Phase III Progress Report Building the Strategy to End AIDS in Fulton County: Progress and Priorities

Fulton County Task Force On HIV / AIDS

July 31, 2017

OUR Time Is NOW!

OUR VISION

Fulton County will be a community without new HIV infections or AIDS-related deaths, where all individuals living with HIV will be virologically suppressed while receiving uninterrupted care and treatment, free from stigma and discrimination, and grounded in the recognition that access to healthcare is a human right. Persons without HIV will be educated, empowered, and able to access tools to prevent HIV transmission.

JOHN H. EAVES, PH.D
CHAIRMAN

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FULTON COUNTY

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July 31, 2017

Dear Friends,

Over the last three decades, medical advances have transformed the HIV infection from a death sentence into a manageable condition. People with HIV who receive effective treatment can live a normal lifespan without developing AIDS. Over the last decade, new HIV infections in America have decreased for the first time ever. We can prevent new HIV infections by providing treatment to people with HIV and pre-exposure prophylaxis (PrEP) to those at risk for acquiring HIV. But sadly, all people are not benefitting equally from this amazing progress. Right now, Fulton County sits within the epicenter of HIV/AIDS in America. While other cities and states have seen their epidemics lessen, our epidemic has stubbornly persisted, feeding off of economic and social inequities, stigma, and discrimination.

The Fulton County Task Force on HIV/AIDS was conceived on World AIDS Day (December 1, 2014), when the late Vice-Chair Joan Garner and I heard the horrifying data about the HIV epidemic in our county. We immediately resolved to fight back. The Task Force quickly identified the need for a comprehensive *Strategy to End AIDS in Fulton County* and set about developing that strategy. In phase I of the task force's report on December 1, 2015, there were bold objectives and challenges presented to the Board of Commissioners. Phase II contained specific recommendations to achieve these objectives. Phase III, presented today, provides a progress update and prioritize key recommendations for the remainder of 2017 and 2018.

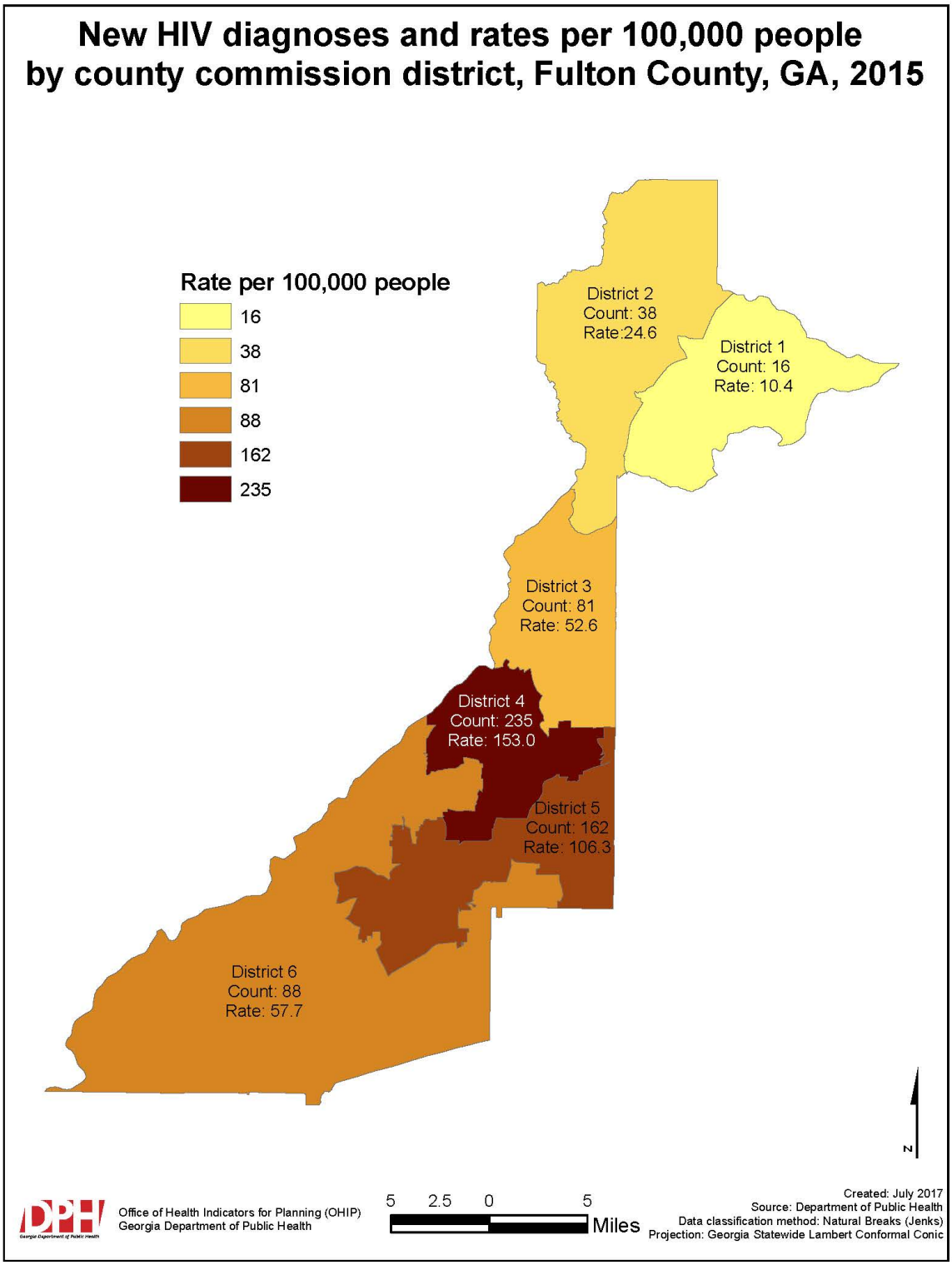
The Task Force has surpassed our expectations. Its *Strategy* demonstrates that there are many years of work ahead to end our HIV epidemic. Therefore, Vice-Chair Garner and I co-sponsored a resolution, later joined by Vice-Chair Ellis, to create a permanent HIV Prevention, Care, and Policy Advisory Committee to continue work on the *Strategy* and to advise the Board on actions and policies we can enact to "turn the tide."

