provide nPEP outreach and education? **[CHECK ALL THAT APPLY]**

  ☐   Community-based organizations

  ☐   Community health centers/federally-qualified health centers

  ☐   Emergency departments

  ☐   Family planning clinic

  ☐   Outpatient clinics

  ☐   LGBT health centers

  ☐   Local health departments

  ☐   Other primary care clinics

  ☐   Rape crisis center

  ☐   Specialty clinics

  ☐   STD clinics

  ☐   Substance abuse clinics

  ☐   Tribal organizations

  ☐   Other: Please describe:

18b. Does your nPEP program target specific populations? **[CHECK ONE]**

  ☐ Yes   ☐ No **[IF YES, GO TO 18c. IF NO, GO TO 19.]**

18c. If yes, which populations do your nPEP program(s) target? **[CHECK ALL THAT APPLY]**

  ☐   Gay and bisexual men/MSM

  ☐   People who have been sexually assaulted

  ☐   Substance users

  ☐   Transgender women

  ☐   Women

  ☐   Other: Please describe:

---

19. Which reasons best describe challenges in supporting an nPEP program?
    [CHECK ALL THAT APPLY]

    ☐ Funding requirements of 12-1201

    ☐ Funding is inadequate

    ☐ Evidence from modeling/assessment indicate nPEP is not cost-effective

    ☐ Community interest to take nPEP

    ☐ Provider willingness to provide nPEP

    ☐ nPEP does not meet the needs of the priority population(s)

    ☐ Other: Please describe:

    _____

Pre-Exposure Prophylaxis

A pre-exposure prophylaxis (PrEP) program may include planning, education, personnel, and other support for PrEP provision by a licensed physician.

20. Does your health department currently support a pre-exposure prophylaxis program(s) (PrEP)?
    [CHECK ONE]

    ☐ Yes   ☐ No   ☐ I don't know **[IF YES, GO TO 20a. IF NO or I DON'T KNOW, GO TO 21.]**

20a. Are you conducting or plan to conduct in the next 12 months community outreach or engagement for PrEP? **[CHECK ONE]**

    ☐ Yes   ☐ No   ☐ I don't know

20b. Are you conducting or plan to conduct in the next 12 months provider outreach/education for PrEP? **[CHECK ONE]**

    ☐ Yes   ☐ No   ☐ I don't know

20c. Which populations do your PrEP program(s) target? **[CHECK ALL THAT APPLY]**

    ☐ Gay and bisexual men/MSM

    ☐ Serodiscordant couples

    ☐ Sex workers

    ☐ Substance users/Injection drug users

    ☐ Transgender women

    ☐ Women considering contraception

    ☐ Other: Please describe:

    _____

20d. Through which venues does your health department support PrEP outreach and education to the community? **[CHECK ALL THAT APPLY]**

☐ Bars and clubs

☐ Bathhouses

☐ Community-based organizations

☐ Community health centers/federally-qualified health centers

☐ Hospitals

☐ Family planning clinic

☐ LGBT health centers

☐ Local health departments

☐ Other primary care clinics

☐ Specialty clinics

☐ STD clinics

☐ Substance abuse clinics

☐ Tribal organizations

☐ We do not provide outreach and/or education

☐ Other: Please describe:

_____

20e. To whom are you targeting efforts to increase awareness and promote uptake of PrEP? **[CHECK ALL THAT APPLY]**

☐ Gynecologists

☐ HIV/Infectious disease specialists

☐ Primary care clinicians

☐ I don't know

☐ Other: Please describe:

_____

21. If no or I don't know, what are the reasons for not supporting a PrEP program?
    [CHECK ALL THAT APPLY]

    ☐ Access to/availability of training

    ☐ Difficulty bringing to scale

    ☐ Evidence from modeling/assessment indicates PrEP is not cost-effective

    ☐ Funding is inadequate

    ☐ Funding requirements of 12-1201

    ☐ HIV planning group does not recommend PrEP

    ☐ PrEP is not appropriate for meeting the needs of the priority population(s)

    ☐ Community willingness to take PrEP

    ☐ Provider willingness to provide PrEP

    ☐ Other: Please describe:

    _____

Integration

Integration means organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate comprehensive delivery of services.

