



Phase II Progress Report Building the Strategy to End AIDS in Fulton County: Objectives and Actions

Fulton County Task Force On HIV / AIDS

June 27, 2016

OUR Time Is NOW!

Board of Commissioners of Fulton County

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June 20, 2016

Dear Friends,

On World AIDS Day, December 1, 2014, we heard disturbing data about the magnitude of the HIV/AIDS epidemic in Fulton County and recognized an urgent need to respond to this crisis. We heard that the South, Georgia, and Fulton County are now the epicenters of HIV/AIDS in America. We heard that HIV disproportionately affects the most vulnerable populations, and that stigma and discrimination fuel the epidemic of HIV/AIDS. Yet we were reminded that HIV positive people can live healthy and long lives if they receive the remarkable medical therapies now available, and that those who receive effective treatment are extremely unlikely to transmit HIV to others. We learned that PrEP, a new prevention tool, is highly effective in preventing people who are HIV-negative from acquiring HIV, but that it is underutilized by the very people who could most benefit from it.

Our response was to create the Fulton County Task Force on HIV/AIDS and to endorse its ambitious goal of developing a comprehensive Strategy to End AIDS in Fulton County. The first report on this Strategy was presented to the Board of Commissioners and the people of Fulton County on December 1, 2015, and contained bold new objectives for attacking this crisis. Now, six months later, the Task Force presents Phase II of the Strategy, including recommendations for specific actions aimed at achieving these objectives.

These recommendations are the result of an extensive consultative process, including in-depth discussions with local and national HIV experts, leaders from county and state health departments, staff at funded agencies and clinics, residents of communities across Fulton County, and, importantly, those living with and at highest risk for HIV/AIDS. The recommendations will assist the Board of Commissioners in adopting effective, evidence-based policies to address the epidemic, support the work of the Fulton County Department of Health and Wellness in creating and implementing its programs, and provide a blueprint for effective collaboration among government agencies, community organizations, academic institutions, businesses, faith institutions, advocacy groups, funders, and the general public as we work together to attack and end the epidemic of HIV/AIDS in our community.

The Board of Commissioners supports the work of the Fulton County Task Force on HIV/AIDS and invites you to join us as we commit to End AIDS in Fulton County.

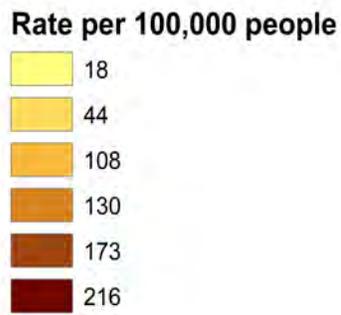
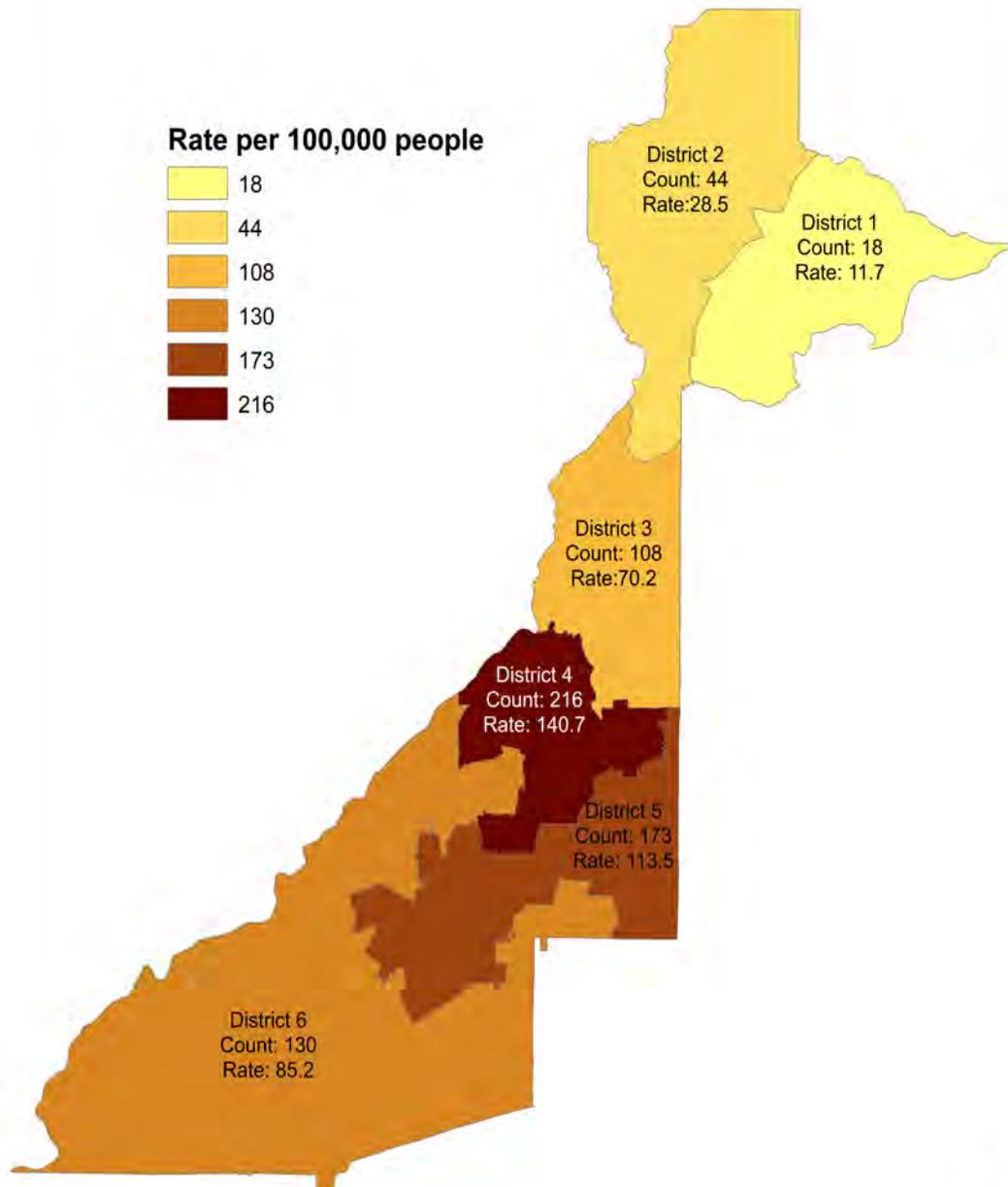
Sincerely,

John Eaves, Ph.D.
Chairman
Fulton County Board of Commissioners

Sincerely,

Joan P. Garner
Commissioner, District 4
Fulton County Board of Commissioners

New HIV diagnoses and rates per 100,000 people by county commission district, Fulton County, GA, 2014



THE FULTON COUNTY TASK FORCE ON HIV/AIDS

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June 27, 2016

As Co-Chairs of the Fulton County Task Force on HIV/AIDS, and on behalf of the full Task Force, we are very pleased to present Phase II of the "**Strategy to End AIDS in Fulton County**". Since the resolution sponsored by Chairman John Eaves and Commissioner Joan Garner established this Task Force in December 2014, we have been working on the strategy. This document builds on Phase I of the Strategy, which was presented on December 1st, 2015 and presented the overarching goals and objectives of a comprehensive plan to End AIDS for Fulton County. In Phase II, we present the action plans and priorities needed to develop a blueprint for moving forward.

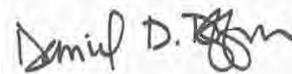
The document represents the contributions of individuals across Fulton County, the City and the State of Georgia and importantly draws from the expertise of persons living with and affected by HIV in addition to HIV care providers, epidemiologists, community workers, advocates, public health officials, caregivers, and others. Task Force members have participated in hundreds of hours of listening sessions and have sought community input and expert consultation at every step of the way. We have sought to incorporate not only recommendations for prevention strategies and the delivery of care but also to recognize the critical role that social determinants play in perpetuating the epidemic and the significant impact that can be made through policy initiatives. At every step of the process, we have reminded everyone that HIV remains a formidable problem in Atlanta but also that we are not powerless and that, working together we can turn the tide of HIV in our community.

We have benefitted from tremendous support across our community and in particular, from the Fulton County leadership. Through this leadership, Fulton County and the Fulton County Department of Health and Wellness are poised to bring transformative change to our approach to the HIV/AIDS epidemic which we believe can benefit the Atlanta community as a whole and lead the way for our region.

We thank you all for your support and continued commitment to fighting the epidemic. OUR Time is NOW!!



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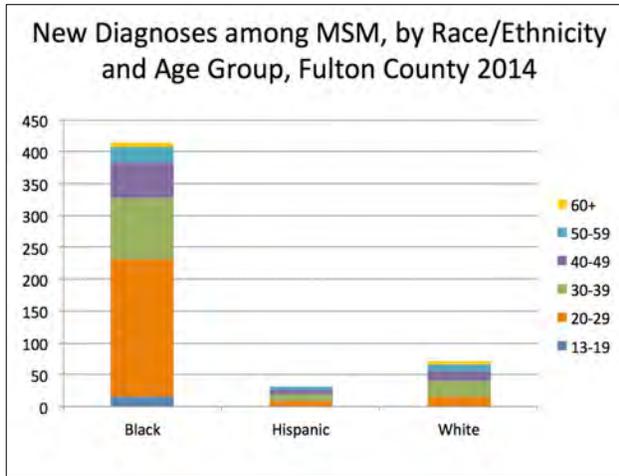
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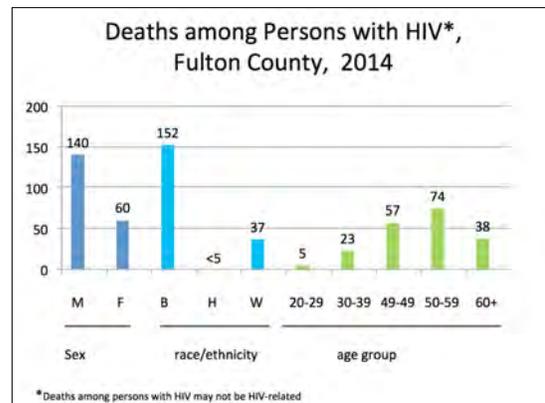
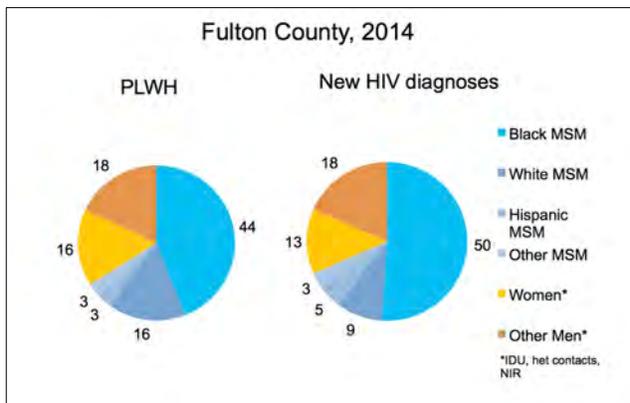
OUR Time Is NOW!

At a time when new HIV diagnoses are dropping precipitously in other communities, and when only 302 persons were diagnosed with HIV in San Francisco in 2014 (SFDPH, 2015), Fulton County's new diagnoses remain stubbornly above 600 per year. And the disparities we face are stunning. In 2014, 431 gay and bisexual men were newly diagnosed with HIV, amounting to



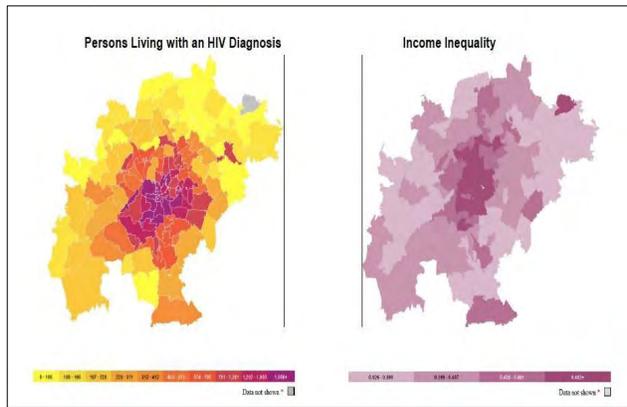
approximately two-thirds of all new diagnoses. Four out of five of these men were black and over half of them were less than 30 years old. (Georgia Department of Public Health (GDPH) Epidemiology Unit, 2016) Data on transgender populations are sorely lacking, but there is every reason to expect unacceptable rates in these populations as well. Fortunately, new diagnoses in women are declining. But racial disparities are not. Making up only 44% of the county's population, Blacks comprised 70% of new diagnoses in 2014. And while deaths of people with HIV are not

necessarily from AIDS anymore, of the 200 deaths that occurred in 2014, approximately 75% were Black. (GDPH Epidemiology Unit, 2016). Even one death due to AIDS-defining opportunistic infections and malignancies is too many in 2016, when we know how to prevent AIDS.



So much is wrong with this picture. Why is our epidemic so entrenched, when others move toward gaining control? Why is the epicenter of the civil rights movement now an epicenter of HIV/AIDS? How have we tolerated such stark disparities for all these years without taking to the streets in favor of LGBTQ and racial equality? Do we really believe that #BlackLivesMatter, or that #GayLivesMatter or that #TransLivesMatter or that #WomensLivesMatter or that #HIVLivesMatter? And if so, what can we actually do to make a difference?

Our Southern HIV epidemic is mired in a stew of inequality, with Atlanta having the highest income inequality ratio in the nation (Berube, 2015). HIV never saw an inequality it didn't like, or couldn't exploit. Maps of HIV prevalence mirror maps of inequalities of all sorts. Historic



vestiges of racism, homo- and transphobia, and stigma emanating from societal institutions including – perhaps especially – those of faith, mix in a cauldron with poverty, unstable housing, inadequate transportation infrastructures, high levels of unemployment and incarceration, and low levels of educational achievement to form the perfect poison that is our HIV epidemic. (AIDSvu.com Atlanta, 2012)

Meanwhile in our affluent northern suburbs, a new opioid epidemic brews with increasing heroin and fentanyl overdoses stealing the lives of high school youth, and threatening to become an Indiana-like epidemic just waiting for the first case of HIV or hepatitis C. Will we learn from past mistakes and rise up to avert another epidemic in our midst?

While these statistics, and the realities they represent, are disturbing, our community is resilient. In the face of the horrific LGBTQ massacre in Orlando, an interfaith vigil in one of our highest HIV prevalence zip codes drew 3000 people who vowed together that #LoveWins. Blacks and whites and Latino/Hispanic and Asian-Americans and Native Americans and Republicans and Democrats and gay and trans and straight and gender fluid and business executives and politicians and homeless people and stockbrokers and teachers and rabbis and ministers and imams came together on that day. As a single community, we cried and laughed and and spoke truth about the need to unite, to seize the moment, to stand up against hate, violence, and stigma, and to put our differences aside.

And this is why we know that this community can win against HIV. We are a community with heart and an illustrious history of bending the moral arc of the universe toward justice.

The passion is there, and so is the knowledge. Now, so is the political will in the form of leadership from the Fulton County Board of Commissioners. We know how to end new HIV infections. We know how to stop babies from being born with HIV. We know how to help people with HIV live long and healthy lives. We know how to eliminate death from AIDS. But we need a blueprint to guide the way. We need a **bold Strategy to End AIDS in Fulton County**. Together, we are making this Strategy a reality. If we are ever going to do this, **OUR Time is NOW!**

About the Fulton County Task Force on HIV/AIDS

In December 2014, Board of Commissioners Chairman John Eaves and District 4 Commissioner Joan Garner proposed resolution #14-1109 creating and establishing a Task Force on HIV/AIDS for Fulton County. The resolution, approved at the December 17, 2014 meeting of the Board, envisioned this entity would “provide input and recommendations in areas of public

education, advocacy, treatment, prevention, housing and related issues pertaining to HIV/AIDS in Fulton County.” To accomplish the charge set forth by the Board, the Task Force recognized the necessity of developing a comprehensive, evidence-based “Strategy to End AIDS in Fulton County” which can then be implemented and monitored to assess progress.

The Task Force consists of 14 members who reside in Fulton County and who are appointed by the Board of Commissioners. The Board and the Task Force members recognized an effective strategy would require individuals with significant, wide-ranging content expertise, many of whom work but do not reside in Fulton, to address appropriately the many areas that require attention in a truly comprehensive plan. Therefore 25 non-appointed contributors also are members of the Task Force, along with other content experts who serve as consultants. The Director of the Fulton County Department of Health and Wellness (FCDHW), the Director of Part A of the Ryan White HIV/AIDS Program (RWHAP), and the Director of the High Impact Prevention Program (HIPP) are ex officio members of the Task Force as well. Co-Chairs of the Task Force were elected by the group and consist of an appointed member and a non-appointed contributor. The Executive Committee, consisting of the Co-Chairs and the Chairs of standing committees, is the leadership body of the Task Force.

Building the Fulton County Strategy to End AIDS: Methodology

The primary undertaking of the Task Force is to develop and monitor a comprehensive *Strategy to End AIDS in Fulton County*. The Strategy, when complete, will consist of clear goals and objectives, and achievable action plans that can subsequently guide promotion, implementation, monitoring and reassessment over time.