We are devastated by the loss of our beloved Vice-Chair Garner, her voice was strong and unwavering in her support for the Task Force and her commitment to end the epidemic. It is, therefore, fitting that the Task Force dedicate its last chapter of work to her memory as we pass the torch of this great work to the new Advisory Committee. Please join the Board of Commissioners as we renew our commitment to end AIDS in Fulton County.

Sincerely,

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

Fulton County
at your service...


New HIV diagnoses and rates per 100,000 people
by county commission district, Fulton County, GA, 2015
Rate per 100,000 people
16
38
81
88
162
235
District 2
Count: 38
Rate:24.6
District 1
Count: 16
Rate: 10.4
District 3
Count: 81
Rate: 52.6
District 4
Count: 235
Rate: 153.0
District 5
Count: 162
Rate: 106.3
District 6
Count: 88
Rate: 57.7
N
Office of Health Indicators for Planning (OHIP)
Georgia Department of Public Health
5 2.5 0 5
Miles
Created: July 2017
Source: Department of Public Health
Data classification method: Natural Breaks (Jenks)
Projection: Georgia Statewide Lambert Conformal Conic

THE FULTON COUNTY TASK FORCE ON HIV/AIDS

AN ADVISORY BODY TO THE FULTON COUNTY BOARD OF COMMISSIONERS

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July 31, 2016

As Co-Chairs of the Fulton County Task Force on HIV/AIDS, and on behalf of the full Task Force, we are pleased to present Phase III of the "**Strategy to End AIDS in Fulton County**". The vision for an "End of AIDS" in Fulton County began in December 2014 with the leadership of Chairman John Eaves and then Commissioner Joan Garner establishing this Task Force. Since that time, volunteers from in and around Fulton County have worked tirelessly to develop a comprehensive blue print to End AIDS in Fulton County. Phases I & II of the Strategy focused on overarching goals, objectives, action plans and priorities and in Phase III we aim to refine and focus and the priorities necessary to advance the journey to End AIDS in Fulton County.

As with each of the prior Phases of *The Strategy* this document was informed by evidenced-based practices and represents contributions from people living with and affected by HIV, officials from Fulton County, the City of Atlanta, and the State of Georgia, HIV care providers, scientists, epidemiologists, advocates and public health officials. Phase III highlights successes of the Task Force, to date, such as: a resolution (16-13-32) to make syringe service exchange a legitimate medical use in Fulton County; the launch of Fulton County PrEP clinic and scale up of PrEP services within Fulton County; the implementation of Rapid Entry programs (into HIV care) at various sites in Fulton County; and making recommendations for the sexual health curriculum of Atlanta Public Schools. While celebrating some successes, it is important to recognize that the process of Ending AIDS in Fulton is only just beginning and Phase III lays out the Task Force's priorities on the most important steps to take to End AIDS in Fulton County.

The positive strides in the local fight against HIV/AIDS over the past 30 months are reassuring. Yet young people continue to become infected, while persons living with HIV continue to die from AIDS-related complications in an age where HIV should be a chronic disease. These new infections and poor care continuum outcomes disproportionately affect black gay men and transgender women - these statistics and individual stories remind us of the work left to do. In addition to the release of Phase III of the Strategy, today marks the transition from the Fulton County Task Force on HIV/AIDS to the Fulton County HIV/AIDS Prevention, Care, and Policy Advisory Committee. The formation of the Advisory Committee came from the foresight and leadership of Chairman Eaves and then Vice-Chair Joan Garner who understood that Ending HIV/AIDS in Fulton County would require a more permanent body to continue the work, in place of a temporary Task Force effort. In a time when undetectable=untransmittable and a daily pill (PrEP) can prevent new HIV infections, the vision of an end to new infections and zero AIDS related deaths is more achievable than ever. It will require vigilance, advocacy, innovation and community involvement to accomplish the goal!