22. Please indicate the activities that take place between your jurisdiction's HIV prevention program and the programs listed in the first column. **[CHECK ALL THAT APPLY]**

Programs	None	AIDS director oversees staff	AIDS director oversees budget	Inter-program meetings are held	Programs collaborate on projects (content and/ or funding)	Other (Please describe below)
HIV Testing	☐	☐	☐	☐	☐	☐
Linkage to HIV-related Medical Care	☐	☐	☐	☐	☐	☐
HIV-related Care and Treatment	☐	☐	☐	☐	☐	☐
HIV Support Services (includes ADAP and medicine)	☐	☐	☐	☐	☐	☐
HIV Surveillance	☐	☐	☐	☐	☐	☐
Viral Hepatitis Testing	☐	☐	☐	☐	☐	☐
Viral Hepatitis Activities, (Training, other services)	☐	☐	☐	☐	☐	☐
Viral Hepatitis Surveillance	☐	☐	☐	☐	☐	☐
STD Screening (excluding Partner Services)	☐	☐	☐	☐	☐	☐
STD Treatment (excluding Partner Services)	☐	☐	☐	☐	☐	☐
Partner Services	☐	☐	☐	☐	☐	☐
STD Surveillance	☐	☐	☐	☐	☐	☐
TB Testing	☐	☐	☐	☐	☐	☐
TB Treatment	☐	☐	☐	☐	☐	☐
TB Surveillance	☐	☐	☐	☐	☐	☐
Immunization Services	☐	☐	☐	☐	☐	☐
Refugee Health Services	☐	☐	☐	☐	☐	☐
Reproductive Health Services	☐	☐	☐	☐	☐	☐
Other (Please describe)	☐	☐	☐	☐	☐	☐

Please describe "other" from above:

As you complete the next two questions, please use the following definitions when asked to select the appropriate level of integration.

No integration of services at the client level: Clients are provided a single prevention service (e.g., HIV testing without STD screening) at the point of access, with or without a referral to other services.

Limited integration of services at the client level: HIV testing is provided along with health information and referrals to other non-HIV services like STD, viral hepatitis and TB.

Expanded integration of services at the client level: Services are integrated across HIV, viral hepatitis, STD and TB for certain populations based on risk assessment.

Comprehensive integration of services at the client level: Services are integrated across HIV, viral hepatitis, STD and TB and include other services like reproductive health, substance abuse, mental health, etc. for certain populations based on risk assessment.

23.   Generally, which of the above definitions best describes the level of integration in publicly-funded health care clinics (e.g., STD clinics, TB clinics, etc.) between your jurisdiction's HIV prevention program and your jurisdiction's STD program? **[CHECK ONE]**

☐   No integration

☐   Limited integration

☐   Expanded integration

☐   Comprehensive integration

24.   Generally, which of the above definitions best describes the level of integration in publicly-funded health care clinics (e.g., STD clinics, TB clinics, etc.) between your jurisdiction's HIV prevention program and your jurisdiction's viral hepatitis program? **[CHECK ONE]**

☐   No integration

☐   Limited integration

☐   Expanded integration

☐   Comprehensive integration

25. Generally, which of the above definitions best describes the level of integration in publicly-funded health care clinics (e.g., STD clinics, TB clinics, etc.) between your jurisdiction's HIV prevention program and your jurisdiction's TB program? **[CHECK ONE]**

☐ No integration

☐ Limited integration

☐ Expanded integration

☐ Comprehensive integration

26. Generally, which of the above definitions best describes the level of integration in community-based settings (e.g., CBOs) between HIV prevention and STD? **[CHECK ONE]**

☐ No integration

☐ Limited integration

☐ Expanded integration

☐ Comprehensive integration

27. Generally, which of the above definitions best describes the level of integration in community-based settings (e.g., CBOs) between HIV prevention and viral hepatitis? **[CHECK ONE]**

☐ No integration

☐ Limited integration

☐ Expanded integration

☐ Comprehensive integration

28. Generally, which of the above definitions best describes the level of integration in community-based settings (e.g., CBOs) between HIV prevention and TB? **[CHECK ONE]**

☐ No integration

☐ Limited integration

☐ Expanded integration

☐ Comprehensive integration

Collaboration

Questions in this section address the relationships between the HIV prevention program and other programs and external partners in general. State or local specific collaborations are indicated.

29. Indicate the relationship between your jurisdiction's HIV prevention program and the programs and external partners listed in column one. Check the boxes that apply. For jurisdictions with multiple entity partners represented by one category, please respond reflecting the highest amount of collaboration among them. As you complete this question, please use the following definitions.