The Strategy aligns with the primary goals of the *2020 National HIV/AIDS Strategy* (NHAS):

- To reduce new HIV infections
- To increase access to care and improve health outcomes so people living with HIV/AIDS can lead healthy, long lives
- To reduce HIV-related health care disparities
- To achieve a more coordinated response to HIV/AIDS

The Strategy is being built in three phases. To balance the urgent need for such a Strategy with the necessity of careful thought, data collection and broad-based input, the first phase, released on World AIDS Day 2015, included only draft objectives. This Phase II document contains objectives and recommended actions for achieving the objectives. Phase III will include resource analysis and gap analysis for the objectives and actions, including timelines and annual targets, where appropriate. The Phase III Strategy, including SMART objectives and specific action plans with metrics and targets will be released in December 2016 in association with World AIDS Day. The Task Force created four committees and an Executive Committee, each charged with evaluating needs and developing objectives and action plans in areas of critical importance for the Strategy. Co-Chairs of the Task Force appointed the Committee Chairs. As part of this process, each committee is charged with conducting an inventory of current HIV/AIDS resources and activities in the area of focus and a gap analysis. The committees are as follows:

1. Prevention and Care

The Prevention and Care Committee is responsible for developing recommendations regarding HIV testing, prevention and care. Those recommendations include cross cutting structural issues related to the delivery of healthcare for persons at risk for and living with HIV in Fulton County and the role of the FCDHW in HIV care and prevention in Fulton County.

2. Social Determinants of Health

The Social Determinants of Health Committee is responsible for developing recommendations regarding services that impact health but are not traditionally considered direct health services, such as housing and transportation.

3. Data and Evaluation

The Data and Evaluation Committee is responsible for identifying data sources and developing and advising on pragmatic and scientifically sound metrics for the objectives in the Strategy. The Committee also identifies areas where data systems need strengthening or enhanced coordination.

4. Policy

The Policy Committee is responsible for identifying policy needs to facilitate implementation of the Strategy, to reduce stigma and health care disparities and otherwise promote the health and wellbeing of persons with and at risk for HIV infection.

Community Input and Engagement

Policies and programs work best when they are based on the experiences of the people they are meant to serve. The Task Force encouraged feedback by creating many opportunities to engage in discussion and receive feedback. All meetings were open to the public, including monthly Task Force meetings and half-day Face-to-Face meetings focusing on key topics such as testing, prevention, linkage to and reengagement in care, retention in care, viral suppression, housing, food insecurity, job training, and stigma. Targeted meetings explored topics such as perinatal transmission, issues involving adolescents, and HIV and the Ballroom community. Beginning in 2015, dozens of listening sessions occurred with different population groups, including black gay and bisexual men and transgender women, people who use drugs or are in recovery, veterans, and women, and with general populations in diverse settings, such as Neighborhood Planning Units, the Alpharetta Public Library, and a church health fair. Two rounds of online surveys were distributed, one to identify key objectives, and one to assist in prioritizing them.

Implementation, Monitoring and Evaluation

Evaluation will require annual targets and metrics for measuring progress toward meeting objectives and implementing actions. During the process of building the Strategy, the Data and Evaluation team found that some data sources are entirely lacking or incomplete for measuring outcomes of objectives and actions. No baseline data are available for some objectives, while for others, including many of the social determinants data, are outdated and only available for selected populations (usually, persons receiving services supported by Ryan

White Part A funding). In these cases, development of data sources and accumulation of baseline data become action items. A full evaluation plan will accompany Phase III of the Strategy.

The Strategy to End AIDS in Fulton County: Objectives and Actions

Priorities of the Strategy to End AIDS in Fulton County

Setting and reevaluating priorities for the *Strategy* will be an ongoing process. Input for initial prioritization of objectives was obtained through community engagement sessions, face to face meetings with stakeholders and leaders providing direct HIV-related services and care, discussions with Task Force members and contributors, and responses to an online survey offered to Task Force contributors, the Metropolitan Atlanta HIV Health Services Planning Council (Ryan White Planning Council), the High Impact Prevention Program (HIPP) list serve, the HIPP Jurisdictional Prevention Planning Group, and employees working in HIV-related fields at Fulton County and the State of Georgia Department of Public Health. The Executive Committee was responsible for developing the initial Top Ten priorities listed below, based on this comprehensive input. Additional input from all communities will be collected and will assist in ongoing prioritization.

The following priorities are the guiding principles of this *Strategy*:

Stigma Kills. Don't Tolerate It.

Eliminate stigma and discrimination associated with HIV, sexual orientation, gender identity and expression, race/ethnicity, gender, socioeconomic status, and mental health and substance use disorders from our healthcare settings, faith communities, educational institutions, government institutions, media coverage, and from all policies and laws.

Make Care and Services Client-centered

Re-focus HIV services and care systems on the holistic needs of those being served to create compassionate environments that are culturally competent, customer service-oriented and where meaningful patient feedback matters.

Make it Easy to Get into Care Fast and Stay Healthy.

Eliminate health system barriers that make it difficult to get into care, stay in care, access life-saving medications, and reduce the virus to undetectable levels.

Everyone Should be Tested for HIV.

Provide free, routine opt-out HIV testing in all healthcare settings and jails, and coordinate targeted (or risk-based) HIV testing so that people at highest risk of infection always have easy access to free, safe, and confidential screening.

HIV is Preventable.

Provide PrEP/PEP for people without HIV, syringe services for injection drug users regardless of HIV status, immediate access to HIV treatment for PLWHIV, and condoms and lubricants for all.

No More Babies Born with HIV.

Link pregnant women to prenatal care, test all pregnant women for HIV, and treat all HIV positive pregnant women with ART to ensure that no babies are born HIV positive.

Education is HIV Prevention.

Require scientifically accurate, evidence-based HIV and sexual health education in schools so that youth learn skills to protect themselves against HIV and other sexually transmitted infections, and pregnancy.

Housing is HIV Prevention and Treatment.

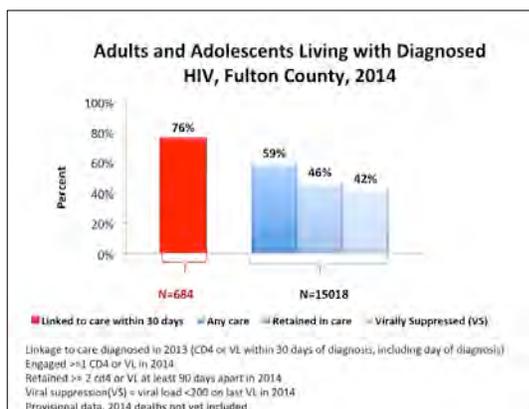
Provide immediate, barrier-free access to housing for PLWHIV who are unstably housed.

Mental Health and Substance Use Services are Care, Too.

Expand access to mental health and substance use services to prevent HIV transmission and improve care continuum outcomes.

Create Policies that Promote Health.

Close the current coverage gap that denies too many PLWHIV private insurance or Medicaid, advocate for adequate federal funding for HIV care and prevention, and reform HIV criminalization laws to further destigmatize HIV.



Achieving these priorities will require dramatic improvement in the “continuum of care” in Fulton County. Among all PLWHIV, the care continuum tracks, at a minimum, rates of serostatus awareness, linkage to care, retention in care, and viral suppression. Each of these landmarks is necessary to achieve optimal care outcomes and to decrease HIV transmission. The 2014 continuum for Fulton County, based on outcomes of persons diagnosed in 2013, shows three-quarters linked to care within 30 days (see definitions in the graph), 59% meeting minimal standards of engagement in

care over a year, only 46% being retained in care, and 42% being virally suppressed. Clearly, there is a dramatic drop off between linkage and retention, translating to approximately 8710 patients known to have HIV who are not optimally engaged in care.

Reflecting these priorities, new key Care Continuum objectives were selected.

- *Decrease the number of new HIV diagnoses by at least 25% (NHAS Indicator 2)*
 - Reduce disparities in the rate of new dx by at least 15% in the following disproportionately affected populations: young black gay and bisexual men, gay and bisexual men regardless of race/ethnicity, black females, transgender women (NHAS Indicator 9 adapted).
- *Increase the percentage of people living with HIV who know their serostatus to 90%. (NHAS Indicator 1)*
 - Decrease the proportion of people with AIDS at the time of diagnosis to <10%.
 - Increase identification of persons with acute HIV infection.
- *Increase the proportion of newly diagnosed persons linked to care, defined as attending a medical provider visit within three days of diagnosis, to 85%.*
- *Increase the number of people retained in care to 90% of those diagnosed (NHAS Indicator 5).*
 - Decrease the number of persons who are out of care by 50%.
 - Reengage individuals identified as out of care within 3 days of contact.
- *Increase the proportion of persons with diagnosed HIV who achieve HIV RNA levels <200 c/mL to 80% (NHAS Indicator 6).*
 - Increase the proportion of persons with diagnosed HIV who achieve continuous HIV RNA levels <200 c/mL to 80%.
 - Decrease the time from HIV diagnosis or reengagement in care to viral suppression to an average (mean) of 6 months

Increasing serostatus awareness will likely result in increased numbers of new diagnoses before decreases are seen. Our aim is to decrease the number of new HIV diagnoses by at least 25% by 2020, and reduce disparities by at least 15% in young black gay and bisexual men, gay and bisexual men regardless of race/ethnicity, black females, and transgender women, although we do not yet even have a good baseline for transgender women. We also aim to increase serostatus awareness to 90%. A concentrated effort to implement routine opt-out testing and to target testing more effectively toward disproportionately affected populations and high prevalence geographic areas will be required to

achieve this end. Saturation of testing will decrease rates of persons with AIDS at the time of diagnosis (to less than 10%), currently estimated at approximately one-quarter of new diagnoses, but higher in most vulnerable populations such as at the Grady Hospital Emergency Department where, in 2014, half of new diagnoses had AIDS. (Unpublished data GDPH, 2016)

Among the most challenging of the objectives are those that seek to link newly diagnosed or out of care patients to a medical provider visit within 3 days of diagnosis or contact with an out of care person. Attaining this objective will require entirely reevaluating and revamping current systems for care linkage and entry. Decreasing the number of out of care persons by 50% will bring as many as 4,400 additional patients into the care system. The objective for retention in care seeks to more than double the current rates of retention to 90% of those diagnosed. Achieving these last two objectives alone will require substantial expansion of health care system capacity, and increased numbers of care providers of all types. Achieving 80% viral suppression, especially 80% continuous viral suppression, will require changes in care systems to facilitate continuous access to antiretroviral drugs without interruption due to barriers in AIDS Drug Assistance Program (ADAP) recertification, inability to cover drug cost sharing, or delays due to prior authorization or quantity limits. Accomplishing all of this will greatly decrease the number of people progressing to and dying from AIDS, reduce community viral load, and, in turn, decrease new infections.

Cross Cutting Objectives

As the Task Force gathered data through community engagement sessions, stakeholder meetings, and conference calls about HIV testing, prevention, and care; mental health and substance use services; housing; incarceration; education; stigma; and areas relating to other social determinants, certain themes emerged consistently and passionately. These themes are addressed in the form of cross-cutting objectives that apply to all subsequent topics of the Strategy.

We Must Create Welcoming Clinics Through Cultural Sensitivity, Competence, and Customer Service

- *Create welcoming HIV services by increasing the cultural sensitivity and competence, and customer service orientation of staff working throughout the continuum of HIV testing, prevention, linkage, and medical, substance use and mental health care.*
 - *Survey current status by assessing client satisfaction and perception of stigma at testing, prevention, and care sites.*
 - *Engage AETC and external providers to deliver ongoing cultural competence and customer service training for administrators and all HIV testing, prevention, linkage, DIS, medical clinic, substance use and mental health staff.*
 - *Ensure training is integrated with anti-stigma training to reduce homophobia, transphobia, racism, classism, sexism, HIV-associated and other forms of stigma and discrimination.*
 - *Utilize mechanisms for ongoing feedback from service recipients to assure quality of service delivery.*
 - *POLICY: Include language requiring cultural competency and sensitivity and anti-stigma training in Fulton County contracts.*

Cultural competency is defined as the ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one's own, based on various factors. (Tapscott, 2002) PLWHIV are not a homogenous group, yet often are stereotyped, leading to stigma, discrimination, marginalization of already vulnerable populations, and poorer health outcomes. At the same time it is important to understand and respect cultural differences, whether they are based on sexual identity or orientation, gender identity or expression, age, race, ethnicity, spoken language, gender, religion, or socioeconomic status. Ensuring that HIV prevention, care and treatment services are infused with cultural competency and cultural sensitivity to diverse communities will likely improve health outcomes and certainly create welcoming healthcare spaces. Related and equally important is attention to a framework of customer satisfaction throughout the care continuum and related services.

Creating a more culturally competent and client-centered care system begins with assessing satisfaction and perception of stigma by current clients to understand successes and opportunities for improvement. This should be a continuous conversation with a plan for evaluation and timelines with accountability for implementation of improvements. Confidential feedback mechanisms such as digital applications and online surveys (such as Press-Ganey) should be considered. The Georgia AIDS Education and Training Center (AETC), as well as external providers, will be responsible for offering a curriculum for cultural competency and

customer satisfaction through an anti-stigma lens, and incorporating HRSA health literacy modules. A comprehensive effort is needed to educate all staff at sites that are providing services for HIV testing, prevention, linkage and reengagement, medical care, substance use and mental health services. It is important that all staff, including those providing intake services, transportation services, navigation services, or janitorial services, should be included in these trainings. In addition including a requirement for cultural competency and sensitivity training with an anti-stigma framework in Fulton County contracts would strongly advance the County's stated commitment to equality regardless of "race, color, religion, sex, national origin, sexual orientation, gender identity, ancestry, age, disability and genetic information," as stated in a Resolution unanimously adopted by the Fulton County Board of Commissioners, on June 15, 2016.

We Must Embrace Meaningful Involvement of People Living with HIV/AIDS

- *Ensure that people living with HIV (PLWHIV) are involved in substantial ways in all aspects of program planning, development, implementation, and evaluation for HIV testing, prevention, and care in Fulton County, and on the Fulton County Task Force on HIV/AIDS.*
 - Ensure that FCDHW includes PLWHIV and disproportionately affected populations in decision-making about potential funding opportunities and the design and implementations of programs for HIV testing, prevention, and care.
 - Embrace the Denver Principles in the creation of all programs involving PLWHIV.
 - Include PLWHIV in staff training activities at agencies and clinics in Fulton County.
 - Solicit ongoing feedback from PLWHIV who receive services at agencies and clinics.
 - Create HIV-friendly and stigma-free workplaces, including by hiring PLWHIV.
 - Create funded leadership opportunities for PLWHIV.
 - Create funded speakers' bureau of PLWHIV.

Ensuring meaningful involvement of people with HIV/AIDS serves as a foundational principle of this *Strategy to End AIDS in Fulton County*. The Task Force facilitated a series of public meetings and listening sessions with various communities and the theme of meaningful involvement of PLWHIV presented itself repeatedly, leading to the development of this objective and the recommended actions outlined above. With more than 55,000 people living with HIV/AIDS in the State of Georgia, and two thirds of those living within Fulton County, it is essential to incorporate meaningful involvement of people with HIV/AIDS (MIPA) as a core principle of any *Strategy to End AIDS* here at home. Documents of the Joint United Nations Programme on HIV/AIDS (UNAIDS) lay out principles that uphold the rights and responsibilities of PLWHIV, including the right of self-determination and participation in decision-making processes that affect their lives (UNAIDS, 2007). These documents echo the Denver Principles of 1983 that boldly affirmed the rights of people with AIDS. (Denver Principles, 1983) FCDHW should embrace the Denver Principles and adopt strategies for involving PLWHIV in all aspects of HIV program development. As PLWHIV are the only subject matter experts on their own experiences, client-centered programs that involve PLWHIV meaningfully increase their acceptability and effectiveness. Neither public health leaders, researchers, government officials nor other community members should create policies, programs, or actions without the meaningful participation of these subject matter experts. PLWHIV (as well as disproportionately affected populations) should be included in all aspects of planning, design, implementation,

and evaluation of programs for HIV testing, prevention, and care, and their feedback should be solicited to assess satisfaction and perception of stigma. In addition, agencies and clinics are encouraged to create HIV-friendly and stigma-free workplaces, including hiring PLWHIV. Funded leadership opportunities for and speakers' bureaus of PLWHIV should be created.

We Must Facilitate Access to Substance Use (SU)/Mental Health (MH) Services and Trauma-Informed Care

- *Improve access and linkage to mental health and substance use treatment programs for persons with HIV and those being tested for HIV.*
 - **POLICY: Require contracts for Fulton County behavioral health services, including substance use and mental health, to include offering routine opt-out HIV testing, and establishing an HIV linkage to care plan including designated liaison with HIV care facilities.**
 - Include information about SU/MH providers, especially those providing Medication Assisted Treatment on centralized Resource Hub.
 - Establish designated liaison between mental health/substance use treatment agencies and HIV care providers.
 - Increase routine screening for SU/MH by providers using screening tools for non-SU/MH professionals (such as Substance Abuse Mental Illness Symptom Screener (SAMISS))
 - Create infrastructure for assessing severity of illness at various points along care continuum.
 - Encourage co-location of SU/MH services with HIV medical services where possible.
 - Work with housing providers to allow access to housing for persons with substance use disorders.
 - Expand access to substance use and mental health services through telemedicine.
 - Assess current status and increase incorporation of trauma-informed care into substance use/mental health services.
 - Increase infrastructure for HIV care among persons with severe mental illness.

Addressing behavioral health concerns is essential to a comprehensive biopsychosocial service delivery strategy across the HIV continuum of care. Given the psychosocial stress burden of HIV disease, along with neuropathology associated with its central nervous system impact, prevalence of co-occurring mental health conditions is high, approximating 50% in both nationally representative and primary care HIV samples (Bing, 2001; Del Guerra, 2013; Gaynes, 2008; Treisman, 2004). Additionally, HIV prevalence among individuals with psychological disorders is significantly higher than that of the general population, as many of these individuals, particularly those with severe mental illness, are especially vulnerable to engaging in behavior that increases their risk of HIV infection (Blank, 2014). Left untreated, psychological co-morbidities are associated with compromised outcomes for HIV primary care access, medical adherence, retention in care, disease progression, and overall HIV-related health (Gonzales, 2011; Leserman, 2008; Treisman, 2004). For these reasons, behavioral health services are integral to optimizing clinical outcomes across the continuum of HIV health service delivery, and play a critical role in enhancing quality of life and emotional well-being (Farber, 2012; Treisman, 2004). Behavioral health services also contribute to treatment as prevention strategies aimed at reducing new infections by supporting efforts to retain individuals in care and sustain viral suppression. As such, a key *Strategy* objective that cuts across the HIV continuum is to improve access, linkage, and provision of mental health and substance use intervention for individuals being tested for HIV and for individuals living with HIV.