We thank you all for your support and the continued, community-wide commitment, to ending the epidemic.

Sincerely,

Jonathan Colasanti, MD, MSPH Daniel Driffin, BS

The Fulton County Task Force on HIV/AIDS
Hereby Dedicates our Phase III Progress Report on
the *Strategy to End AIDS* in Fulton County
to our Founding Mother
Vice-Chair Joan Garner

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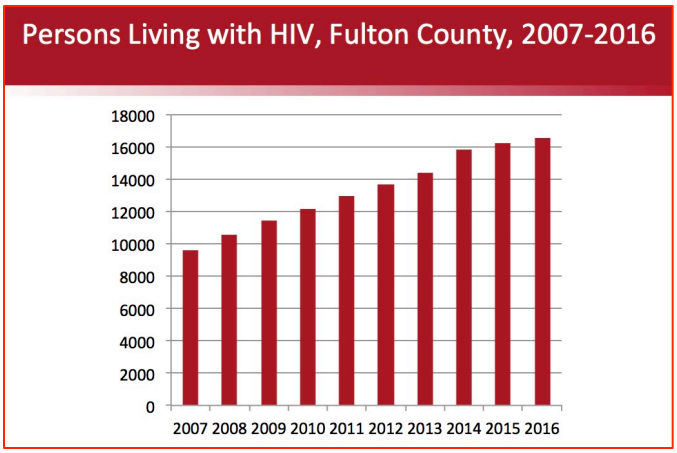
OUR Time Is NOW

There are just too many distractions in today's world. Will we be attacked by North Korea? Will the Russians steal the vote? What to do about Syria? Will Ebola come to Georgia again? Will Zika? Will Congress take our healthcare? What happened on Scandal? Did I miss a Tweet?? We are so distracted by the loud and messy world in which we live, we hardly notice that a silent killer still lurks among us. It is not high blood pressure or diabetes, but, like them, it is silent because it kills you slowly. It is silent because it hides in the shadows and thrives on inequality, the powerless, and the voiceless. It is silent because it is stigmatized, a shadow figure of shame. With the Plague Years remembered only in a documentary or two by increasing numbers of people, there are no more headlines about HIV. It was once a death sentence. That was when ACT-UP had to shake us up, claiming the streets, the FDA, the NIH. The good news is that we have made so much progress that the anger is now mostly gone, and the demonstrations have dispersed. When a person with HIV takes their antiretroviral medications and their virus is suppressed, they can live a healthy, near-normal life span. Having suppressed virus means they don't pass it to partners. We can stop new infections just by treating everyone with HIV with life-saving medications, getting a one-two punch to save their lives but also the public's health. And people without HIV can take PrEP to protect themselves and stay HIV negative. AIDS wards in hospitals around the country have closed, but not in Atlanta. The silent killer has found a comfortable home here in the South. So what is wrong with this picture?



Why are we now the epicenter of America's HIV epidemic? Why do we have over 16,000 people living with HIV here in Fulton County? Why do we have young men dying of AIDS, right downtown on Jesse Hill Drive, right now in 2017? Why are the rates of HIV in young gay and bisexual men in Atlanta similar to those in Zimbabwe? Why can't we do something about this? Why can others do it when we – apparently - cannot?

These are the questions that led to the formation of the Fulton County Task Force on HIV/AIDS in December 2014. Chairman John Eaves and Commissioner Joan Garner decided enough was enough after hearing these shocking data. The Task Force – including over 120 volunteers - has struggled to get its hands around this vexing problem. It has held dozens of meetings all over the county, where members mainly listened as people told their stories of having HIV, watching loved ones die of HIV, having babies with HIV, and also trying their best not to get HIV. It has hosted workshops with experts, scientists, medical providers, case managers, psychologists, epidemiologists, prevention specialists, teachers, and ministers – all trying to decide how to end this silent plague.

The answer is not simple. If it were, Fulton County would not have nearly 700 new infections year after year, and young black men would not be dying in front of our eyes. And although there is not a silver bullet, no golden path, and no simple solution, there are indeed answers. There are paths that have worked for others. There are many, many steps that we can take to bring us closer to the day when we end the HIV epidemic here at home. We have to start somewhere. And so, the Task Force now presents its Phase III Progress Report on the *Strategy to End AIDS in Fulton County*. It will not be easy or fast or simple. Yes, it will take money. It also will require pushing beyond comfort zones. It will require advocacy and, yes, maybe getting out in the streets again. But we can, as a community, get it done. Join us as we "bend the curve" of the epidemic back toward zero. Join us as we lock arms, take back the streets, and #EndAIDSFulton. There is no other time. 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 could then be implemented and monitored to assess progress, and continually revised to serve as a living blueprint to end the epidemic.