■ **Cooperation:** Fully autonomous entities share information to allow each to independently maximize its effectiveness, in awareness of the other's activities and goals.

■ **Coordination:** Fully autonomous entities willingly align activities, sponsor particular events, or deliver targeted services in support of compatible goals.

■ **Collaboration:** Entities actively share decision-making, planning efforts and resources to achieve common goals. Accountability and rewards are shared. Each relinquishes some degree of autonomy to achieve a jointly determined purpose.

Programs and External Partners	Cooperation	Coordination	Collaboration	None
State Medicaid	☐	☐	☐	☐
State Insurance Program (High risk pools, SPAP, etc.)	☐	☐	☐	☐
Private Health Insurance Plans	☐	☐	☐	☐
Community Health Centers/FQHCs	☐	☐	☐	☐
Other Healthcare Institutions/ Private Providers	☐	☐	☐	☐
Ryan White Part A(s)	☐	☐	☐	☐
Ryan White Part C	☐	☐	☐	☐
All Other Ryan White Funded Programs (B, D, F)	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐
Maternal and Child Health	☐	☐	☐	☐
Family Planning/Reproductive Health	☐	☐	☐	☐
Minority Health/Health Equity	☐	☐	☐	☐
Local/County Corrections	☐	☐	☐	☐
State Corrections	☐	☐	☐	☐
Education (Colleges and Universities)	☐	☐	☐	☐
Education (Local Level, secondary/primary)	☐	☐	☐	☐
Education (State level, secondary/primary)	☐	☐	☐	☐
State Housing Authority	☐	☐	☐	☐
Business	☐	☐	☐	☐
Civic Organizations	☐	☐	☐	☐
Faith-based Organizations	☐	☐	☐	☐
Office of Aging/Senior Citizen programs	☐	☐	☐	☐
Domestic Violence/Sexual Assault Programs (State or Local)	☐	☐	☐	☐
Tribal Healthcare Organizations	☐	☐	☐	☐
Immunization Programs	☐	☐	☐	☐
Refugee/Immigrant Health Programs	☐	☐	☐	☐
Tuberculosis Programs (State or Local)	☐	☐	☐	☐
Other: Please describe:	☐	☐	☐	☐
Other: Please describe:	☐	☐	☐	☐

30. Has your jurisdiction's HIV prevention program developed any relationships with other programs and/or external partners in an effort to specifically address racial and ethnic health disparities? **[CHECK ONE]**

☐ Yes ☐ No **[IF YES, GO TO 30a. IF NO, GO TO 31.]**

30a. Please describe:

_____

_____

_____

HIV Care Continuum

The HIV care continuum, also known as the HIV treatment cascade, is a model that identifies issues and opportunities related to improving the delivery of services to persons living with HIV from diagnosis of HIV infection and linkage to care to initiation of antiretroviral therapy (ART), retention in care, and eventual viral suppression.

31. Has your jurisdiction created a jurisdiction-specific HIV care continuum/HIV treatment cascade? **[CHECK ONE]**

☐ Yes ☐ No ☐ I don't know **[IF YES, GO TO 31a. IF NO or I DON'T KNOW, GO TO 31g.]**

31a. If yes, did you have data for all bars of the continuum?

☐ Yes ☐ No **[IF NO, GO TO 31b. IF YES, GO TO 31c]**

31b. If no, for which bars did you not have data? **[CHECK ALL THAT APPLY]** [GO TO 31c]

☐ HIV-infected

☐ HIV-diagnosed

☐ Linked to HIV care

☐ Retained in HIV care

☐ Prescribed ART

☐ Suppressed viral load

31c. If yes, have you created population-specific continua based on race/ethnicity? **[CHECK ONE]**

☐ Yes ☐ No ☐ I don't know

31d.   If yes to 31, have you created population-specific continua based on risk behaviors? **[CHECK ONE]**

☐ Yes   ☐ No   ☐ I don't know

31e.   If yes to 31, how has creating the jurisdiction-specific continuum been useful for your prevention program? **[CHECK ALL THAT APPLY]** [GO TO 32]

☐   Framed planning conversations

☐   Framed conversations with prevention partners

☐   Changed focus of interventions

☐   Changed which interventions were being funded

☐   Other: Please describe:

_____

31f.   If yes to 31, what are some barriers associated with creating a jurisdiction-specific care continuum? **[CHECK ALL THAT APPLY] [GO TO 32]**

☐   Access to sources of data outside of HIV prevention programs

☐   Incomplete HIV surveillance data including electronic lab reporting

☐   Lack of staff expertise/staff time

☐   Quality of data

☐   Unable to share HIV surveillance data/local and state policy

☐   Other: Please describe:

_____

31g.   If no to 31, what are some barriers associated with creating a jurisdiction-specific care continuum? **[CHECK ALL THAT APPLY]** [GO TO 32]

☐   Access to sources of data outside of HIV prevention programs

☐   Incomplete HIV surveillance data including electronic lab reporting

☐   Lack of staff expertise/staff time

☐   Quality of data

☐   Unable to share HIV surveillance data/local and state policy

☐   Other: Please describe:

_____

32. Please describe any technical assistance you need related to creating and using a jurisdiction-specific HIV care continuum:

_____

_____

_____

HIV Prevention and Affordable Care Act (ACA) Implementation

33. What ACA planning and implementation activities are occurring in the health department regarding HIV prevention? **[CHECK ALL THAT APPLY]**
    - ☐ Assessing readiness of contracted providers (e.g., bill for services, enroll clients, interact with public/private insurance)
    - ☐ Developing and implementing ACA-related training for prevention program staff of health department
    - ☐ Developing and implementing ACA-related training for prevention program staff of contracted providers
    - ☐ Increasing billing capacity of contracted providers
    - ☐ Increasing health department billing capacity
    - ☐ Participating in health department led ACA implementation work groups
    - ☐ Providing technical assistance to contracted providers
    - ☐ Working with state Medicaid to support Pre-Exposure Prophylaxis (PrEP)
    - ☐ Working with state Medicaid to get HIV prevention services covered
    - ☐ Other: Please describe:

    _____

34. Which of the following stakeholders are participating in ACA implementation activities? **[CHECK ALL THAT APPLY]**
    - ☐ HIV planning group members
    - ☐ Outreach and testing providers
    - ☐ Prevention manager
    - ☐ PS/Disease Intervention Specialists (DIS)
    - ☐ Other: Please describe:

    _____

35. Is the HIV prevention program working with other health department programs on ACA implementation? **[CHECK ONE]**

  ☐ Yes ☐ No **[IF YES, GO TO 35a. IF NO, GO TO 36.]**

35a. Which of the following programs is HIV prevention working with on ACA implementation? **[CHECK ALL THAT APPLY]**

  ☐ ADAP

  ☐ Family planning

  ☐ HIV care and treatment

  ☐ Immunization

  ☐ Medicaid

  ☐ Refugee/Immigrant health

  ☐ STDs

  ☐ Substance Abuse

  ☐ Tuberculosis

  ☐ Viral hepatitis

  ☐ Other: Please describe:

36. Are HIV prevention program staff engaged in ACA outreach and enrollment activities? **[CHECK ONE]**

  ☐ Yes ☐ No **[IF YES, GO TO 36a. IF NO, GO TO 37.]**

36a. What ACA outreach and enrollment activities are occurring in the health department regarding HIV prevention program? **[CHECK ALL THAT APPLY]**

  ☐ Developing ACA outreach and enrollment training for prevention program staff and contracted providers

  ☐ Incorporating ACA outreach and enrollment information into linkage to care activities

  ☐ Received ACA certified application counselor training

  ☐ Received ACA Patient Navigator or in-person assister funding

  ☐ Targeting individuals at high-risk for acquiring HIV to ACA navigators

  ☐ Other: Please describe:

37. In the past year, has the prevention program undertaken any activities to increase billing capacity?

☐ Yes   ☐ No **[IF YES, GO TO 37a] [IF NO, END.]**

37a. What activities are occurring in the health department to increase billing capacity regarding HIV prevention? **[CHECK ALL THAT APPLY]**

☐ Assessed third-party billing practices and capacity of contracted providers of prevention services

☐ Developed or increased internal health department billing infrastructure

☐ Engaged with other public health programs on health department billing capacity

☐ Identified billing technical assistance resources for contracted providers

☐ Identified billing technical assistance resources for health department

☐ Other: Please describe:

Thank you for taking the time to complete this survey. If you have any questions regarding this survey or its purpose please contact Todd Harvey at tharvey@NASTAD.org.