Action plans for addressing SU/MH along the HIV care continuum and for HIV prevention include a contractual obligation to offer routine opt-out HIV testing in all Fulton County behavioral health services programs and to establish a liaison mechanism to facilitate coordination of services between behavioral health providers and HIV care providers to facilitate service linkage and coordination of care. Because all clients and patient should be screened for SU/MH disorders, it will be important to identify and adopt a process for routine screening by providers who are not SU/MH experts. These individuals will need to be trained to offer initial screening and determination of intensity of intervention required, including determination of when referral is needed to SU/MH treatment specialists. As co-located SU/MH services may improve HIV outcomes, health systems and clinics are encouraged to explore the development of infrastructure to support care environments that integrate behavioral health services with HIV services. Due to a shortage of SU/MH care providers, developing infrastructure to support SU/MH service provision using telemedicine models of care are of high interest. HIV service programs should receive training on strategies for engaging and retaining persons living with severe mental illness in HIV care. Because vulnerable populations often are unstably housed, it will be essential to evaluate policies and procedures for housing placement for PLWHIV and co-occurring mental health or substance use disorders to optimize housing access for these individuals. Ensure that a centralized Resource Hub, whether at Fulton County or through the Georgia DPH CAPUS program, includes a listing of mental health and substance use providers, including those providing medication assisted therapies for persons with injection drug use.

Additionally, recognizing the role of injection drug use in HIV transmission, the Task Force has identified specific objectives for HIV prevention in persons who engage in injection drug use (people who inject drugs; PWID). (See Prevention with PWID)

- *Integrate trauma-informed care principles and practices into prevention and clinical services.*

Persons living with HIV also are disproportionately affected by past or current experiences of psychological trauma. These experiences can adversely affect health and health-related behavior, including HIV transmission risk behavior, adherence to medical treatment, and overall HIV treatment outcomes (Brezing, 2015). For these reasons, successful HIV prevention and treatment efforts must take into account the intersection of trauma with HIV disease by adopting principles of trauma-informed care. Trauma-informed care ensures that institutional cultures and health care environments take into account the potential and actual impact of trauma on individual adaptation to HIV and how they interface with health care systems. A trauma-informed care approach focuses on creating healthcare environments that are welcoming and safe spaces, ensuring that proper screening for trauma and its psychological and behavioral sequelae is included as part of the standard of care for HIV treatment, and ensuring that resources are available to provide trauma-specific clinical services for those who need them or mechanisms for linkage to community resources that provide services and support for trauma-associated concerns and needs (Brezing, 2015).

The initial step toward implementing a trauma informed care framework involves assessing the degree to which current HIV testing, prevention, and care programs in Fulton County are incorporating this approach. Based on this assessment, strategies for implementing trauma-informed care should be developed and implemented, including trainings, developing standardized methods for trauma screening, and implementation of protocols for linkage to trauma-specific services for those needing such intervention as part of their comprehensive HIV care.

We Must Increase Community Awareness and Education About HIV

➤ Increase community awareness and education about HIV in Fulton County

- Create and implement a multi-media 5-year community awareness and education plan focusing on HIV prevention and treatment, using a sexual health and wellness and an anti-stigma framework, and grounded in the experience of PLWHIV. Social media should be emphasized.
- Involve professionals from marketing and advertising to help craft messages, but ensure that disproportionately affected populations and PLWHIV from diverse backgrounds are involved at all stages of conception, design and implementation, and that messages are scientifically sound and approved by PLWHIV.
- Create a funded Ambassadors Program and/or Speakers' Bureau of experts, including PLWHIV and individuals from disproportionately affected populations, to provide education for schools, businesses, faith institutions, and community gatherings.
- Engage and educate local media to encourage scientifically accurate coverage of issues pertaining to HIV/STI/viral hepatitis/TB.
- Provide Spanish translation of materials and programs.

Sessions with community and other stakeholders identified an ongoing need for increased community awareness and knowledge about the basics of HIV transmission, prevention, and treatment. They noted that a diverse representation of PLWHIV and persons from disproportionately affected populations must be involved in the planning and implementation of these programs to ensure success, and that programs should be coordinated such that messaging is scientifically accurate, consistent across campaigns, and approved by PLWHIV. Further, the timing of campaigns should be coordinated such that there is always some form of messaging that is active at all times. Engaging groups of PLWHIV (such as Undetectables Atlanta) and key populations of gay, bisexual, and transgender youth (such as the Ballroom community) to become Ambassadors and Speakers Bureau participants, will be helpful in getting messages to target populations. Communities often commented that they found messaging to be stigmatizing, or simply not appealing to young populations. Social media should be especially targeted. In addition, education of local media, including print-based and electronic, should be ongoing to assure that reporters and writers receive and understand scientifically accurate information. Spanish translation of all materials is needed.

We Must Address Structural Issues Affecting Healthcare Access and Delivery

➤ Expand access to medical care for PLWHIV

- **POLICY: Expand Medicaid to improve access to care for PLWHIV and those at risk.**
- **POLICY: Advocate for increased funding of the Health Resources and Service Administration's Ryan White HIV/AIDS Program, CDC's HIV/STI/Viral Hepatitis/TB prevention programs, and**

Housing and Urban Development's Housing Opportunities for Persons With AIDS (HOPWA) program.

- Expand access to premium, deductible, co-pay, and co-insurance through the Health Insurance Continuation Plan (HICP) for persons with HIV.
- Expand the ability of Ryan White clinics to accept private insurance plans, especially those through the Affordable Care Act Healthcare Marketplace.
- Increase accessibility of HIV medical services within underserved areas of high HIV prevalence.

While health care should be viewed as a priority for all persons, access to health care is a necessity for persons with HIV, more than most. HIV is still lethal if not treated. The Ryan White HIV/AIDS Program is a remarkable "medical home" for PLWHIV, and serves as our primary safety net in Georgia for patients without private insurance, or who qualify for Medicaid or Medicare. We must advocate vigorously for continuation and increased funding of Ryan White, as well as CDC prevention and HOPWA programs. Unfortunately, our state chose not to expand Medicaid, thus leaving a coverage gap estimated at 409,000 uninsured persons (48% of whom are Black, 6% Latino/Hispanic) who would have been covered by an expanded Medicaid program. (Kaiser Family Foundation, 2014) While Ryan White pays for antiretroviral therapy (ART) through ADAP, it does not provide other needed drugs, such as those for common comorbidities such as diabetes. Studies have shown that hospitalized patients with HIV are 40% more likely to die if they are uninsured compared to those with insurance. (Hellinger, 2016) Purchasing insurance through HICP is viewed as cost-effective for Ryan White programs, and ADAP funding is allowed to pay for premiums and cost sharing for these plans. Georgia's program should be expanded with full coverage of all patient costsharing regardless of where the patient chooses to receive care. Because many health departments do not fully participate in private health insurance programs, they are unable to reap the benefit of receiving payment for care, and their patients must seek other providers when they obtain insurance. Fulton County, for example, cannot bill for services when it sees a patient in the STD clinic who has private insurance. Developing systems to allow third-party billing should be a priority for Fulton County, as it will also provide financial support to further expand clinic services. Finally, location of HIV medical services within high HIV prevalence areas should be explored.

- *Increase the HIV provider workforce and decrease attrition across testing, prevention, and care sites in Fulton County.*
 - Develop a workforce recruitment and retention plan to address provider and support staff shortages.
 - Provide greater flexibility in hours for HIV providers to attract and utilize part time staff.
 - Partner with Emory University School of Medicine and Morehouse School of Medicine to increase exposure to HIV medical care among medical students, residents, and physician assistant students, including rotations in HIV care facilities.
 - Partner with nursing schools to increase exposure to HIV care among nursing and nurse practitioner students, including rotation in HIV care facilities.

The diminishing HIV workforce adds to the challenges of meeting the goals outlined within the 2020 National HIV/AIDS Strategy. The current HIV medical workforce is largely composed of first generation HIV medical providers who entered the field more than 20 years ago. An

American Academy of HIV Medicine (AAHIVM) survey of its membership conducted in November 2008 revealed that roughly one-third of current HIV providers were in the last quarter of their careers and planned to retire within the next 10 years (US Department of Health and Human Services, 2010). At the same time, however, the number of PLWHIV is continuously increasing. A 2008 survey of Ryan White HIV/AIDS Program-funded clinics noted that 51% of clinics reported up to a 25 percent increase in caseloads, yet replacing the aging HIV workforce has been challenging, with 69% of clinics reporting difficulty recruiting HIV clinicians, citing low reimbursement and a lack of trained providers as leading causes (Weddle, 2010). Over the past 7 years, the number of trainees entering fellowship in Infectious Disease has declined each year, with the most recent data showing more than 57% of training programs not filling all their training slots. Those not pursuing specialty training are ill-prepared to be primary HIV providers. In 2004, the HIV Medicine Association (HIVMA) conducted a survey of 729 first-year medical residents in Internal Medicine programs in ten states with the highest HIV prevalence. Fifty-one percent felt their residency had not prepared them to practice HIV medicine. Patients living in rural areas are at even greater risk of not being able to access convenient skilled care. In 2010, six counties in Georgia had no family medicine physician, 31 counties lacked an internal medicine-trained physician and 63 had no pediatricians in the county (Georgia Board for Physician Workforce, 2010).

The current health care workforce requires an increase in the capacity of providers to offer skilled, culturally competent, quality care that is sufficient to meet the widening gap between supply and demand of HIV care. Without appropriate workforce capacity building, clinics that serve PLWHIV may be forced to reduce services, increase visit wait times, cut back clinic hours, and even close. It will be necessary to devise a strategy to recruit, train and retain a provider workforce that includes both primary providers (MDs, nurse practitioners, and physician assistants) as well as nurses and pharmacists trained in HIV/AIDS care. This will require a commitment to and advocacy for adequate reimbursement, estimation of appropriate caseloads, and adequate staffing so that a provider's capacity to care for patients will not be exceeded, allowing them to remain customer service oriented, and limiting burnout. Creative solutions to allow for part-time schedules, job-sharing and other workplace accommodations are necessary. For those working in clinics within a larger healthcare system, clear guidance may be required to advocate for these changes given that HIV clinics, while serving a critical purpose, are often not seen as revenue generating growth opportunities. In addition, incentives for HIV providers to work in rural areas are needed as well as telemedicine training opportunities for rural providers. The Georgia AETC can play a critical role in enhancing training opportunities for these low volume providers. As research has shown that HIV infected patients do better when treated by experienced HIV providers (O'Neill, 2015), teleconsultation to aid in therapeutic decisions rather than solely as a training mechanism may be helpful.

Experience in HIV care during training (medical school, residency, PA and nursing schools) not only increases trainee preparedness to care for patients at the completion of training, but also is critical to develop interest in further specialization in HIV care. Trainees without specific HIV exposure are highly unlikely to pursue this as a career. While in some settings within the 20 county Atlanta Eligible Metropolitan Area there is robust exposure for trainees, attention must

be paid to maximizing both the amount of exposure to HIV care, including rotating in HIV care facilities, and the quality of that experience. Training institutions, including the GA AETC, should work together to optimize these experiences.

- *Improve communications among healthcare providers across and within healthcare systems to enhance continuity of care for persons with HIV.*
 - Create mechanisms to share data from CAREWare Part A and B across all Ryan White Clinics in Georgia to allow tracking of patients who are linking to care or moving from one care facility to another.
 - Create a secure online repository for patient-level documents required to qualify for Ryan White, AIDS Drug Assistance Program (ADAP), Health Insurance Continuation Program (HICP), housing and other necessary services.

Continuity of care is important, even - perhaps especially - during the initial care linkage process. At present, metro Atlanta Ryan White clinics are only able to access their own clinical data through Part A CAREWare, the Ryan White clinical database used by all clinics. The Ryan White Part A Grantee is working to expand this access, as all clinics expressed frustration with this limitation. The Part A CAREWare server is housed at Fulton County. Clinics that are funded through Part B (mostly, but not entirely, outside of metro Atlanta) use CAREWare that resides on an entirely separate server, housed at the state DPH). Because there is constant churn among Part A clinics, but also between Part A and B clinics, sharing of clinical data between these clinics CAREWare systems should be facilitated in a systematic way rather than by the current case-by-case approach. Collaboration between DPH and the Part A Grantee will be required to solve this problem, but both patients and clinics will benefit.

Access to information is crucial for communities, patients, and providers of care and services. Community and stakeholder sessions consistently pointed out the need to provide a secure, HIPAA-compliant, online repository for patient-level documents and data needed to qualify for multiple services including Ryan White programs, ADAP, pharmaceutical industry patient assistance programs, HICP, and housing assistance. This will decrease duplication of effort and shift the burden of document collection away from vulnerable patients who may not have any secure location in which to store birth certificates, wage statements, and other materials. It will facilitate coordination of services for vulnerable populations and enhance rapid clinic entry and rapid and continuous access to ART.

HIV Testing

Knowledge of HIV Status

- *Increase the percentage of people living with HIV who know their serostatus to 90%. (NHAS Indicator 1)*
- *Decrease the proportion of people with AIDS at the time of diagnosis to < 10%.*

CDC estimates that 18.7% of Georgians who have HIV are not aware of their infection, thus are not getting care for themselves and are continuing to transmit HIV to others. For gay and bisexual men, this number is estimated to be 20.4%. (Hall, 2015) Based on these models,

approximately 3000 people are likely to be undiagnosed in Fulton County alone. The primary interventions for testing are routine opt-out testing in healthcare settings, as recommended by CDC a decade ago (Branson, 2006), and targeted testing aimed toward disproportionately affected populations. "Partner services" was once interpreted only as "contact tracing," or locating partners for testing, but should be broadened to offer prevention services to individuals at highest risk. Because of overlapping populations and worse outcomes associated with co-infection, persons with HIV should be offered testing for sexually transmitted infections, viral hepatitis, and tuberculosis (TB) and those being tested for these entities also should be offered screening for HIV.

The CDC-funded High Impact Prevention Program (HIPP) at FCDHW had its best year in 2015, conducting 61,000 screenings, including 33,000 by community-based organizations and health departments (an increase of 40% over the previous year), and over 20,000 in clinical healthcare settings.

Routine Opt-Out Testing in Healthcare Settings

- *Ensure that patients admitted to hospitals or jails, and treated at emergency departments and outpatient clinics in Fulton County are offered routine opt-out HIV screening in compliance with CDC and USPSTF recommendations.*
 - **POLICY: Establish county policies requiring routine opt-out HIV testing in all healthcare settings under the jurisdiction of Fulton County, including jails and behavioral health services.**
 - Provide training to hospital, jail, and clinic staff to institute routine opt-out HIV screening within their facilities.
 - Establish rapid linkage to care mechanisms for facilities instituting routine opt-out HIV screening.
 - Create data systems for monitoring and evaluation of routine opt-out screening in health care facilities.
 - Implement routine opt-out screening at
 - Federally Qualified Health Centers and Community Health Centers.
 - Substance use and mental health treatment facilities.
 - Internal Medicine, Family Practice, and OB-Gyn private practices.
 - Urgent care clinics.

A substantial amount of HIPP clinical aggregate testing was accomplished by sites previously funded by Gilead Sciences as HIV FOCUS Projects. The primary objective of the FOCUS Program was to make HIV testing a routine part of medical care. The development of collaborative partnerships to extend or expand FOCUS projects at Grady, Emory and Mercy Care, where Gilead funding had been discontinued or reduced in 2015, was responsible for nearly one third of all tests performed. Each of these agencies operates high volume clinics and each serves a large proportion of the jurisdiction's most vulnerable populations who are at high risk for HIV infection. In August 2015, Grady Healthcare and Mercy Care each received carryover funding to continue clinical testing. Emory received funding to do the same in October 2015. Altogether, these agencies were contracted by HIPP to conduct more than 10,000 tests in total, but by the end of 2015, they reported testing double this amount. These programs should be continued and expanded in the future, while directing additional

attention to linkage mechanisms to assure that all diagnosed patients are linked to care within 3 days.

Agency	#Target	#Tests	Balance	% Completed
Emory	3,000	5,671	(2,671)	189%
Grady	5,000	13,032	(8,032)	260%
Mercy Care	2,500	1,376	1,124	55%
TOTALS	10,500	20,079	(9,579)	191%

Routine opt-out testing in the Fulton County jail using a nurse-led program, also previously funded by FOCUS, was effective in identifying large numbers of HIV positive persons who were previously undiagnosed or out of care. (Spaulding, 2015) Fulton County jail seroprevalence was 2.13% and, over a 12 month period ending in 2014, 17,035 persons accepted testing, resulting in 458 linkages to care, including 89 persons who were newly diagnosed. Programs offering routine opt-out testing and HIV education on medical intake upon entry to Fulton County and City of Atlanta jails should be funded and evaluated.

In 2015, the Task Force recommended that FCDHW offer routine opt-out testing within its ambulatory clinics. Official policies should be established to ensure implementation of this recommendation, and a monitoring and evaluation plan should be established by FCDHW and HIPP. Providing rapid linkage to care and care engagement will be a key component to ensure the success of this activity. Federally Qualified Health Centers (FQHCs) in Fulton County and metro Atlanta serve hundreds of thousands of patients and could be major contributors to the effort to identify persons with HIV and help them get into care. Additionally, urgent care clinics are increasingly used by persons who are not established in medical care, especially young people, and routine opt-out screening in these settings, particularly in high prevalence geographic areas, should be explored. Because of outsourcing of behavioral health services, the Task Force recommends that Fulton County require routine opt-out HIV screening along with cultural competency training as a contract deliverable for its behavioral health services contracts.