The Task Force's appointed membership consists of 14 members who reside in Fulton County and who are appointed by the Board of Commissioners. Early on, the Board and Task Force members recognized that an effective strategy would require individuals with significant, wide-ranging content expertise, many of whom work but do not reside in Fulton, to appropriately address the many areas that require attention in a truly comprehensive plan. Therefore up to 25 non-appointed contributors also are members of the Task Force, along with other content experts who serve as contributors. The Director of the Fulton County Department of Health and Wellness, now Fulton BOH, the Director of the Ryan White HIV/AIDS Program Part A Recipient Office, and the Director of the High Impact Prevention Program 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 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 Fulton BOH 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.

The Executive Committee, consisting of the Co-Chairs and the Chairs of standing committees, is the leadership body of the Task Force. One member of the Executive Committee serves as the Executive Editor of the *Strategy*.

Now as we produce our third report, the Board of Commissioners has made a new commitment to create a permanent body rather than a temporary Task Force, to address this crisis. As of August 1, we pass ownership of the living *Strategy to End AIDS* to the new HIV/AIDS Prevention, Care, and Policy Advisory Committee.

Methodology

In addition to providing advice to the Board of Commissioners, the primary undertaking of the Task Force has been to develop and monitor a comprehensive *Strategy to End AIDS in Fulton County*. The *Strategy* consists of goals, objectives, and recommendations that can subsequently guide promotion, implementation, monitoring and reassessment of the *Strategy* 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 was 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. The Phase II document contained objectives and recommended actions for achieving the objectives. This Phase III document prioritizes key objectives, identifies highest priority recommendations for 2017-2018, and reports on current status.

Much of the work of the Task Force has been done in committees and subcommittees. In addition to regular face-to-face meetings, there have been frequent conference calls, sometimes weekly or even

more often. The emphasis throughout has been to collect broad input from as many stakeholders as possible and to ensure that the voices of PLWHIV are especially heard.

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 has created an open and inclusive process and has actively sought feedback, especially from those who may not generally have their voices heard. We created many opportunities to engage in discussion and receive feedback across the entire county. 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, 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 identification of 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 data sources for many objectives 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.

Data Challenges

The Georgia DPH HIV Epidemiology Division has worked closely with the Task Force and our entire community to produce timely and accurate data for use in understanding our epidemic, designing new programs, and monitoring them over time. The epidemiology team strives to address obstacles to data collection, cleaning, and analysis in order to produce data that successfully balance timeliness and completeness such that they are useful for guiding program decisions. Here are three data challenges that impact the epidemiologic data presented in this report.

Timeliness: At present, the number of new diagnoses for 2016 will not be final until mid-2018. This is because cases diagnosed in 2016 are followed up for missing data elements in 2017. Once the minimum data elements are collected, the case can be submitted to CDC, and the CDC assists states in determining which cases were previously reported by other states by conducting a match based on soundex code because identifiers are not sent to CDC. Once CDC identifies potential matches, states are notified and contact each other to conduct de-duplication activities. As a result of this process, the number of new diagnoses decreases.

To speed up this process, the surveillance program is working towards conducting follow up for collection of minimum data elements during the year of report rather than the subsequent year. As a result de-duplication activities will occur sooner, and data will be available in a more timely way.

Transgender: The HIV case report form contains a field to indicate birth sex, and another to indicate current gender identity. When available, information is also obtained from CAREWare, and from STD case management. To a large extent, the ability of the HIV Surveillance program to identify transgender persons with HIV is limited by what providers report. Increased communication with providers to collect required surveillance data may result in better identification of transgender persons.

Care continuum: The main limitation of the care continuum is that persons for whom the surveillance program has not received lab reports (CD4 or viral load) are assumed to be out of care. However, a substantial portion of persons with no labs in the last 12 month period appear to have been out of care for many years, and may in fact have moved to another state and been missed by the deduplication efforts (especially if they moved before the start of HIV reporting), or may have died but been missed by death matching activities. The proportion of persons in care and virally suppressed is most likely higher than reflected by the care continuum. For this reason, the reader should focus on trends over time and patterns, rather than absolute values.

Federal Funding for HIV Services in Fulton County

Funding for HIV services in Fulton County comes largely from two federal sources, the Health Resources Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC). The Substance Abuse and Mental Health Services Administration (SAMHSA) also provides approximately $5.2 million directly to 10 funded agencies. Funding from Housing and Urban Development (HUD) for Housing Opportunities for People with AIDS (HOPWA) flows through the City of Atlanta. The state of Georgia appropriated $342,635 in 2017 to support sexual health programs in Fulton and one nurse at Fulton's PrEP clinic. In addition, the state makes a mandatory contribution to match Ryan White Part B funding for the AIDS Drug Assistance Program (ADAP) for the entire state ($16 million).

There is often confusion about how much federal money comes directly for use by the Fulton Board of Health (BOH). HRSA allocates $25.5 million for Ryan White Part A programs in the entire Atlanta metropolitan area. This funding passes through the Ryan White Part A Recipient Office in the Fulton County Office of the County Manager and is awarded to agencies and local health departments, including $2.9 million to the Fulton BOH. The Fulton BOH receives CDC HIV High Impact Prevention Program (HIPP) funding for Fulton and DeKalb Counties. Of the $8 million awarded for 2017, $3 million stays at the Fulton BOH, $2 million goes to DeKalb, and the remainder is awarded to local agencies. Total federal funding for care and prevention services allocated to Fulton BOH was just under $6.9 million in 2017. In 2017, Fulton County appropriated $334,185 to Fulton BOH that largely funds the Sexual Health Program. Specifics regarding allocation of federal funding for HIV in Fulton County can be found in Appendix A.

Key Priorities

The key priorities identified in our Phase II report have not changed. We repeat them here to emphasize the overall priorities that guide our decision making at every step in the process.

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 in Care to Remain 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. Know your HIV status!

HIV is Preventable. So Prevent It.
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 in the first and third trimesters, 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.

Cross Cutting Issues

Some issues cut across every aspect of HIV prevention, care, and treatment. These cross-cutting issues tend to be difficult, even overwhelming. Yet, overcoming these obstacles can unlock paths to the end of the HIV epidemic. It would be hard to envision ending the epidemic without them. Some will be tough but if we can chip away at them, year after year, the effort will pay back many fold.

Structural Issues Affecting Healthcare Access and Delivery: Access to Care

Key Objective

- *Expand access to medical, mental health, and substance use care for PLWHIV*

Highest Priority Recommendations for 2017-2018

- *POLICY: Advocate for expanding Medicaid to improve access to care for PLWHIV and those at risk.*
  - *POLICY: Advocate for 1115 waivers to expand Medicaid eligibility in Georgia under the Affordable Care Act.*
- *POLICY: Advocate for increased funding of the Health Resources and Service Administration's Ryan White HIV/AIDS Program including AIDS Education and Training Centers; the Minority AIDS Initiative; CDC's HIV/STI/Viral Hepatitis/TB prevention programs; and Housing and Urban Development's Housing Opportunities for Persons With AIDS (HOPWA) program.*
  - *Request that the Board of Commissioners purchase membership in the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition and support travel to meetings for the Ryan White Part A Recipient Office Director.*
- *Expand access to premium, deductible, co-pay, and co-insurance through the Health Insurance Continuation Plan (HICP) for persons with HIV.*

Current Status

The HIV epidemic will not end until all persons with HIV have unimpeded access to continuous medical care and antiretroviral treatment. Georgia has one of the nation's highest uninsured rates, ranking 41st among states. Because of the decision not to expand Medicaid under the Affordable Care Act, people with HIV who are uninsured receive their care through the Ryan White HIV/AIDS Program (RWHAP), the federally funded "payer of last resort." Life-saving antiretroviral therapy (ART) is available through Ryan White's AIDS Drug Assistance Program (ADAP), with additional contributions from the State of Georgia, but patients have limited access to specialty medical services or drugs for most non-HIV conditions. The RWP delivers HIV care that exceeds national averages [HRSA, 2016] but current funding has remained flat, as the number of PLWHIV has continued to increase to the point that the funding is insufficient Access to mental health and substance use services remains inadequate but is crucial to address these common co-occurring syndemic conditions.

Three mechanisms for expanding access are to continue to advocate for Medicaid expansion, to increase funding for the RWP, and to create novel means to expand access to commercial insurance. The Affordable Care Act provides several means by which to expand access to Medicaid, including the use of 1115 waivers (Medicaid.gov). The Task Force encourages lawmakers to approach the need for expanding access to healthcare in a bipartisan fashion and to consider outright expansion as well as exploring waivers to support our most vulnerable populations.

Advocacy at the federal level is essential to maintain, much less increase, funding for Ryan White and other programs essential to ending the domestic HIV epidemic. Recent budget proposals have taken aim at Ryan White Part C, which funds community clinics such as AIDS Education and Training Centers (AETCs), that are crucial to addressing our workforce shortage (see below) and maintaining high quality care, and the Minority AIDS Initiative whose mandate is to promote interagency cooperation to fight HIV among minorities bearing a disproportionate burden from the epidemic. CDC's prevention programs account for the lion's share of funding in our county and state for vital programs to control these key infectious diseases. Housing is both care and prevention, and HOPWA, which provided almost $22,350,000 to the City of Atlanta in 2017, is vital to our ability to provide effective treatment for

unstably housed PLWHIV, but is at risk of significant budget cuts or elimination as this document is being written. Given the challenges that we face in order to End AIDS in Fulton County, it has never been more important that advocates bring strong and informed voices to Washington to fight for the lives of people with and at risk for HIV. The Communities Advocating Emergency AIDS Relief (CAEAR) Coalition is the country's oldest national advocacy organization focused on advocacy for Ryan White "policy, legislation, regulations, and appropriations." [http://www.caear.org/caear/index.shtml] The Task Force strongly recommends that the Board of Commissioners purchase a membership in the CAEAR Coalition for the county and support sending key staff, ideally the Ryan White Part A Recipient Office Director, to its meetings.