Adequate linkage to care services are essential for healthcare-based HIV screening. As Fulton County re-invents its linkage services, high-volume testing sites should have designated linkage resources and teams, and time from diagnosis to a medical appointment should be monitored.

- *Incorporate HIV and Sexually Transmitted Infections (STI) screening into school-based health programs in Fulton County and City of Atlanta high schools, as well as colleges and universities in Fulton County and City of Atlanta.*

- Offer HIV/STI screening and education within school-based health programs in Fulton County.
- Offer HIV/STI screening and education within student health services in City of Atlanta high schools.
- Provide external opportunities for HIV testing at City of Atlanta and Fulton County high schools, and colleges and universities in Fulton County.
- Train staff at student health services in HIV/STI testing, basic HIV/STI education, confidentiality and disclosure, providing access to HIV/STI linkage services, and cultural competency.
- Create tailored linkage to care services for students diagnosed with HIV/STIs through high school student health services and externally offered HIV/STI testing services.

Because youth aged 20-29 represent the highest number of new HIV diagnoses, and because too many people are being diagnosed late, after substantial deterioration of the immune system, even to the point of having AIDS, it is crucial to increase awareness and HIV testing among high school students. Offering testing to high school students through school-based health programs and student health clinics not only provides an opportunity for early identification of undiagnosed youth, but also establishes a mechanism for confidential ongoing evidence-based education about HIV, STIs, viral hepatitis, and prevention opportunities. This will require the support of Boards of Education and the education of parents, as well as training student health staff to provide HIV/STI/hepatitis C virus (HCV) testing and education, including reevaluating vaccination status for Hepatitis A and B. Any youth who receives an HIV diagnosis also should receive intensive and culturally competent linkage services with rapid entry to care.

- *Increase identification of, and rapid linkage to care for persons with acute HIV infection.*
 - Educate care providers and community members to recognize symptoms of acute HIV infection.
 - Create mechanisms to ensure priority rapid linkage to care, Rapid Entry, and Rapid Start of antiretroviral therapy within 72 hours of diagnosis of acute infection.
 - Develop surveillance systems to quickly identify acute infection based on 4th generation HIV testing.

Acute HIV infection is a time of high infectivity due to extremely high HIV viral loads. Persons with acute HIV infection are often unaware of their serostatus, although some may have classic symptoms of a “viral syndrome.” The shift to 4th generation antigen-antibody testing means that HIV infection can be diagnosed earlier than with 3rd generation antibody-only tests. This offers an important opportunity to identify acutely infected persons and offer them highest priority rapid linkage to care and rapid start of ART, as well as an array of other services that they need, including housing, SU/MH services, and assessment for other co-infections. Surveillance systems need to be developed to rapidly identify such persons and ensure communication to public health jurisdictions in order to provide timely and culturally competent services.

Targeted Testing for Disproportionately Affected Populations in Non-healthcare Settings

- *Ensure that 90% of targeted HIV testing is directed toward disproportionately affected populations and high prevalence geographic areas.*
 - Create an ongoing collaborative planning system among funded and non-funded agencies to coordinate targeted testing, including sharing of strategies and data and incorporation of geomapping.

- Create a metro-wide geomapping group that will produce monthly maps of HIV testing activities, new HIV diagnoses, and newly diagnosed acute HIV infections, to facilitate targeting of HIV testing and prevention services toward high prevalence geographic areas.
- Create systems for confidential real-time mapping of new HIV diagnoses, location of testing services, prevalence at each testing site.
- Require participation of entities funded by or through Fulton County (including HIPP and Behavioral Health and Developmental Disabilities).
- Engage CDC to require data sharing by directly funded CBOs and require coordination with HIV testing programs funded through FCDHW.
- Invite academic partners providing HIV testing as part of research studies to participate [Emory, GSU, Morehouse School of Medicine, Morris Brown, GA Tech, Spelman, Morehouse College].
- Coordinate mobile testing unit activities [Fulton County, Someone Cares, AIDS Healthcare Foundation, Mercy Care] to target areas of high HIV prevalence.
- Offer HIV screening at pharmacies and urgent care centers in areas of high HIV prevalence as defined by geomapping.
- Seek input from disproportionately affected populations, including PLWHIV, regarding best venues and approaches for HIV testing.
- Provide HIV prevention programming tailored to the unique needs of sex workers, including education on HIV transmission routes and risk, and information on how to access prevention technologies, such as condoms and PrEP.
- Standardize protocols among agencies conducting HIV testing.
- Train targeted HIV testing providers funded through Fulton County to conduct couples' counseling and testing.
- Provide access to home-based testing for persons at high risk for HIV and unlikely to present for HIV testing.
- Develop client feedback mechanism to obtain information about their experience with funded providers.

While testing numbers funded by HIPP increased substantially in 2015, the proportion targeted toward highest risk populations remained suboptimal. Stakeholder meetings hosted by the Task Force identified the need to better coordinate targeted testing efforts, including sharing data in real time about ongoing testing activities and outcomes (especially among funded agencies), using geomapping to assess "hot spots" in need of more intensive testing activities, and providing specific direction to funded agencies about targeting of their testing activities. FCDHW's HIPP program has begun to organize such efforts.

Experts in geomapping from Emory University School of Medicine, Atlanta Regional Commission, and Fulton County participated in a Task Force-sponsored stakeholder meeting on geomapping and agreed to form a working group to advise on these issues. County-level HIV maps are increasingly being used to not only characterize the impact of sociocontextual variables on HIV care outcomes, but also to help inform and evaluate neighborhood-level outreach activities. (Goswami, 2012) A person's local neighborhood environment, encompassing his or her sense of safety, proximal access to site-specific HIV educational activities, testing services, transportation, and HIV care sites, is a key determinant of success in achieving viral suppression (Goswami, 2016; Eberhart, 2015; Dasgupta, 2015; CDC Care Continuum, 2014). Where an HIV-positive person resides may be as critical, if not more so, than

individual-level factors in the ability of a patient to connect to an HIV provider and stay in care (Eberhart, 2015). Characterizing the geographic clustering or “hot spots” of acute HIV infections, HIV-infected persons with either delayed or absent linkage to care, and those with significant viremia may facilitate better local interventions to test and link HIV-infected persons to care and to reduce local sources of ongoing viral transmission in the population.

Coordination of testing should include non-HIPP funded entities who offer testing, including those doing research studies through Emory, Georgia State University, Morehouse School of Medicine, Morris Brown and others; those conducting testing under other federal programs, such as agencies receiving CDC 15-1502 funds and those funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). PLWHIV should be integrated into this process. Stakeholders identified the need for standardized linkage protocols across agencies, training on couples’ testing and counseling, and institution of continuous customer satisfaction mechanisms to inform programs. Novel programs for access to home based testing should be explored.

- *Increase cultural sensitivity and competency of HIV testing providers working with disproportionately affected populations, especially young black gay and bisexual men and transgender populations.*
 - Require initial and ongoing cultural sensitivity and competency training for all employees of agencies receiving funding for HIV or STI testing, or Ryan White services.

Please refer to “Cross Cutting Issues” for further discussion of this issue.

Partner Services

- *Ensure that culturally competent testing, prevention education (including about PrEP/PEP), and linkage services are offered to sexual and needle-sharing partners of 95% of newly diagnosed persons and persons being reengaged in care.*
 - Require that all partner services staff receive ongoing cultural sensitivity and competency training, including HRSA health literacy training.
 - Explore implementation of online or text STI notification services [NYC Dept of Health, South Carolina; Florida].
 - Establish mechanisms for recipients of partner service interventions to give feedback about their experience.
 - Provide education for community, clinicians, and community-based organizations (CBOs) about partner services.

In 2015, 426 newly diagnosed clients were referred to FCDHW partner services, 73% of these were interviewed and named 1027 partners, or about 3.32 partners per index client. Theoretically, this strategy provides an excellent means of educating high risk individuals about HIV prevention, including PrEP and PEP. The emphasis of FCDHW partner services should shift from a “contact tracing” approach to a prevention services approach that includes offering testing for HIV, STIs, viral hepatitis and TB and PrEP/PEP education and PrEP referral and linkage. Community listening sessions strongly suggested that FCDHW partner services need mechanisms for continuously receiving feedback from clients who receive services, in order to improve the service experience. Ongoing cultural competency and sensitivity training and

adopting an anti-stigma framework were highly recommended by community and other stakeholders alike. Exploration of novel methods for delivery of STI results deserve attention, including online and text systems such as those used in New York City, South Carolina, and Florida. (Rodriguez-Hart, 2015; South Carolina Department of Public Health personal communication, 2016)

Program Collaboration and Service Integration: HIV, STI, Viral Hepatitis, and TB

- *Increase access to testing for other STIs, viral hepatitis, and TB in disproportionately affected populations being tested for HIV, and for HIV in persons with, and being tested for, STIs, viral hepatitis, and TB.*
 - Obtain resources to ensure that HIPP-funded entities also offer screening for syphilis, chlamydia, gonorrhea, hepatitis C, and TB.
 - Coordinate and collaborate with Metro Atlanta TB Task Force to ensure HIV testing is offered at all shelters and by outreach staff that offer TB testing.
 - Provide HIV education for shelter staff and shelter residents.
 - Provide Rapid Entry linkage to unstably housed persons testing positive for HIV.
 - Ensure that FCDHW STI clinic offers HIV screening to all persons presenting for STI screening, including referrals for PrEP for appropriate individuals.
 - Ensure that all persons with HIV/TB coinfection are provided immediate antiretroviral therapy (ART) unless TB meningitis is suspected.

In Fulton County, like most places in the county, funding for testing for HIV, STI, viral hepatitis, and TB occurs in different funding streams that sometimes overlap, but imperfectly. These silos are obstacles to providing the breadth of screening needed for persons with overlapping risk. Persons being tested for HIV may well be at high risk for STIs, or HBV/HCV, or TB, depending on their circumstances. Some coinfections actually worsen outcomes dramatically, such as the vulnerability of persons with HIV to contract TB, higher risk for serious TB outcomes in HIV coinfection, and the preventative effect of ART on preventing TB in persons with HIV. Likewise, HIV coinfection worsens progression to liver failure in persons with HCV. It will be important that groups focused on one of these infections should be cognizant of and cooperative with those who are working in related areas. For example, the TB Task Force has worked with HIV testing providers to ensure that persons being testing for TB in the midst of Fulton County's prolonged TB outbreak in homeless shelters also are offered HIV screening. Closing the gap among silos will require working with funders and fostering collaboration among agencies and health departments. Importantly, Fulton County can ensure that persons with HIV/TB coinfection receive immediate ART, as long as TB meningitis is not suspected, and that unstably housed persons with HIV receive priority for Rapid Entry to care. The FCDHW STI clinic serves a high volume of clients and also provides HIV testing to these individuals. With the institution of a PrEP clinic within the STI clinic, it will be important in the future that adequate training is provided to ensure that STI clinic staff are able to fully participate in HIV testing and prevention interventions, including offering and initiating PrEP. Close collaboration between HIV and STI leadership and staff will be essential to providing integrated services while being meticulous about complying with funding deliverables.

Preventing HIV Infection

- *Decrease the number of new HIV diagnoses by at least 25% (NHAS Indicator 2)*
- *Reduce disparities in the rate of new diagnoses by at least 15% in the following disproportionately affected populations: young black gay and bisexual men; gay and bisexual men regardless of race/ethnicity; black females; transgender women (NHAS Indicator 9 adapted)*

The integration of biomedical and behavioral approaches including the integration of care and prevention services now offer a unique opportunity for curbing the HIV epidemic. Engaging HIV-infected persons in care and prescribing them ART so that they control their HIV and become “undetectable” not only offers individual health benefits but also confers reduced infectiousness to others. This is true for transmission between sexual partners or injection drug using partners, and for mother-to-child transmission. For these reasons, the term “Treatment as Prevention” has been reconceived as “Treatment is Prevention” in order to emphasize both the individual and public health impact of ART provision and support. In addition, antiretroviral drugs are now an important way to prevent transmission of HIV to those who are HIV-uninfected but at risk. This strategy is known as pre-exposure prophylaxis (PrEP) when antiretrovirals are given to an HIV-negative person before a possible exposure and post-exposure prophylaxis (PEP) when given to an HIV-negative person after an HIV exposure to prevent infection. Ensuring that clinicians and public health practitioners work together to increase the proportion of HIV-infected persons who are virally suppressed on ART and making PrEP and PEP available to those uninfected but at risk are at the core of “Ending AIDS”.

PrEP and PEP

- *Ensure access to PrEP for eligible persons at high risk of HIV infection.*
 - Increase community awareness and education about PrEP, especially among disproportionately affected populations and in high prevalence geographic areas.
 - Increase awareness and knowledge of PrEP among care providers in Fulton County.
 - Ensure adequate staffing for the FCDHW PrEP Clinic.
 - Investigate opportunities for PrEP funding, including foundations, community fundraising, and government grants.
 - Create multiple access points for PrEP throughout Fulton County, including PrEP clinics in college and university health services, FQHCs, pharmacies, urgent care clinics, and community-based organizations. Partner with Grady Health System to create PrEP access in neighborhood health centers and among OB-Gyn, Internal Medicine, and Family Practice providers.

As the use of antiretrovirals has expanded beyond treatment of HIV infection, PrEP has been recognized as a critically important HIV prevention tool that, when used as directed, prevents HIV infection. However PrEP does not prevent other bacterial and viral STIs and thus should be considered as part of a “prevention package.” Several clinical studies have demonstrated that fixed dose combination of tenofovir plus emtricitabine (TDF/FTC; Truvada®) is highly effective for HIV-prevention against both rectal and vaginal exposures when used daily with high adherence (Grant, 2010 & 2014; Volk, 2015; McCormack, 2015; Baeten, 2012; Thigpen 2012). Although one study of intermittent PrEP among men who have sex with men demonstrated high levels of protection compared to placebo, there are insufficient data for

recommending intermittent dosing and the current CDC recommendation for daily dosing of PrEP must be followed.

The CDC has published guidelines for PrEP (CDC, 2014). Candidates for PrEP include persons from populations with an HIV incidence greater than 2% per year, HIV-negative persons with multiple sexual partners of unknown HIV serostatus, HIV-negative persons in a serodiscordant relationship with an HIV-infected partner who is not suppressed on ART, and persons who inject drugs and share needles. PrEP should not be prescribed to those with impaired kidney function (creatinine clearance less than 60 ml/min), and it should be used with caution in those with chronic hepatitis B or who have or are at risk for osteopenia/osteoporosis.

Since the FDA approval of Truvada® for PrEP in 2012, uptake has been suboptimal in cities like Atlanta where scale up is urgently needed. Multiple barriers to PrEP use in Fulton County have been identified including lack of community and provider awareness of PrEP or lack of knowledge of sites where PrEP is available. Lack of Medicaid expansion in Georgia also is a barrier. For uninsured persons, lack of financial support for medical visits and necessary laboratory monitoring for PrEP limits access, although the drug itself is available for free through pharmaceutical industry patient assistance programs. Stigma also becomes a barrier for some people, as the use of PrEP is sometimes viewed as a surrogate for promiscuity. Increasing community awareness and education about PrEP will require implementation of ongoing educational campaigns targeted to disproportionately affected populations in high prevalence geographic areas, as well as creation and maintenance of an up-to-date directory of PrEP clinics and providers. Although a national PrEP telephone line exists, integrating PrEP into the our local AIDS Hotline could provide locally relevant information. Education of providers about PrEP also will be important, and the GA AETC will participate in this effort. In particular, sexual and reproductive healthcare providers should be included. It is critical to increase linkages between sexual and reproductive healthcare with HIV care and prevention to ensure that PrEP is presented as an option to maintain one's sexual and reproductive wellbeing in a mixed HIV-status relationship or where a sexual partner's status is unknown. PrEP should be combined with comprehensive prenatal and perinatal care necessary for a mixed-status couple to safely conceive and complete pregnancy and childbirth without risk of transmission. PrEP additionally has a uniquely significant value for individuals who may be exposed to intimate partner violence as a medical tool that can be taken discreetly to prevent HIV exposure. Finally, expanding the clinical sites that are capable of providing PrEP and ensuring that they are adequately staffed will be critical in order for PrEP to have an impact on HIV infection in Atlanta. Opening PrEP clinics in college and university student health clinics, FQHCs, pharmacies, urgent care centers, and community-based organizations could dramatically increase access to PrEP. Partnering with Grady Health Systems could facilitate introduction to PrEP in neighborhood health centers and through Internal Medicine, Family Practice, and Obstetrics-Gynecology care providers.

- *Ensure access to PEP for eligible persons following occupational or non-occupational exposure to HIV.*
 - Educate the community about the difference between PrEP and PEP, including how and when to access PEP.

- Create and maintain an online, regularly updated registry of PEP access points.
- Increase awareness and knowledge of PEP among care providers in Fulton County, especially those in emergency departments, urgent care settings, and private practices.
 - Conduct ongoing education and cultural competency training for Grady Emergency Department staff, and those of other Emergency Departments to encourage prescribing of PEP.
 - Share protocol and computerized order set templates for use in hospital emergency departments.
 - Create and maintain an online PEP Resource Hub for providers, including national guidelines, protocols for prescribing PEP, educational materials for providers and patients, and links to provider resources and live technical assistance.