Using RWP funds to purchase commercial insurance premiums under the HICP saves funds due to the high price of HIV medications. (McManus, 2016) All cost sharing, however, is not provided by subsidy and many patients cannot afford deductibles, co-pays or co-insurance associated with these plans. Expanded use of ADAP funds for HICP, including out of pocket costs is still a cost saving measure. It takes the burden of care and drugs off of the RWP and allows more people to be served.

Additional Recommendations

- Expand the ability of Ryan White clinics to accept commercial insurance plans, especially those available through the Affordable Care Act Healthcare Marketplace and Medicare Advantage plans.
- Increase accessibility of HIV medical services within underserved areas of high HIV prevalence

Many clinics are not able to accept commercial insurance, or accept limited plans. Expansion of this ability will be crucial to maintaining continuity of services when patients shift from Ryan White to private insurance, or perhaps lose insurance. HIV medical services are not always available in areas of highest HIV prevalence, and transportation is challenging in our sprawling metro area, creating a barrier for many patients. Expansion of HIV clinical services, whether by use of mobile units, expansion of HIV capability into existing clinics, or creation of new clinics is needed.

Structural Issues Affecting Healthcare Access and Delivery: Workforce Shortages

Key Objective

- *Increase the HIV provider workforce and decrease attrition across testing, prevention, and care sites in Fulton County.*

Highest Priority Recommendations for 2017-2018

- *Expand capacity for HIV testing and counseling through increased numbers of trainings of testers and trainers.*
- *Expand capacity for HIV care through Federally Qualified Health Centers and Community Health Centers.*
- *Develop a workforce recruitment and retention plan to address provider and support staff shortages, and explore models of care requiring fewer clinic visits, and employing telemedicine and task shifting.*
- *Advocate for National Health Service Corps eligibility for providers at HIV clinics in Fulton County.*

Current Status

As the number of PLWHIV grows annually in Fulton County, local clinics struggle to meet the demand. Severe health workforce shortages cause difficulty in hiring staff, especially medical staff, to implement HIV programs. Unfilled positions result in lower capacity to accommodate patient needs and potential loss of unspent funds at the end of the grant cycle. Without adequate staffing, objectives for rapid

linkage to care cannot be achieved, nor can human resource-intensive objectives related to retention and reengagement. Likewise, the demand for HIV testing and counseling training has outstripped the number of available trainers, thus slowing the expansion of HIV testing capacity. While the need for doctors, physician assistants, and nurses (including nurse practitioners) is most acute, other staff such as specialized pharmacists, social workers, navigators, and counselors are also in short supply.

During 2016 and 2017, the Georgia AIDS Education and Training Center (GAETC) at Morehouse School of Medicine has collaborated with DPH to increase capacity for training in HIV testing and counseling around the state, including in Fulton County. GAETC worked collaboratively with DPH to provide a Train-the-Trainer program to help expand the number of trainers available to conduct HIV testing and counseling training, including in Fulton County. GAETC also provided additional trainings in HIV counseling and testing to assist Fulton. Work is ongoing to meet the demand for HIV counseling and testing trainings.

GAETC has worked with Mercy Care and Southside Healthcare, both FQHCs, on staff trainings to help non-HIV physicians be more comfortable with HIV testing and counseling, and with managing HIV care. Recently 20 non-HIV doctors from Southside attended a 4-hour training on a Saturday morning to learn about HIV testing and counseling and hear an update on HIV care. Ongoing trainings of this sort are needed across all metro FQHCs.

Formulation of a comprehensive strategy for workforce recruitment and retention has not yet been attempted. First steps toward implementing this recommendation include finding a "home" for this effort, whether at a medical school or through another stakeholder, and ensuring broad inclusion of individuals from different disciplines who can contribute to planning for recruitment and retention of multi-disciplinary teams. The strategy should also explore the use of telemedicine and task shifting.

The National Health Service Corps provides debt relief for eligible providers, but most HIV clinics are not eligible venues for service. National advocates recommend expanding the definition of eligible locations to include HIV clinics because of the public health impact of the work.

Additional Recommendations

- 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.

Attracting new clinicians to work in HIV is an ongoing challenge. Flexible working conditions can be motivators, sometimes compensating for salaries that may be less than competitive, and creative solutions should be sought to attract candidates. Exposure to HIV clinical situations is important to attract students to the field, and internship opportunities should be provided to those in medical or nursing training. Emory/Grady provides many such opportunities through the Infectious Disease Program (IDP).

Intercultural Awareness, Customer Service, and Stigma Reduction

Key Objective

- *Create welcoming HIV services and reduce stigma by increasing the intercultural awareness and customer service orientation of staff working throughout the continuum of HIV testing, prevention, linkage, and medical, substance use and mental health care.*

Highest Priority Recommendations for 2017-2018

- *POLICY: Include comprehensive, context-based Intercultural Competence plans in all Fulton County contracts, especially those in health services and jails.*
  - *The Board of Commissioners should appropriate dedicated funds to continually develop, revise, and disseminate model Intercultural Competence plans to all county contractors.*
- *Survey current status by assessing intercultural competence, client satisfaction and perception of stigma at testing, prevention, and care sites.*
- *Engage AETC and external providers to implement an intercultural awareness curriculum for administrators and all HIV testing, prevention, linkage, Disease Intervention Specialist, medical clinic, substance use and mental health staff.*
  - *Ensure anti-stigma training is integrated to reduce homophobia, transphobia, racism, classism, sexism, HIV-associated and other forms of stigma and discrimination.*
- *Employ mechanisms for ongoing feedback from service recipients to assure quality of service delivery*

Current Status

In every community listening session, we heard that people disengage from medical care because of the many obstacles they must face to receive care, but also because they simply do not feel that clinics are welcoming to them. Changing culture is a complex and challenging undertaking that requires an intensive commitment. In September 2016, the Task Force created an Intercultural Awareness Subcommittee to begin to analyze and address these issues.

Progress of the Intercultural Awareness Subcommittee

The Intercultural Awareness Subcommittee is composed of HIV/AIDS healthcare providers, community members and activists, social scientists, and other HIV specialists. The Subcommittee started regular meetings on September 26, 2016. A strategic plan was subsequently created with the following vision and mission for the development of an Intercultural Competence curriculum.

Vision

HIV/AIDS health care providers at all levels of service will achieve Intercultural Competence, providing welcoming, relevant, and effective healthcare services.

Mission

To create a core curriculum to train personnel in Intercultural Competence to be implemented among all providers in the continuum of HIV testing, prevention, linkage, medical, substance use and mental health care services in Fulton County.

The following implementation phases were also created as part of the Intercultural Awareness Subcommittee's Strategic Plan:

Phase 1: Assessment of Intercultural Competence in Fulton County HIV Clinics. The subcommittee recommended an assessment phase to determine the Intercultural Competence-related needs of Fulton County providers and other relevant entities. The assessment should involve the evaluation of Intercultural Competence in (at least) the following domains: Ethnic/racial, sexual orientation, gender identity, socioeconomic status, education, age, addictions, religion/spirituality, immigration status, and other areas that are sources of stigma (eg. HIV-associated stigma, transphobia, homophobia, racism, classism). The assessment will also evaluate perceptions and attitudes towards "Cultural Competency Trainings" among personnel.

Phase 2: Intercultural Competence Curriculum Development. The Subcommittee agreed on recommending the development of curriculum from an "Intercultural Competence" paradigm and adapted to the specific sociocultural context and needs of Fulton County. The process of choosing a curriculum to adapt will be done in consultation with the Fulton County HIV/AIDS Prevention, Care, and Policy Advisory Committee, the Intercultural Awareness Subcommittee, relevant community stakeholders, and local experts and advisors. This process will be guided by the vision, mission, core values and general recommendations identified by the Intercultural Awareness Subcommittee.

The following were defined as the core values of the Intercultural Competence Curriculum: Empathy, Cultural Humility, Respect, Compassion, Respect for Autonomy, Promotion of Self-determination and Human Agency, Promotion of Service Provider's Critical Consciousness / Self-awareness, Awareness of Personal Bias, Patient Empowerment, Trauma Informed Care, Addressing Power Dynamics at All Levels of Healthcare Services, Development and Promotion of Intercultural Communication Skills, Promotion of Patient Advocacy, Open Communication/ Transparency, Promotion of Health Literacy, Active and Meaningful Community Participation in the Development and the Ongoing Review of the Curriculum.

Two key target audiences were identified for the implementation of the Intercultural Competence Curriculum: 1. Front line and non-clinical staff: the Curriculum for this group will focus on customer service and respect. 2. Clinical Staff: the curriculum will include elements of customer service but with more emphasis on interpersonal relationships, humility, communication, and respect.

Phase 3: Intercultural Competence Curriculum Rollout. This phase will begin with a six-month Pilot Implementation of the Curriculum with a subsequent review of the Pilot, in order to make any necessary changes and adjustments for optimal full rollout of the Curriculum.

Phase 4: **Intercultural Competence Curriculum Sustainability.** There was agreement that curriculum must be paired with a sustainability plan to ensure efficacy of the curriculum and, where necessary, to facilitate meaningful cultural change among providers.