Post-exposure prophylaxis (PEP) is useful to abort HIV acquisition in the event of occupational (i.e. needlestick or mucous membrane) or non-occupational (sexual or injection drug use) exposures to HIV-infected blood or body fluids. A retrospective study published in 1997 looking at AZT monotherapy for PEP estimated efficacy at about 81% (Cardo,1997) but few other clinical studies, and no placebo controlled trials of efficacy or effectiveness have been conducted. PEP should be administered as quickly as possible after exposure, and the majority of guidelines recommend use only within 72 hours of exposure (CDC, 2016). Baseline assessments should include HIV testing (ideally antibody/antigen combination test), STD testing, pregnancy testing for women of childbearing potential, and hepatitis B and C serostatus. The CDC recommends TDF/FTC + twice daily raltegravir or once daily dolutegravir; TDF/FTC with cobicistat or ritonavir-boosted darunavir or the fixed dose combination of TDF/FTC/COBI/EVG are reasonable alternatives (CDC, 2016). PEP regimens should be continued for 28 days, and HIV status reassessed 4-6 weeks, 3 and 6 months post exposure. Persons who request PEP repeatedly are candidates for PrEP.

For non-occupational PEP to be expanded in Atlanta we will need to educate the community about how and when to access PEP and providers (especially in emergency departments and urgent care clinics) will need education on PEP. The up-to-date directory and hotline for information mentioned for PrEP will also be useful for PEP.

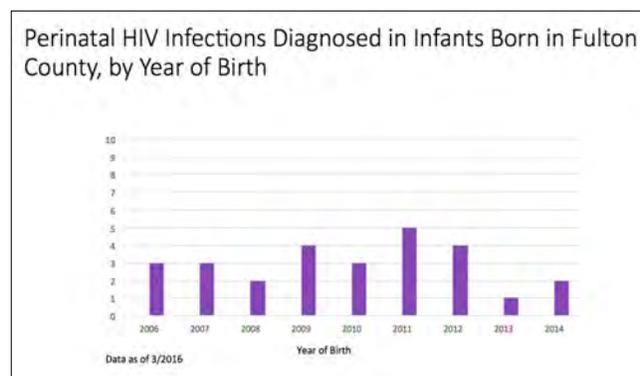
Perinatal Transmission

➤ Eliminate perinatal transmission in Fulton County.

- Evaluate and meet staffing needs required to provide comprehensive perinatal prevention and services for HIV-infected pregnant women.
- Increase collaborations with medical provider societies, especially in obstetrics and gynecology, to ensure that all obstetricians and obstetric nurses receive training in the care of HIV positive pregnant women.
- Increase HIV prevention campaigns directed at practicing obstetrician and obstetric nurses in Fulton County and surrounding counties.
- Increase enforcement of the Georgia HIV/Syphilis Pregnancy Screening Act of 2015.
- Explore expanding the HIV Health Information Exchange to identify out of care pregnant women with HIV when they present for obstetric care at Grady.

Few things in HIV are as clear-cut as prevention of mother-to-child transmission, and the objective of eliminating perinatal transmission in Fulton County is eminently achievable. In the early 1990's the National Institute of Allergy and Infectious Diseases (NIAID) AIDS Clinical Trials Group (ACTG) 076 study was published. ACTG 076 results proved that providing ART to HIV positive pregnant women during their pregnancy and labor and then treating their newborns after delivery significantly reduced the risk of HIV transmission from the mother to the baby. Despite this decades-old breakthrough, between 2006 and 2014, 27 babies in Fulton County were born infected with HIV. It is estimated that each HIV infection averted would save \$326,500 - \$355,000, not including the cost of secondary transmissions. (Schackman, 2015; CDC HIV Prevention, 2015)

In order to eliminate perinatal HIV transmission in Fulton County a collaborative effort among medical providers, professional provider organizations, hospitals and the community is needed. Staffing needs for providing comprehensive perinatal prevention and services for HIV-



infected pregnant women should be evaluated and deficits addressed to provide adequate full-time staffing. Medical providers and hospitals must be held accountable for following the Georgia HIV/Syphilis Pregnancy Screening Act of 2015 which requires any health care provider that assumes care for a pregnant woman to offer HIV testing in the third trimester. Ensuring that every pregnant woman is aware of her HIV status at the

time of pregnancy diagnosis and during the third trimester is a critical step in preventing mother-to-child transmission. All pregnant women with HIV should be provided antiretroviral treatment during the pregnancy, to be continued life long. Through direct outreach and collaboration with professional societies, every obstetrics care provider in the county must be educated about proper screening for HIV and treatment of women with HIV. Outreach to obstetricians and obstetric nurses in surrounding counties is also essential, as patients delivering in Fulton County sometimes do not live or receive prenatal care here. Physicians and nurses must also be made aware of specialized care for women with HIV that is available in Fulton should they decide to make a referral to another provider. In addition to medical providers and hospitals, community-based organizations could assist in providing education and outreach to women of childbearing age during encounters for testing and prevention services, and especially pregnant women. The existing DPH HIV Health Information Exchange (HIE) identifies HIV positive persons who are out of HIV care but presenting for other medical care. The HIE at Grady should explore expansion to obstetric services.

Prevention for People Who Inject Drugs

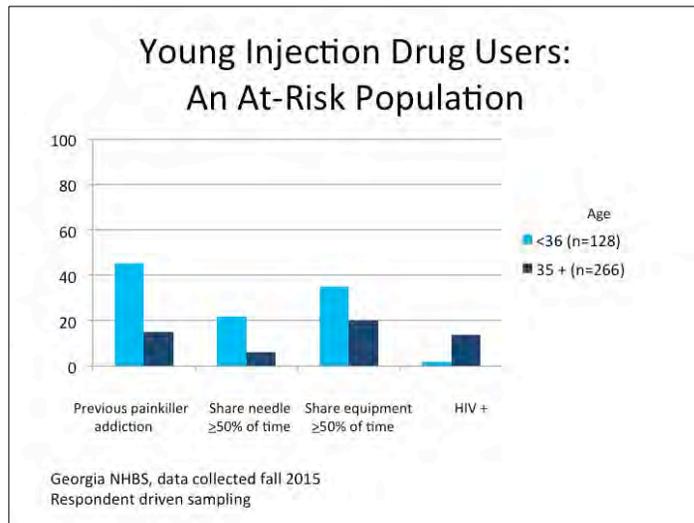
- *POLICY: Clarify the legality of syringe services programs for the legitimate medical purpose of preventing HIV, hepatitis B and C, and other blood-borne infections in Fulton County and the State of Georgia.*

- Introduce a resolution to the Fulton County Board of Commissioners to clarify the legality of syringe services programs for the legitimate medical purpose of preventing HIV, hepatitis B and C, and other blood-borne infections in Fulton County.
- Introduce legislation at the State legislature in 2017 to clarify the legality of syringe services programs and to allow persons to possess and carry a needle or syringe for the legitimate medical purpose of preventing HIV, hepatitis B and C, and other blood-borne infections in Georgia.
- *Increase access to safe, free, and confidential syringe services programs in Fulton County.*
 - Request that Fulton County directly fund syringe services programs throughout the county.
 - Explore integrating syringe services programs into FCDHW HIPP services through its mobile units.
 - Explore providing syringe services programs for PLWHIV through Ryan White clinics.
 - Ensure that PLWHIV who inject drugs are linked to syringe services programs and SU/MH services.
 - Ensure that all syringe services programs offer HIV and HCV screening.
 - *POLICY: Advocate for use of local, state, and philanthropic dollars to support the purchase of clean needles and syringes to be used by syringe services programs.*
- *Ensure access to naloxone for PWID and others with opiate use disorders in Fulton County.*
 - Examine legal barriers to providing naloxone without prescription through pharmacies.
 - Ensure ongoing funding for naloxone access for first responders in Fulton County.
- *Increase access to substance use and mental health treatment for PWID and others with opiate use disorders.*
 - Ensure that Fulton County's centralized Resource Hub contains a listing of SU/MH providers, including those providing Medication Assisted Therapy for PWID.
 - Ensure that all syringe services programs have relationships with and provide linkage to substance use and mental health treatment services.
 - Ensure linkage to substance use and mental health services is offered to PLWHIV who inject drugs.
 - Expand the number of providers who are certified to prescribe buprenorphine and other Medication Assisted Treatment.

People who inject drugs (PWID) are at the core of the HIV and Hepatitis C Virus (HCV) epidemics in the US. Injection drug use is the third most frequently reported risk factor for HIV infection and is considered the primary mode of HCV transmission in the US. HCV is more transmissible than HIV (Alter, 2006) and even without sharing a needle, HCV can be transmitted through shared equipment such as tourniquets (Hagan, 2001). In fact, PWID have an 80-90% chance of acquiring HCV due to needle sharing by the age of 45 (Mehta, 2011). HCV diagnoses in Fulton County have increased each year from 2012, but this may represent expanded testing in the "baby boomer" population rather than new infections. (See graph) However, the number of confirmed HCV infections in persons aged 30 years or less also is increasing. (Unpublished data GDPH, 2016) Based on state surveillance data, 4,229 people have confirmed hepatitis C infection in Fulton County and an additional 4,306 have been reported with only a positive HCV antibody and have unknown infection status. (Unpublished data GDPH, 2016) Coinfection with HIV and HCV is common among PWID and associated with more rapid progression of liver disease.

The number of overdose-related deaths due to opioids and fentanyl in Fulton County are also increasing. Overdose deaths due to heroin with or without fentanyl are thought to be

underreported. In 2015, of 198 drug related deaths of all types, 104 were due to heroin and/or fentanyl overdose-related deaths were reported. (Unpublished data GDPH, 2015) Other substances besides opioids are frequently injected, including methamphetamine and cocaine. Local investigative reporters have described a “Heroin Triangle” in the northern, affluent suburbs of Atlanta (www.herointriangle.com), where an astounding increase in heroin (and fentanyl) use is taking place among youth. These youth are at high risk for opioid overdose, but



also for HIV and HCV infection. Rates of HIV and HCV are currently unknown in this cluster.

While addressing the problem of addiction is essential for PWID, syringe exchanges (or syringe services programs; SSPs) are an effective and cost-effective intervention to prevent HIV, HCV, and other blood borne infections. (Ruiz, 2016) Harm reduction and access to clean needles, however, are much more effective in reducing HIV incidence than HCV. In the ALIVE Cohort in

Baltimore, HIV incidence has declined to zero, while HCV incidence has declined approximately 50% (Mehta, 2011). These SSPs not only should provide access to clean needles but also to education, testing, linkage to medical care, training, materials, and resources that can help in prevention of HIV, HCV, and accidental overdose-related deaths amongst PWID. Naloxone reverses opioid overdoses and should be provided to first responders including police officers, and ideally should be accessible in pharmacies without a prescription. Fulton County allocated funds for naloxone distribution and should continue to provide funding to assure and expand its availability. On December 18, 2015, President Barack Obama signed the Consolidated Appropriations Act, 2016 (Pub. L. 114-113) which modified the restriction on the use of federal funds for programs distributing sterile needles or syringes for Health and Human Services programs. While this provision still prohibits the use of federal funds to purchase sterile needles or syringes for the purposes of hypodermic injection of any illegal drug, it allows federal funds to be used for other aspects of SSPs based on evidence of a demonstrated need by the state or local health department in consultation with the CDC. As a result Georgia and Fulton County, in particular, can now use federal funds to support SSPs and use non-federal funds to purchase the needles or syringes. However, current Georgia paraphernalia laws still make it illegal to possess a needle for use of illicit drugs. PWID need access to mental health and substance use treatment, and all persons being served in syringe services programs should be offered these services. As discussed earlier, facilitating access to these services is an important objective for all persons with HIV and those at risk for HIV and viral hepatitis. Enhanced access to medication assisted therapy is needed both for PWID but also those with non-injection drug opiate use disorders. This latter group is at increased risk of converting to injection drug use and addiction therapy for these individuals is also a critical prevention step.

In addition, PrEP has been shown to have efficacy reducing the risk of HIV in persons who inject drugs when taken with high adherence, and should be offered to HIV-uninfected persons who inject drugs and share needles or who have sexual risk. (Choopanya, 2013; CDC MMWR, 2013)

Condom Distribution

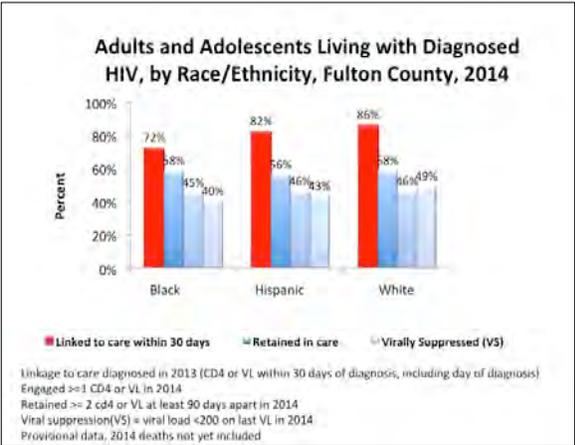
- *Increase the number of condoms distributed to persons with HIV and high-risk seronegatives to 3.5 million units per year.*
- *Improve the coordination of condom distribution and education in Fulton County to achieve appropriate targeting and consistent access by persons with HIV and disproportionately affected populations without HIV.*
 - Ensure that condoms and lube are routinely made available to local bars and sex clubs.
 - Provide condoms and lube to all HIV care sites.
 - Pilot test mailing of condoms and lube through online requests.
 - Integrate condom distribution with coordination of targeted HIV testing.

While antiretroviral treatment of HIV-positive persons dramatically decreases HIV transmission, and PrEP and PEP for HIV-negative persons at highest risk also is remarkably effective in preventing new infections, neither prevent 100% of transmissions nor do they prevent sexually transmitted infections (STIs) or pregnancy. Condoms are still effective in preventing HIV and other STIs, and are recommended as part of a comprehensive prevention package. Condom distribution is not always coordinated so that condoms and lube are routinely available in bars, sex clubs, and HIV care sites; however, distribution could easily be coordinated through the recommended new approach for coordination of targeted HIV testing. In 2015, HIPP exceeded its condom distribution goal of 2,170,068 by distributing 2,439,562 condoms within the jurisdiction. Approximately 349,780 (14%) of all condoms distributed went to individuals and to organizations that serve HIV positive individuals only. Increasing the number of condoms distributed by FCDHW by an additional 1 million per year will assist in broadening access and assuring consistent availability.

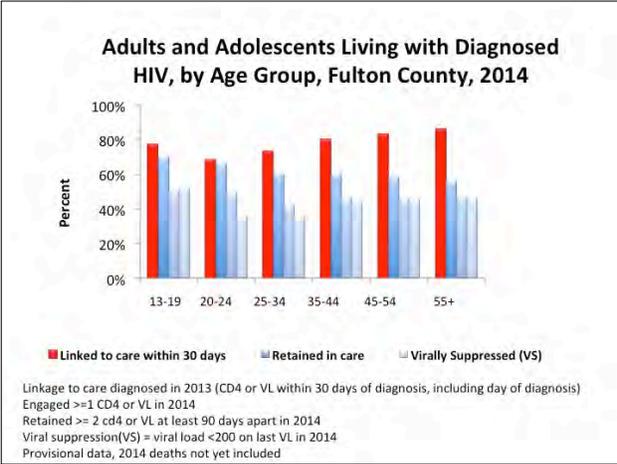
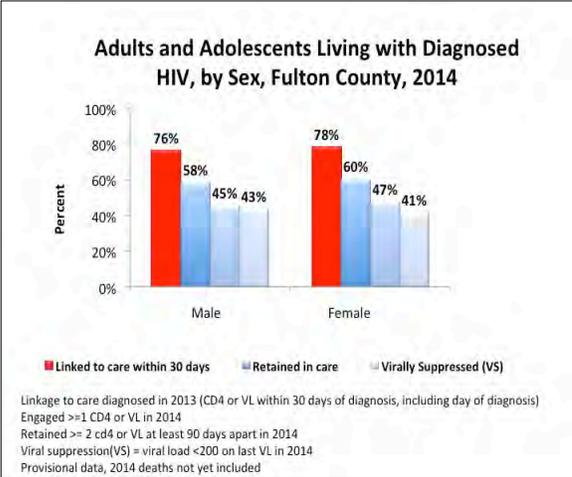
Care and Treatment for Persons Living with HIV

The goal of HIV treatment is to preserve the quality and length of life for people with HIV infection. This is optimally accomplished through rapid linkage to medical care following an HIV diagnosis, early provision of and continuous access to ART, maintenance of high levels of medication adherence, and consistent and continuous participation in medical care. As previously mentioned, the “care continuum” is a useful construct that allows measurement of critical processes - diagnosis, linkage, engagement, and retention - that lead toward viral suppression. Those who achieve viral suppression (here defined as an HIV-1 RNA viral load below 200 copies/mL) have optimal health outcomes and are substantially less likely to transmit HIV to others. Each pillar of the care continuum offers substantial challenges, but is critical to success. In Fulton County, our largest challenges are to get people into care quickly, whether they are newly diagnosed or reengaging in care after being out of care, and to retain them in care.

Although 76% of diagnosed individuals were linked to care (defined as a CD4 count or HIV RNA level within 30 days of diagnosis), the number retained in care (defined as 2 visits within 12 months, at least 90 days apart) drops off precipitously to only 46 percent of diagnosed persons. This is literally a recipe for opportunistic diseases and death. And while deaths have declined over time due to the advent of potent treatments, far too many people continue to die needlessly of AIDS in

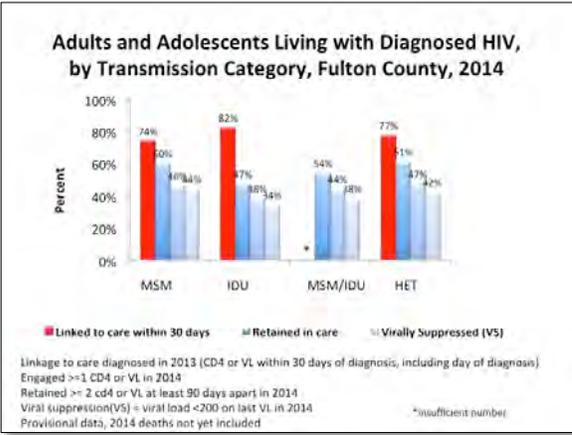


Fulton County. Moreover, when over 60% of new HIV infections come from people with HIV who are diagnosed but out of care, poor retention in care stokes the fires of the epidemic. (Skarbinski, 2015) But it gets worse. There are care continuum disparities by race, ethnicity, age and transmission mode. Blacks



and Latino/Hispanics are less likely than whites to be linked to care (72 vs 82 vs 86%) or virally suppressed (40 vs 43 vs 49%). Injection drug users are less likely to be engaged in care, retained in care, or virally suppressed than other transmission groups.

There are no substantial differences by gender, but data on transgender individuals are lacking and needed. Persons 20-29 years of age have the lowest rates of viral suppression among all age groups. (Unpublished data, GA DPH Epidemiology)



Linkage To Care

- *Increase the proportion of newly diagnosed persons linked to care, defined as attending a medical provider visit within three days of diagnosis, to 85%.*
 - Conduct a complete assessment of linkage resources, staffing, training, capabilities, and processes to inform a reinvention of linkage services in Fulton County.
 - Ensure that newly diagnosed persons in vulnerable populations (youth, those with mental health or substance use disorders, those with unstable housing, and those recently released from incarceration) receive intensive linkage navigation services.
 - Eliminate barriers to patient entry at Ryan White clinics.
 - Create and implement Rapid Entry pathways at Ryan White clinics to ensure an initial medical visit for newly diagnosed patients within 3 days of diagnosis.
 - Evaluate synergies between allowable CDC HIPP and Ryan White activities to maximize linkage resources and decrease duplication of effort.

Linkage of the newly diagnosed HIV infected person to care is a critical step in the care continuum. Approximately one quarter of diagnosed patients in Fulton County do not have an initial visit with an HIV care provider within three months of diagnosis. There are many reasons that linkage may not occur. Testing can occur at a variety of sites often not associated with sites that provide care for the infected person. Determining which site might be the best to recommend to a newly diagnosed patient can be challenging as it may require knowledge of insurance status, transportation status, county of residency, and other factors with individual clinical care sites having different rules and requirements that must be met by those seeking HIV care at that site. In addition, the moment of diagnosis is a particularly vulnerable time for the newly diagnosed patient, who may have personal barriers to care including an inadequate understanding of the life-saving nature of ART, preexisting mental health or substance use disorders, lack of social support and stigma, unstable housing and other factors. Several new studies (from settings as diverse as South Africa and San Francisco) show significant improvement in linkage statistics using programs designed to facilitate rapid linkage to care, with support to overcome barriers to care (Rosen, 2016; Christopolous, 2011). Systems like these, adapted to the unique environment in Fulton County, are needed to assist our patients to successfully link to care, without which the ultimate goal of viral suppression cannot be achieved. Therefore, the Task Force adopts the objective of linking 85% of newly diagnosed persons to a medical provider visit within 3 days of diagnosis, and providing intensive linkage services to vulnerable populations.

Achieving this target will require a “reinvention” of the linkage to care system in Fulton County. The critical first step is to convene a working group composed of appropriate stakeholders, including county HIPP leadership and the Ryan White Part A grantee, clinic leaders, representatives from testing sites, federal HIPP and Ryan White project managers and, importantly, PLWHIV among others. This group will need to assess current resources and practices across Fulton County, including care facility requirements, to best understand the current state and existing limitations. Focus groups composed of PLWHIV are needed to provide critical consumer input to the design of a new system and to participate in critical decision-making processes. We envision that a new system will be predicated on the approach that every new diagnosis of HIV in the county represents a “sentinel health event” much like

any new infection of a contagious and life-threatening disease that then requires a coordinated emergency response. As such, components of a new linkage program could include (1) a centralized rapid enrollment system that would aid the newly diagnosed patient not only with clinic entry but enrollment in Ryan White, Medicare and Medicaid services, ADAP, or HICP as appropriate; (2) restructuring of clinic schedules to allow patients more rapid access to provider visits and centralized monitoring of the number of days until the first available new patient appointment, with a goal of less than 3 days; (3) on-call Rapid Response linkage teams including peer or patient navigators, case managers/social workers and nurses to assess individual barriers to care and provide assistance with clinic enrollment; (4) development of a community health worker force with the capability of performing outreach to the patient to facilitate clinic enrollment, enrollment in substance use or mental health services, aid with housing, and, potentially, HIV care utilizing a mobile unit; and (5) the establishment of a secure, central electronic repository for patient documentation necessary for enrollment into clinics, healthcare systems, ADAP, Medicare or Medicaid, HICP, housing and other support services - including, but not limited to, copies of essential documents such as birth certificates, photo IDs, residency and wage verification.

A new county-wide uniform linkage program will require standardized core protocols with key components including sharing of best practices and protocols for rapid entry into care, protocols to assess and identify patients who are less likely to successfully link to care and to provide enhanced supports needed to ensure they access care, protocols for smoothly and rapidly linking newly diagnosed inpatients of any hospital in Fulton County to immediate outpatient care, and enhanced systems to obtain necessary documentation which may serve as a barrier to entry to care (including issuing photo IDs and obtaining in- and out-of-state birth certificates).

Recognizing that the patient's new diagnosis represents a "sentinel health event," sexual and needle-sharing partners must be offered partner services (see Testing section) using a culturally competent and compassionate approach. While those found to be HIV negative should be referred for PrEP and other prevention services, those that are positive must be immediately offered linkage services as above.

Development of an efficient linkage system will require training individuals at testing sites and other sites where the "first touch" with a newly diagnosed patient is likely to occur. Clear communication among sites to share best practices is critical and the system must be designed to facilitate this. One potential asset for dissemination of linkage information is the CAPUS Resource Hub, maintained by the Georgia DPH, however this requires re-assessment from stakeholders and systems to determine whether it will be feasible to expand resources included in the Resource Hub and, most importantly, keep it current. If this is determined to be the optimal tool to disseminate information, then the CAPUS Resource Hub requires reinvigoration and a clear plan for maintenance of this tool as the "one-stop shop" with the most current and accurate information.

Successful linkage to care requires not only clear instructions at the time of a new diagnosis, and facilitated referral to a care facility, but clinics, especially Ryan White Clinics, must work to eliminate barriers to entry and have adequate capacity with available near term (less than 3 days) appointments in order for this initiative to be successful. In many cases, this will require radical redesign. Requirements for Ryan White clinic enrollment must be explicit, as lenient and minimal as allowed by the federal Health Resources and Services Administration and the Ryan White Part A Grantee, and protocols must be standardized at all clinics. The Grantee should ensure that additional site- or agency-specific barriers must not be allowed to interfere with Ryan White enrollment. Access to the previously described central repository for essential documents and Ryan White Part A CAREWare must be available for all Ryan White agencies in the Atlanta EMA. The established but unusual system of patient triage by CD4 count in the EMA needs to be eliminated in a strategic and stepwise manner over time, such that undue burden on the Grady Infectious Disease Program does not occur.

In addition, clinic scheduling processes should facilitate rapid entry with provider visits available within 3 days of diagnosis (and/or contact with a person who is out of care, as described later). This will require a careful evaluation of capacity, caseloads (for providers, nursing, case management and other support staff), reconfiguration of scheduling systems to maximize access, and institution of outreach programs to limit and rapidly reschedule missed appointments. One consequence of success with optimized linkage to care (and retention in care, see later section) will be an exacerbation of existing workforce shortages of HIV providers and nurses. Maximizing capacity by establishing capable care teams at FQHCs and Community Health Centers is needed. Enrollment in HICP will allow some patients to receive care in the private sector, although needed supplementary services not covered by health insurance but available through the Ryan White program will still be required. Competitive compensation and benefits at Ryan White health clinics is critical but challenging in a time of essentially flat Ryan White funding (see Cross Cutting section). Appropriate task-shifting and adequate support staff is critical, including adequate staff to assist with medication access issues (paperwork for prior authorization; enrollment in pharmaceutical industry patient assistance programs and other medication assistance programs; enrollment in ADAP, Medicare and Medicaid, HICP), reminder phone calls and timely outreach to those with missed visits, and peer/patient navigators to aid with barriers to care, stigma, education, supportive care, etc. New technologies like telemedicine may allow increased capacity and decreased need for transportation.

Standardized rapid entry pathways and protocols must be established with common data collection and evaluation protocols. For those sites unable to redesign clinic structures to accommodate the rapid entry visit within 3 days, free-standing Rapid Entry clinics may be helpful with a patient "handoff" to a long term treating facility. Opportunities for shared resources and synergies between prevention and testing resources (CDC HIPP grants) and care resources (HRSA-funded Ryan White programs) to support linkage and case management services is critical, as these two entities cannot exist separate from one another at this stage in the epidemic.

Development of appropriate metrics and monitoring strategies is of the utmost importance to benchmark the current state, to measure progress, to identify programs that work and those that do not, and to advocate for additional support for programs that positively impact the epidemic.

Lastly, but critically, efforts to facilitate patient linkage and throughput must be undertaken with a close eye on providing culturally competent, compassionate and patient-centered care (see Cross Cutting section). In addition to being a core tenet in the care of PLWHIV, numerous studies have shown that the degree of patient comfort with their care provider and clinic environment are critical for successful care. Excessive attention to throughput could risk the patient-provider relationship and efforts must be made to ensure that adequate time is allotted for visits, otherwise downstream effects on the care continuum with decreased retention and/or adherence are more likely. (Beach, 2006; Dang, 2012).

Retention in Care

- *Increase the number of people retained in care to 90% of those diagnosed (NHAS Indicator 5).*
 - Increase cultural sensitivity and competence of all staff members delivering HIV, substance use, and mental health care. [see Cross-Cutting] and educate all staff on principles of trauma-informed care.
 - Identify patients at high risk for loss to follow up and design individualized retention plans.
 - Provide reminders for visits and medication refills, including use of online platforms for streamlined client communications (Google Boomerang, Mailchimp).
 - Follow up on missed visits during the same day to assess reason, need for medication refills, and to reschedule.
 - Use patient navigators to assist with retention for vulnerable populations, especially those previously lost to care.
 - Develop standards for obtaining and maintaining accurate contact information and permission to contact, including phone (text), email, and social media outlets (Snapchat, Instagram, Facebook, Twitter, dating sites).
 - Decrease long clinic wait times (see Linkage).
 - Explore strategies to simplify and synchronize Ryan White, ADAP, and HICP recertification without undue burden on patients, and to ensure that documents are submitted in advance of necessary prescription refills.

Retention in care is critical to achieving viral suppression and is now considered the most vulnerable step in the HIV care continuum. Currently only about 50% of persons diagnosed with HIV are retained in care over 12 months and even less over 24 and 36 months (Colasanti, 2015). Since HIV infection requires lifelong treatment, retention will need to be also life-long. Even in a system with few financial barriers to care like the Veterans Administration, a substantial portion of HIV-infected patients have poor retention in care (Giordano, 2007). Poor retention in care also predicts high risk of death (Mugavero, 2014). In addition, the majority of HIV transmissions now occurring in the U.S. come from HIV infected persons who know their diagnosis but are not retained in care (Skarbinski, 2015). For all these reasons, improving retention in care is key in increasing the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80 percent (NHAS Indicator 6).

Defining and monitoring retention in care is difficult and no one measure is perfect. Retention is usually measured and conceptualized in 3 different ways: appointments missed, medical visits at regularly defined intervals or a combination of these (Horstmann, 2010). The Institute of Medicine and the U.S. Department of Health and Human Services core indicators define retention in care as at least 2 attended visits at defined intervals to an HIV medical provider within one year, while HRSA performance indicators for Ryan White programs define retention as at least one HIV medical care visit in each 6 month period of a 24 month measurement period with a minimum of 60 days between the first medical visit and the last medical visit in the 6 month period (HRSA, 2013). Data suggests that there is agreement between the different measures used for retention (Rebeiro, 2014). While these measures are adequate for reporting, but the missed clinic visit is an important way to monitor for patients at high risk of poor outcomes including mortality (Mugavero, 2014).

Improving retention in care will not be easy as no one strategy is likely to work for every person at risk of falling out of care. In a systematic review conducted to identify best practices to improve retention (Higa, 2016), three evidence-based interventions (EBI) for retention were identified. The EBIs demonstrated to improve retention included co-location of opioid treatment and HIV care for opioid-dependent HIV-infected patients (Lucas, 2010), a clinical decision-support system to alert providers when patients had virologic failure or missed appointments (Robbins, 2012), and enhanced personal contact with in-person or telephone reminders for patients to keep appointments (Gardner, 2014).

It will be important for clinics to identify those patients at risk for loss to follow up and to implement strategies and dedicate resources to prevent patients from being lost to care which is much more cost-effective than trying to reengage patients once lost to follow up. The use of simple interventions such as enhanced personal contact, telephone reminders and the use of mHealth strategies such as SMS/text messaging may be useful approaches to improve retention in care. A patient who misses a scheduled appointment is at high risk of being lost to follow up as well as high risk for death. It will be important for clinics to contact those patients who do not show up to an appointment as soon as possible in order to reschedule their visit and prevent lapses on medications. Having accurate contact information for all patients - including their nickname, as well as where they usually hang out - and obtaining from patients permission to contact them or someone they trust and to use less traditional methods such as SMS/text messaging and social media are all important strategies to engage patients in care, prevent loss to follow up and immediately intervene when they miss a visit.

Clinics must be welcoming and all people that work in HIV care (not just providers but also administrative and clerical personnel) should receive training in cultural sensitivity and competence. Patients who receive Ryan White funded care are required to recertify every 6 months. While this is a requirement that is mandated by the HRSA it needs to be easy to accomplish and not something that unnecessarily burdens patients or clinics.

Clinicians must also recognize that HIV outcomes, including continuous retention in care, are influenced by psychological states and past experiences. Provision of adequate mental health care and recognition of past or current psychological trauma are critical to successful treatment outcomes [See Cross-Cutting]. Principles of trauma-informed care should be incorporated into the healthcare environment and attention to these individual circumstances with development of personalized care strategies can improve the likelihood of long term retention in care.

Reengagement in Care

- *Decrease the number of persons who are out of care by 50%.*
- *Reengage individuals identified as out of care within 3 days of contact.*
 - Conduct a complete assessment of reengagement resources, staffing, training, capabilities, and processes to inform a reinvention of reengagement services in Fulton County.
 - Institute and evaluate reengagement strategies using surveillance data to improve care reengagement.
 - Institute and evaluate a community health worker model pilot program for locating out of care individuals and assisting them in care reengagement.
 - Use mobile vans, including the Fulton testing van to do outreach and medical visits.
 - Develop a mechanism by which providers can query the DPH Health Information Exchange (HIE) to verify whether an individual is out of care or receiving care elsewhere.
 - Ensure that reengagement staff receives cultural competency and customer service training. [see Cross-Cutting]
 - Expand the HIV HIE to encompass the entire county.
 - Develop individualized patient-centered retention plans for each reengaging patient to address reasons that the patient was previously out of care.
 - Assess and address transportation and housing needs for each reengaging patient.
 - Develop an individualized communication plan for each reengaging patient
 - Integrate mental health/substance use services into the reengagement process with emphasis on patient centered care [see Cross Cutting]
 - Engage patients and other PLWHIV for ongoing feedback on programs and services [see Cross Cutting]
 - Develop mechanism for eliciting patient feedback on reengagement process, including a stigmatization assessment metric [see Cross Cutting]

As discussed in the previous section, retention in care is a key step in the HIV care continuum but one that can be difficult to achieve. Studies modelling the source of HIV transmission among newly infected patients based on data from CDC's Medical Monitoring Project (Skarbinski, 2015) suggest that the majority of HIV transmission occurs from those known to be infected with HIV but not retained in care. Even in clinics where one year retention in care and suppression is very good, long term retention can be a difficult challenge with fewer patients staying consistently in care (Colasanti, 2015). Strategies to find and reengage these patients in care are critical, as are strategies to transition these patients from those that move in and out of the medical system to those that remain consistently in care for life. In many ways, this population may be among the most challenging as these patients have already demonstrated challenges to retention and failure of the standard of care. The goal for the Fulton County HIV/AIDS Strategy is to decrease the number of patients diagnosed but not retained (out-of-care) by 50%.

Reengagement strategies require two phases. The first is identifying patients as out of care and locating them; the second is developing systems to overcome barriers to care and help maintain them in care. The development of robust systems to identify patients who have left HIV care is critical. Optimally this can include clinic-based assessments, surveillance systems utilizing Georgia DPH resources, including the current HIE, and outreach. HIV care clinics must develop timely mechanisms to monitor the “missed visit,” a known predictor of mortality (Mugavero, 2014). Referral to a reengagement team would be ideal for patients not easily reached to reschedule an appointment or for those with rescheduled appointments that are not kept. The reengagement team need not be clinic-based but would have access to DPH eHARS data to verify that referred patients are indeed out of care, and have not transferred care elsewhere. Reengagement teams should have expertise in linkage and access to unique outreach strategies including trained community health workers to assist with finding patients, assessing barriers to care, and aiding with reengagement.

An additional critical tool is the Health Information Exchange (HIE) currently available in different forms to a minority of sites across the County. The HIE allows for identification of patients touching a healthcare setting who have been diagnosed with HIV but without recent HIV laboratory evaluation. The system sends an alert to a physician that the patient may be out of care. At the present time, this information may not get to the treating facility in real time. The HIE needs to be expanded across the entire county and ideally, the Eligible Metropolitan Area, with progress toward real time alerts. Patients identified through this mechanism, particularly without immediate notification, should be referred to the reengagement team for assistance locating them and reengaging them in HIV care.

Once patients are located, both the reengagement team and the clinic site must assess barriers that led to loss of retention previously in order to better understand the patient’s personal challenges and to develop a plan to achieve long term retention in care. Strategies to do this are not well understood and require careful evaluation and study. Several barriers and patient characteristics have been identified that are associated with poor retention including age, race, history of mental health disorders, substance use and others, but social support, transportation status, inconsistent phone numbers and others have been identified as well (Cohen, 2011; personal communication). There is increasing recognition that personalized strategies will need to be developed which may employ many interventions including patient navigation (Metsch, 2016).

Critical to all these efforts is close attention to culturally competent, compassionate care with a strong emphasis on customer service among reengagement staff and clinic staff. Additionally, as there is little data to guide interventions, careful assessment of all interventions, clear evaluation metrics (including reengagement within 3 days of contact with an out of care patient), and guidance from the patients and the community of PLWHIV is vitally important.

Viral Suppression

- *Increase the proportion of persons with diagnosed HIV who achieve HIV RNA levels <200 c/mL to 80% (NHAS Indicator 6).*

- Increase the proportion of persons with diagnosed HIV who achieve continuous HIV RNA levels <200 c/mL to 80%.
- Decrease the time from HIV diagnosis or reengagement in care to viral suppression to an average (mean) of 6 months
 - Implement community awareness and education programs to promote ART at the time of HIV diagnosis, regardless of CD4 cell count, and the benefits of ART for HIV prevention.
 - Educate providers on the need to offer ART to all persons with HIV, regardless of CD4 cell count.
 - Create systems that facilitate immediate access to ART for newly diagnosed persons or individuals reengaging in care.
 - Optimize drug delivery systems to ensure patients have consistent access to antiretroviral therapy and other critical therapies.
 - Where feasible, mail drugs to keep people on therapy when unable to make clinic visit.
 - Create “bridge” systems for all clinics so that patients do not stop meds when ADAP recertification is late.
 - Expedite enrollment in HICP for eligible patients to enhance access to medical care and ART through health insurance. [see Cross cutting]
 - **POLICY: Advocate against adverse tiering, quantity limits and prior authorization imposed by insurance companies.**
 - Expedite submission and processing of ADAP applications, and track turnaround times and reasons for delays in processing.
 - Create systems to assess and address adherence and provide adherence support to vulnerable populations beginning or reinitiating ART, including youth, persons with substance use and mental health disorders, unstably housed persons, persons being released from incarceration, recently hospitalized persons, and transgender persons.
 - Establish systems for in-house pharmacies and ADAP pharmacies to communicate with patient and provider immediately when a prescription is not picked up, and institute adherence interventions for those demonstrating poor adherence.
 - Create social/recognition events to recognize achieving undetectable viral load.

Viral suppression is essential in order to achieve the ultimate goal of HIV care, increased quality of life and longevity. In 2016, a cure and a vaccine remain on the horizon while ART is our greatest tool to decrease morbidity and mortality in PLWHIV. Moreover, because “Treatment is Prevention,” antiretroviral medications double as one of our greatest tools for the prevention of new infections. Public health surveillance data from San Francisco demonstrate declining new infections as the community viral load declines (Das, 2010) and randomized controlled trial data prove that viral suppression prevents transmission to a discordant partner (Cohen & Chen, 2011). Despite the substantial individual and societal benefits of ART and viral suppression, estimates for viral suppression in the United States for PLWHIV are only 50% and even less optimistic in Fulton County, at 42%. (CDC, 2015; GDPH, 2016)

Given the importance of maximizing the time one is virologically suppressed, the Strategy puts forth a secondary objective of decreasing the time from HIV diagnosis or reengagement in care to viral suppression to an average (mean) of 6 months. This objective emphasizes the importance of rapid entry into care and access to ART for people who are newly diagnosed or returning to care. Achieving viral suppression as quickly as possible decreases risk of

progression or development of AIDS defining illness and decreases the risk of transmission. Yet, the benefits of viral suppression are fully realized only when that viral suppression is maintained, a more difficult goal than simply “becoming undetectable” at one moment in time (Colasanti, 2016). A secondary objective related to viral suppression emphasizes the importance of continuous viral suppression: Increase the proportion of persons with diagnosed HIV who achieve continuous HIV RNA levels (all levels within the interval) below 200 c/mL to 80%.

Achieving and maintaining viral suppression requires the successful navigation of the full care continuum from diagnosis to linkage to retention in care. The majority of patients retained in care are virologically suppressed, emphasizing the importance of the retention in care objectives and action items contained in this strategy. Inherent to achieve and maintain viral suppression, patients require the prescription of effective ART, daily adherence to that therapy, and uninterrupted access to the medications.

We aim to reach the overarching viral suppression objective through the following actions. Community awareness and education programs will be implemented to promote ART at the time of HIV diagnosis, regardless of CD4 cell count, and the benefits of ART for HIV prevention. In parallel to the community education efforts, education to providers will focus on delivering guideline-informed care, prescribing ART to all PLWHIV. Furthermore, education will encourage providers to initiate ART for inpatients, particularly for those with an opportunistic disease, in consultation with an HIV expert.

In programs and agencies throughout the county, immediate access to ART for both newly diagnosed patients and patients reengaging in care is needed. Access to medication is largely dependent on the patient’s insurance status and income. If insured, patients may require assistance by obtaining co-pay cards or through organizations such as the *Patient Access Network Foundation* or *Patient Advocate Foundation*. Ryan White’s ADAP functions as a payer of last resort for antiretrovirals. Agencies require human resources to assist insured patients with prior authorizations, enrollment in payment assistance programs and HICP. Furthermore, it is necessary to expedite enrollment in the HICP. The policy team will advocate against adverse tiering, quantity limits and prior authorization imposed by insurance companies.

Uninsured patients enrolled in Ryan White require assistance with enrollment in ADAP. We aim to facilitate rapid submission and processing of ADAP applications, and track turnaround times and reasons for delays in processing. This requires adequate ADAP staffing at DPH that matches demand and education of clinic staff to assure ADAP applications are complete and accurate prior to submission. Technology can be leveraged to prevent incomplete applications by optimizing the electronic ADAP application submission system to include real time edit checks. The development of electronic interfaces with the Georgia Department of Labor and Internal Revenue Service should also be explored, to facilitate income verification.

Ensuring initial access to ART is one among many steps on the quest to viral suppression. Improved systems for completing ADAP recertification on-time are necessary, along with backup “bridge” options to prevent gaps in ART for those who miss their recertification

window. Once a patient has access to medications, daily adherence is a requisite for achieving and maintaining viral suppression. We must create systems to effectively assess adherence and potential barriers to adherence (many of which are discussed in the *Social Determinants of Health Section*). In tandem with assessment, adherence support programs will be developed, which focus on vulnerable populations, such as youth, persons with mental illness or substance use disorders, unstably housed persons, incarcerated persons reentering care, those with recent hospitalizations, and transgender persons. These programs may be as simple as periodic phone call check-ups or as in-depth as intensive community health worker programs with directly observed therapy for selected patients struggling to achieve or maintain viral suppression. The pharmacy serves a critical role in monitoring and strengthening patient adherence since ART currently has 30-day pickup windows. We need systems for in-house and ADAP pharmacies to communicate with the patient and provider immediately when a prescription is not picked up. This should serve as a sentinel event that results in investigation of the reason for the late pick-up and enrollment in adherence programs if necessary. Finally, those patients who work daily to maintain optimal adherence and are virologically suppressed should be rewarded with positive feedback such as social and community recognition for this achievement.

As the diagnosis, linkage and retention steps of the HIV care continuum improve within Fulton County, we will continue to require a focus on the assurance of early and consistent medication access and adherence assistance in order to achieve the objectives laid forth around viral suppression.

Quality of Care

- *Reduce the AIDS-related death rate among persons by at least 33%. (NHAS Indicator 8)*
- *Improve linkage to mental health and substance use treatment programs within one month of assessment.[see Cross cutting]*
- *Ensure that all patients receive HIV care consistent with current HIVMA Guidelines for the Care of Persons with HIV; DHHS Guidelines for Antiretroviral Therapy of Adults & Adolescents, Pediatrics; and DHHS Perinatal Guidelines, including the following:*
 - ART consistent with DHHS Guidelines is offered immediately after HIV diagnosis regardless of CD4 count.
 - Screening is performed to identify substance use and mental health disorders.
 - Needs assessment is performed to identify and address critical needs including housing, food insecurity, transportation, and job training.
- *Ensure that patients coinfecting with HIV/HCV receive HCV treatment.*

Achieving a reduction in AIDS related deaths in Fulton County is dependent on the execution of the entire *Strategy to End AIDS in Fulton County*. Much of the strategy focuses improving early and comprehensive diagnosis, optimization of the care continuum, elimination of barriers related to social determinants of health, and policy. In a setting where each of those domains are executed perfectly, we are left with ensuring quality care is provided to the patients. We will ensure that patients receive guideline based care with respect to screening, prevention and management of opportunistic infections, perinatal care, initiation of ART and management of their primary care needs (AIDSinfo 2016; DHHS, 2016). Furthermore, as cures for hepatitis C

have become more effective combined with improved tolerability and toxicity profiles, hepatitis C treatment has become a priority in co-infected populations. We need programs to ensure treatment of HCV in co-infected populations.

Indicators will be selected from domains such as prevention of opportunistic infections, ART initiation, HIV/AIDS management, care continuum metrics, primary care metrics (e.g. vaccines), cardio-metabolic disease screening, cancer screening, and mental health/substance use screening. A secondary objective of the task force is to link those identified with mental health or substance use illnesses are linked to appropriate care and services within 30 days. Interval reassessment of selected indicators will provide a foundation from which to implement new and targeted programs.

Structural Issues Affecting Fulton County Government, Including Fulton County Department of Health and Wellness

- *Ensure transparency regarding the use of federal, state, and county funds impacting HIV, STIs, viral hepatitis, and TB by FCDHW.*
- *Improve Program Collaboration and System Integration among HIV, STI, viral hepatitis, and TB programs for prevention and care at FCDHW.*
- *Ensure that structural changes affecting Communicable Diseases and Ryan White programs at FCDHW include a transparent and public process for input from program staff, stakeholders, PLWHIV, and that planning is collaborative and inclusive.*
- *Evaluate and address hiring processes that impede timely implementation of HIV, STI, viral hepatitis, and TB initiatives at FCDHW.*
- *Evaluate and address contracting processes that impede timely implementation of HIV, STI, viral hepatitis, and TB initiatives at FCDHW.*
- *Ensure that FCDHW is accountable for actions and outcomes mutually agreed upon as its responsibility in the Strategy to End AIDS in Fulton County.*
- *When Fulton County's Board of Health is reconfigured to comply with legislative requirements, ensure that at least one member appointed by the Board of Commissioners is an expert in HIV treatment and policy.*
- *Ensure that a transparent and public process is employed for input from program staff, HIV care providers, stakeholders, community members, and PLWHIV regarding integration of Fulton County's health department with the Georgia Department of Public Health, and that planning is collaborative and inclusive.*

Early in its existence, the Fulton County Task Force on HIV/AIDS established a culture of transparency regarding federal, state, and county funding awarded to FCDHW for the prevention and treatment of HIV and other infections. The Task Force recommends that FCDHW continue to maintain this transparency following its transition to become a traditional health department. Activities of Communicable Diseases, HIPP, and the Ryan White programs are of high interest to the provider and PLWHIV communities. Changes to these programs, and the process of transition to a traditional health department, should be informed by the experiences of consumers who access the programs, as well as provider and stakeholder communities that interact with programs. Difficulties with hiring staff and issuing contracts for

services have had substantial adverse impact on the ability of FCDHW to fulfill its mission. Some of these problems have been addressed but structural problems with hiring and contracting must continue to be monitored by the Board of Commissioners while the processes are under revision. To ensure that the HIV epidemic in Fulton County remains a high priority for the newly reconstituted Board of Health, the Task Force recommends that the Board of Commissioners appoint at least one member with HIV treatment and policy expertise to the Board of Health.

Addressing Social Determinants of Health

The Task Force examined the county's HIV epidemic using a social determinants of health framework in an effort to understand the many co-occurring issues that contribute to its severe burden on heavily impacted populations. Several factors that are not explicitly related to individual risk behavior affect one's risk of becoming infected with HIV, progressing to AIDS, dying from AIDS, and transmitting HIV to others. Poverty, homelessness, unemployment, insufficient access to food and transportation, lack of access to healthcare, mental health and substance use comorbidity, high incarceration rates, inadequate education, and stigma and discrimination are among many social determinants that fuel the HIV epidemic. The Task Force facilitated a series of public meetings and listening sessions with various communities to elucidate barriers to HIV prevention and care. During these sessions, stakeholders consistently and emphatically identified issues related to social determinants of health as among the most important obstacles preventing successful engagement in HIV prevention and care services.

- *HOUSING: Address suboptimal housing such that <5% of people with HIV are unstably housed. (NHAS Indicator 7 – adapted)*
 - Adopt a "Housing First" approach.
 - Implement a centralized online repository for documents needed to qualify for services and ensure that service providers and CBOs interacting individuals most impacted by housing challenges are educated about this repository, and are able to refer clients to the specific resources needed to meet their most pressing housing needs.
 - Create an online resource portal for housing resources and ensure that service providers and CBOs interacting individuals most impacted by housing challenges are educated about this resource portal, and are able to direct clients to the most relevant features of the portal.
 - Create a mechanism to assist service providers and CBOs to identify, monitor, and report the most pressing and recurrent housing needs of clients, and ensure that service providers and CBOs are equipped to provide hard-copy information on the most relevant housing assistance needs of PLWHIV in Fulton County.
 - Standardize rules and applications across all housing providers.
 - Educate CBOs and HIV care community about housing regulations and requirements.
 - Collaborate with HOPWA to decrease housing barriers for PLWHIV.
 - Advocate for public housing from a public health messaging standpoint, which emphasizes the need for long-term housing as method of reducing the HIV burden on the most impacted communities.

Housing is one of the most important prerequisites for successful health outcomes for people with HIV. Unstably housed persons often find it difficult to engage in medical care or take

medications consistently. Fulton County has a large homeless population, including many LGBTQ adolescents. Homelessness among adolescents is associated with transactional sex and high risk for acquiring HIV. It will be important to increase visibility and support for entities engaged in housing assistance to these populations and to increase incentives for well-positioned entities to expand their services to better serve the most vulnerable adolescents. In Fulton County and the City of Atlanta, homeless shelters have been the epicenter of an ongoing TB outbreak that is, unfortunately, driven by people with HIV who are not in HIV care and not on ART. ART is highly effective in preventing TB in HIV-infected persons. The importance of housing is reflected in a "Housing First" approach that is being adopted by cities across the country. Some cities, like San Francisco, have found that providing long-term housing is cost-effective to the city. Recommendations in this section came directly from housing assistance providers, community advocates, PLWHIV and HIV service and care providers. Increased collaboration with City of Atlanta HOPWA and other non-HIV housing providers in the City of Atlanta will be essential to decrease housing barriers to PLWHIV and other vulnerable populations at risk for contracting HIV.

- *TRANSPORTATION: Reduce unmet need for affordable transportation to HIV and support services.*
 - Contract with a limited number of transportation vendors to provide transportation for all Ryan White clients.
 - Use mobile van to provide medical visits to remote locations with inadequate transportation.
 - Study feasibility of opening satellite clinics in areas with underserved transportation infrastructure.

Fulton County is geographically large and transportation to clinic visits is challenging for many patients. For patients eligible for Ryan White services, transportation can be provided. Ryan White clinic staff recommends assessing the feasibility of using only a limited number of transportation vendors to simplify access to services. Alternative services such as Uber and Lyft also should be considered and are being used occasionally by clinics already. The ultimate solution to transportation issues is to ensure that medical care sites are located closer to where patients live and work. The Ryan White Grantee, as well as health systems with neighborhood clinics such as Fulton County and Grady Health Systems should explore the feasibility of satellite Ryan White options. Mobile health vans could potentially provide bridging services by bringing medical visits to remote locations in the county with poor transportation infrastructure, and feasibility should be explored.

- *FOOD INSECURITY: Reduce unmet need for access to food and nutritional programs among people with HIV.*
 - Ensure screening for food insecurity and other nutritional need such as Medical Nutrition Therapy or guidance/education, nutritional supplements, prepared or pantry meals among clients presenting for services or care.
 - Assess SNAP eligibility for persons being assessed for Ryan White eligibility.
 - Collaborate with existing food programs to ensure access to nutrition services such as Medical Nutrition Therapy or coaching/education, nutritional supplements, prepared or pantry meals for PLWHIV

- Explore establishing food banks within high volume Ryan White clinics.
- Expand Ryan White food voucher program to include farmers markets participating with Wholesome Wave where purchase value doubles for fresh fruits and vegetables.

While adequate food and nutrition are basic to maintaining health for all persons, good nutrition is crucial for the management of HIV infection. HIV infection is an independent risk factor for cardiovascular disorders, liver and kidney disease, cancer, osteoporosis and stroke. Although weight loss and wasting remain common in HIV infection, nutrition-related problems such as obesity, diabetes, hyperlipidemia and hypertension also increasingly affect PLWHIV. A cross-sectional study of HIV-positive adults receiving care at 11 clinics that provide HIV primary care services found prevalence rates of 26% for hypertension, 48% for dyslipidemia, and 13% for diabetes. (Chu, 2011) The Academy of Nutrition and Dietetics Evidence Analysis Library reports PLWHIV infection are at nutritional risk at any point during their illness. Proper nutrition is needed to increase absorption of HIV medications, reduce their side effects, and maintain healthy body weight. Access to food, however, is a tremendous problem locally. 1 out of every 5 persons in Fulton County experiences food insecurity. (Feeding America, 2014) The primacy of hunger takes precedence over other needs, such as attending healthcare visits or obtaining medications. All clients presenting for services or care should be screened for food insecurity and those who are in need should be assessed for SNAP eligibility and linkage to existing food programs. Feasibility of establishing on-site food banks for PLWHIV should be explored within high volume clinics, and the Ryan White food voucher program should be expanded to include Wholesome Wave farmers markets.

➤ *CHILDCARE: Reduce unmet need for childcare among people with HIV.*

- Ensure that need for childcare is routinely assessed during entry to care and periodically thereafter, especially for women.
- Educate women about the availability of childcare support in Ryan White clinics.
- Routinely assess the barriers to uptake of childcare support services in Ryan White clinics, implement awareness measures accordingly, and tailor childcare support services to reduce barriers to uptake of childcare services.

Women consistently highlight the need for on-location child care to facilitate their attendance at HIV medical care visits and other services. Ryan White funding is typically available for childcare needs, and sometimes is not fully expended. Agencies and clinics, especially those receiving Ryan White funding should conduct ongoing assessment of need, especially but not exclusively, among women, and assess barriers to uptake. Likewise women may not be aware that such services are available, and should receive education.

➤ *CRIMINAL JUSTICE PIPELINE: POLICING and COURTS*

- Work with APD to incorporate HIV education, trauma-informed practices, and cultural competency training into courses at the Police Academy and provide HIV education, training on trauma-informed practices, and cultural competency training for APD and Fulton County Sheriff's Department administration and staff. Ensure that this training includes education on the social determinants of health.
- Collaborate with APD and Fulton County Sheriff's Department to conduct an anti-stigma campaign within their departments.

- Work with Atlanta Municipal and Fulton County courts to utilize diversion programs for drug and sex offenses, where appropriate, and incorporate HIV prevention education into these programs. Programs for sex workers should be tailored to their unique needs, including education about PrEP.

The vulnerability to HIV of sex workers and individuals with substance use disorders also overlaps with the criminal justice pipeline because of illegal activities that these individuals may engage in. Therefore, it is critical that criminal justice agencies require HIV education and cultural competency training for all employees, as well as trainees at the Police Academy. Harassment and violence against LGBTQ individuals must not be tolerated by police and sheriff departments, and Zero Stigma policies should be adopted. Diversion programs for sex work and minor drug offenses should be encouraged and these should incorporate HIV prevention education. Education for sex workers should be tailored to their needs and include education about and referrals for PrEP. In addition, sexual activities of PLWHIV are still criminalized by Georgia law in contradiction to current science, and PLWHIV may come into contact with the criminal justice system on this basis, regardless of whether sexual transmission occurred or whether there was intent to transmit. These laws do not prevent HIV transmission but do create stigma and discrimination and they should be revised (see Policy). Close collaboration with the Atlanta Police Department, the City of Atlanta, and the Fulton County Sheriff's Department will be required and needed.

➤ **INCARCERATION**

- **POLICY: Offer routine opt-out HIV testing upon entry at Fulton County jails. [See Testing]**
- Provide HIV education, training on trauma-informed practices, and cultural competency training for jail administration and staff.
- Provide evidence-based sexual health and HIV prevention and treatment education, education on HIV criminalization, and HIV prevention resources for incarcerated persons, including condoms.
- Ensure that incarcerated persons receive HIV treatment according to current DHHS Antiretroviral Guidelines.
- Expand pre-release planning for HIV positive inmates at Fulton County and Atlanta City Jails.
- **POLICY: Eliminate policies or actions that stigmatize incarcerated people with HIV.**
- **POLICY: Provide access to condoms for all incarcerated persons.**

As previously mentioned, HIV is more prevalent among incarcerated populations than in the general population. Routine opt-out testing should be offered to every inmate on entry to county and city jails, and condoms should be provided to incarcerated persons for their own protection. Administration and staff in jails should receive education on HIV, trauma-informed practices, and cultural competency from an anti-stigma framework.. Jails should provide evidence-based HIV prevention and treatment to all incarcerated individuals, including information on PrEP and how to access it. Pre-release planning for HIV positive inmates should be expanded within Fulton County and Atlanta City Jails to be sure that these individuals have continuous access to ART upon release, and easy access to care reengagement. Policies or actions that stigmatize incarcerated people with HIV should be eliminated.

- *EDUCATION: Increase health literacy regarding HIV prevention and treatment, including evidence-based sex and sexuality education in schools.*
 - Improve health literacy among staff at agencies providing HIV care and services in Fulton County.
 - Improve HIV health and treatment literacy among PLWHIV receiving care and services.
 - Increase evidence-based community health literacy programming aimed at youth (ages 10-17).
 - Implement evidence-based comprehensive sex and sexuality education for youth (ages 10-17) in Fulton County and City of Atlanta schools.
 - Implement evidence-based comprehensive sex and sexuality programs aimed at reaching persons 18-28 through community-based approaches.
 - All materials should be made available in Spanish and translated into other languages as needed.

Stakeholders and community members agreed that improved health literacy is needed among PLWHIV, community members (especially among youth), and staff at agencies and clinics providing HIV care and services. HRSA has developed health literacy training modules, with the input of PLWHIV, that will be invaluable to this effort. (HRSA, 2016) Working with school systems to implement evidence-based sex and sexuality education in schools emerged as a high priority for the Strategy. The Atlanta Board of Education has already appointed a Task Force member who is a physician to its Human Growth and Development Advisory Committee, a committee that provides advice on sexual health curricula for the Atlanta Public Schools. Similar collaboration with the Fulton County Board of Education will be a high priority. Materials in Spanish and Spanish-speaking instructors will be necessary to serve monolingual Latino/Hispanic communities.

- *JOB TRAINING AND READINESS: Increase partnerships between organizations providing locally relevant job training and HIV-service or healthcare agencies in order to provide employment opportunities for PLWHIV and persons at high risk of HIV acquisition.*
 - Create resource portal for clothing banks, job training opportunities, GED classes.
 - Identify sources of funding to subsidize GED classes for PLWHIV.
 - Partner with Job Corps and Atlanta Regional Commission Workforce Development to increase job training opportunities for PLWHIV.
 - Partner with employment agencies to provide temporary employment opportunities for PLWHIV.
 - Create flexible clinic hours to facilitate attendance for those who are employed 9am-5pm.

Information gathered in listening sessions with community members and stakeholders reinforced the importance of job training to assist PLWHIV in obtaining employment and becoming self-sufficient. Partnering with agencies that provide job training opportunities, such as Job Corps and Atlanta Regional Commission Workforce Development will be pivotal in increasing access to these agencies for PLWHIV. For those who have not graduated from high school, funding to pay for GED classes was identified as a barrier to obtaining GED certification, an important milestone for job qualification. Communities were vocal about the need for expanded clinic hours for those working traditional 9am to 5pm jobs. Many employed persons do not have sick or personal leave, and cannot afford to take time off of work, or may risk being fired for absences, even for health reasons. Additionally, a criminal record is a

substantial barrier to hiring. Nationally, “Ban the Box” initiatives have been successful in removing a criminal history question from job applications.

➤ *STIGMA AND DISCRIMINATION: Reduce the experience of stigma and discrimination based on HIV status, gender identity and expression, sexual identity and expression, race/ethnicity, and socioeconomic status among PLWHIV in:*

- Healthcare institutions
 - Educational institutions
 - Criminal justice systems
 - Faith institutions
 - Government institutions
-
- Create and implement a public awareness campaign across Fulton County to reduce stigma associated with HIV, LGBTQ identity and expression, substance use and mental health disorders, race, ethnicity, and socioeconomic status. Ensure that the campaign is coordinated with the countywide campaign for HIV education and awareness.
 - Work with the Mayor and City of Atlanta officials to create and implement a campaign across City agencies to reduce stigma associated with HIV, LGBTQ identity and expression, substance use and mental health disorders, race, ethnicity, and socioeconomic status. Ensure that the campaign is coordinated with the countywide campaign for HIV education and awareness.
 - Create compassionate, culturally competent, and customer satisfaction-oriented services and care systems for PLWHIV and disproportionately affected populations. (see Cross Cutting)
 - Adopt policies and procedures supporting the meaningful involvement of PLWHIV across all HIV services (see Cross Cutting)
 - Increase access to peer and social support resources, counseling and education for persons with and at high risk for HIV infection, in order to reduce individual (internalized) and interpersonal HIV stigma.
 - Orient client services for PLWHIV around self-empowerment and meaningful employment; ensure programs are aimed at long-term self-sufficiency to reduce dependency on public support systems. Implement “Bridge to Self Sufficiency” processes as part of client services for PLWHIV.
 - Adopt tools for assessing stigma and implement them within agencies and clinics, and across the broader community.
 - Provide continuing education and/or training in cultural competency and sensitivity for care providers throughout the jurisdiction.
 - Create and implement an anti-stigma campaign in collaboration with faith-based institutions.
 - **POLICY: Reform HIV criminalization laws to align with current HIV science and advance best public health practices for HIV prevention and care.**

HIV stigma is a complex and insidious problem that has overlapping roots in our fear of sickness and death, cultural taboos about sex and drug use and the historical marginalization of people of color, LGBTQ people and women. In practice, stigma leads to discrimination against people living with and perceived to be at risk for HIV, inability to talk about the topic of HIV without shame and fear, and avoidance of HIV-related health behaviors like prevention measures, education, testing, care and medication. These harmful effects of stigma exist at multiple levels: one can experience internalized stigma, characterized by feeling shame and embarrassment about becoming HIV positive or being at risk for HIV; interpersonal stigma,

through which one person imparts stigma-infused judgment upon another (such as from a care provider in a medical appointment, or during an HIV status disclosure situation); community-level stigma, whereby stigmatizing messages or cultural norms reach large groups of people; and structural stigma, where HIV stigma is codified into law and policy, such as bans on HIV positive immigrants or laws that criminalize HIV positive people.

Combatting stigma will require community-level interventions to raise awareness and promote an anti-stigma framework. Fulton County and the City of Atlanta have an opportunity to introduce anti-stigma campaigns among their agencies, and will reach tens of thousands of employees by doing so. Working with faith communities will be particularly important to lift the veil of stigma that has permeated many faith institutions. Health care settings need education in cultural competency, as mentioned previously. Likewise the previously described actions to implement meaningful involvement of PLWHIV will reduce stigma. Reforming stigmatizing and scientifically unsound HIV criminalization laws will reduce stigma and discrimination associated with unfair legal reprisals against PLWHIV.

Cross Cutting Objectives: Policy

The success of the *Strategy to End AIDS* will depend upon the enactment of several key policy changes on the county and state level. Changes such as incorporating strong language around cultural competency in county contracts and implementing coordinated hiring practices can be accomplished on the staff level under the leadership of the County Manager and Director of the Department of Health and Wellness. Changes such as guaranteeing adequate levels of local funding for prevention and care services such as PrEP and PEP, defining syringe services as a legitimate medical purpose and prioritizing HIV policies in the county's legislative agenda clearly fall under the purview of the Fulton County Commission. Other changes such as ensuring that all hospitals and federally qualified health centers adhere to recommendations on routine opt-out HIV testing within a medical setting, addressing homelessness, and revising sexuality education curricula in Fulton County and City of Atlanta schools will require engagement and coordination with stakeholders beyond than the County Commission.

The Task Force also recommends changes in state and federal policy for consideration by members of the County Commission. Chief among these would be to support efforts to close the coverage gap for the thousands of low-income people living with HIV/AIDS and their family members who currently do not qualify for Medicaid and are unable to afford private insurance through the marketplace. Because our current continuum of prevention and care services relies almost exclusively upon federal funds, the Task Force also recommends that the County Commission set aside funds to allow appropriate staff to participate in federal advocacy efforts such as the Communities Advocating for Emergency AIDS Relief (CAEAR) Coalition, a key coalition that supports the Ryan White program. Policy recommendations are in red, throughout the report.

Next Steps

Phase II of the *Strategy to End AIDS in Fulton County* recommends actions that are needed to accomplish the bold objectives set forth by the Task Force in consultation with the community and its leaders. Phase I of this *Strategy* was extremely well received and implementation of some of these recommended Phase II actions began even before Phase II was complete. Phase III will include development of more specific plans with accountability and timelines for implementation. It will include resource and gap analysis where appropriate, and cost analysis for selected objectives and actions. The *Strategy* aims to be a living blueprint that will provide guidance for all entities working in HIV prevention and care and to our Fulton County leaders who have shown they possess the necessary political will to make this *Strategy* a reality. Ending AIDS in Fulton County is not a dream or a platitude or a wish. It is an achievable strategy. It will require collaboration and compromise and passion and practicality. Most of all, it will require working together. The good news is that this community is ready for change. This community is tired of seeing people acquire HIV, tired of seeing babies born with HIV, tired of barriers to care and treatment, and tired of seeing people die with AIDS. This community - service and care providers, public health professionals, academics, advocates, political officials, and PLWHIV - has come together to make a statement. That statement is the *Strategy to End AIDS in Fulton County*. This community is committed. **Because OUR Time is NOW!**

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GLOSSARY

- Acute HIV infection:** Early stage of HIV infection that extends approximately 1 - 4 weeks from initial infection until the body produces sufficient HIV antibodies to be detected by an HIV antibody test. Acute HIV infection can be diagnosed with an HIV RNA test that is positive before HIV antibodies are present.
- AIDS (Acquired Immunodeficiency Syndrome):** An epidemiological term used to define the advanced stage of HIV infection when the CD4 count is < 200 cells/ μ L now also called CDC Stage 3.
- Antiretroviral (ARV/ART):** A drug used to prevent a retrovirus, such as HIV, from replicating. The term primarily refers to drugs used to treat HIV -also known as antiretroviral therapy (ART).

CD4 Cell Count: The number of T-helper lymphocytes per microliter (μL) of blood (which is equal to about 1/50th of a drop of blood). The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 – 1500/ μL . A CD4 count of 200 or less is an AIDS-defining condition.

Co-infection: When a person has two or more infections at the same time. For example, a person infected with HIV may also be co-infected with hepatitis C (HCV) or tuberculosis (TB) or both.

Hepatitis C Virus (HCV) Infection: A type of virus that causes inflammation of the liver (hepatitis). Hepatitis C virus (HCV) is usually transmitted through blood but can also be transmitted sexually, mainly among men who have sex with men (MSM). HCV infection progresses more rapidly in people co-infected with HIV than in people without HIV.

HIV Care Continuum: Successful management of HIV requires that a person be diagnosed, linked to care, started on ART, retained in care and that the patient adheres to both ART and care. The Care Continuum is a term used to describe this process. It is also known as the HIV Care Cascade.

HIV RNA: The genetic material of the human immunodeficiency virus (HIV). It can be measured in the blood and reported as copies/ml. The goal of antiretroviral therapy is to decrease the amount of HIV RNA in the blood to levels below the limit of detection.

HRSA (Health Resources and Services Administration): The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.

Injection Drug Use: A method of using illegal drugs in which the drugs are injected into a vein, into a muscle, or under the skin with a needle. Blood-borne viruses, including HIV and hepatitis B and C, can be transmitted via shared needles or other shared drug injection equipment.

Linkage To Care: The process that leads a patient to enter care after diagnosis. In HIV it refers to the initiation of HIV outpatient care. The goal of the National AIDS Strategy is that a person completes a visit with an HIV medical provider ≤ 30 days after their HIV diagnosis.

Linkage Navigation Services: A process of service delivery to help a person obtain timely, essential and appropriate HIV/STD/HCV- related medical and social services to optimize his/her health and prevent HIV transmission.

Opt-out HIV Screening/Testing: Performing an HIV test after notifying the patient that the test is normally performed but that he/she may elect to decline or defer testing. Assent is then assumed unless the patient declines testing.

Partner Services: Services that are offered to persons with HIV infection, syphilis, gonorrhea, or chlamydial infection AND to their partners.

Perinatal Transmission: When an HIV-infected mother passes HIV to her infant during pregnancy, labor and delivery, or breastfeeding (through breast milk). Antiretroviral (ARV) drugs are given to HIV-infected women during pregnancy and to their infants after birth to reduce the risk of perinatal transmission.

Post-exposure Prophylaxis (PEP): Short-term treatment started as soon as possible after a high-risk exposure, like unprotected sex, to an infectious agent, such as HIV. The purpose of post-exposure prophylaxis (PEP) is to reduce the risk of infection after exposure.

Pre-exposure Prophylaxis (PrEP): An HIV prevention method for people who are HIV negative and at high risk of HIV infection. Pre-exposure prophylaxis (PrEP) involves taking a specific combination of HIV medicines daily to prevent infection if exposed to HIV. PrEP should be combined with condoms and other HIV prevention interventions.

Reengagement: When a person who has dropped out of outpatient care for HIV begins to make and keep appointments again (see "Retention")

Retention: Retention in care means keeping patients engaged in outpatient care. An estimated 50% of persons living with HIV in the US are not retained in care. Retention is essential to providing ongoing treatment to all HIV-infected persons, including those not yet receiving ART. Retention is not necessarily "all or nothing" and some patients may exhibit a cyclical in-and-out pattern of care (see: "Reengagement").

Ryan White HIV/AIDS Act of 2009 (Ryan White HIV/AIDS Program): Enacted in 2009, this legislation reauthorized the Ryan White Program, formerly called the Ryan White CARE Act and the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

Serostatus: The state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test). For example, HIV seropositive means that a person has detectable antibodies to HIV; seronegative means that a person does not have detectable HIV antibodies.

Syringe Exchange Programs (or Syringe Services Programs; SSPs): A social service that allows injecting drug users (IDUs) to obtain clean hypodermic needles and associated paraphernalia at little or no cost.

Targeted HIV Testing: Any screening process that is geared to meet a particular population. Populations identified for targeted testing are considered high risk for exposure to HIV.

Viral Load: In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression and risk of transmission. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

Viral Suppression: Suppressing or reducing the function and replication of a virus. Viral suppression is the goal of a successful HIV treatment regimen.

Fulton County Task Force On HIV / AIDS