Intercultural Competence Assessment Initial Pilot: February - August 2017

With the input of several stakeholders, a core group of the Intercultural Awareness Subcommittee created two pilot surveys (one for clinic clients and one for clinic administrators/providers) to be voluntarily administered at a sample of Atlanta area HIV clinics. These surveys will help assess the clients and staffs' perceived levels of cultural sensitivity, competence, and customer service orientation at the clinics. These surveys are being done as an

initial assessment of Intercultural Competence in order to determine how to better design and implement the full four-phase Intercultural Competence Strategic Plan.

The surveys will be completely confidential. The patient survey will not identify any client by name, medical record number, or any other Private Health Information (PHI). Similarly, the Administrative/Provider survey will not identify clinic staff by name or specific job title and individual clinics will not be identified in any publications or public reports.

Initial Pilot Survey Implementation: July-August 2017
The client survey is currently being administered on paper at three pilot clinics by a Master's student from Emory University's Rollins School of Public Health.

The Administrative/Provider survey will be carried out online during August-September 2017. The Subcommittee will ask the study leader to distribute the link to the survey to all clinic staff (medical and non-medical), as this assessment seeks a holistic approach to understanding organizational dynamics and Intercultural Competence at the clinics.

Facilitate Access to Substance Use (SU)/Mental Health (MH) Services
Key Objective
- *Improve access and linkage to mental health and substance use treatment programs for persons with HIV and those being tested for HIV.*

Highest Priority Recommendations for 2017-2018
- *Compile information about SU/MH providers, especially those providing Medication Assisted Treatment, for inclusion 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)).*
- *Integrate trauma-informed care principles and practices into prevention and clinical services.*
- *Provide training on Medication Assisted Therapy for opioid addiction.*
- *Expand access to substance use and mental health services through telemedicine.*

Current Status
The Georgia DPH CAPUS Resource Hub (gacapus.com) contains a directory of SU/MH providers. It does not specify which are trained in Medication Assisted Treatment and this could easily be added. The plan for integrating routine opt-out HIV testing in Fulton County behavioral health provider contracts also must include providing for linkage to care at HIV clinics and establishment of designated liaison. The GA AETC will commit to training HIV care providers in the use of screening tools to increase routine screening for SU/MH disorders and in the principles and practices of trauma informed care. The DPH is using telemedicine to offer consultation on hepatitis C services statewide, with mixed uptake. To date, no programs in metro Atlanta are known to be actively using telemedicine for behavioral health. There is, however, a Tele-Mental Health counseling program in which DPH collaborates with the University of Georgia and Augusta University. The University of California at San Francisco has recently implemented a warm –line for substance use issues (http://nccc.ucsf.edu/clinician-consultation/substance-use-management/). Although Medicare/Medicaid reimbursement rules currently limit the use of

telemedicine in urban settings, this concept deserves a feasibility analysis and piloting. A needs assessment study of trauma-informed care is currently being conducted at Grady IDP.

The 2016 recommendation to *"work with housing providers to allow access to housing for persons with substance use disorders"* has been fulfilled by new HOPWA housing contract requirements put into place by the City of Atlanta HOPWA Office.

Additional Recommendations

- Increase infrastructure for HIV care among persons with severe mental illness.
- 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.
- Assess current status and increase incorporation of trauma-informed care into substance use/mental health services.
- Train HIV providers in pain management, opioid addiction management, and substitution therapy.

Additional training is needed in order to assist HIV care providers in caring for people with severe mental illness and assessing the severity of mental illness among persons with HIV who are seeking care or receiving care. This is especially important because of the serious shortage of SU/MH providers. Co-location of SU/MH services is ideal but does not commonly occur. Collaborations with SU/MH providers should be explored in order to explore feasibility of co-locating services. Training of HIV providers in proper management of pain and opioid addiction should be required.

Community HIV Awareness and Education

Key Objective

- *Increase community awareness and education about HIV in Fulton County.*

Highest Priority Recommendations for 2017-2018

- *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.*

Current Status

Sadly, many in Fulton County do not know that HIV rages on as an epidemic in our midst. In a region where stigma and discrimination are prevalent, basic HIV education framed with anti-stigma messaging is particularly important. Among persons at highest risk of acquiring HIV, many do not know that HIV is preventable and have never heard of PrEP, while others do not know where to get free confidential HIV testing. Remarkably, even PLWHIV lack information about the benefits of ART, including that it can help them to live a normal lifespan without transmitting HIV to others. Many need basic information about available services and how to access them.

Fulton County HIPP collaborates with *Greater Than AIDS*, an excellent partner for HIV messaging, and has produced several campaigns such as *We Are Family, Empowered, Speak Out, I Got Tested, PrEP,* and *Atlanta > AIDS*. This recommendation envisions a more coordinated and strategic long term effort that would be grounded in the experience of local PLWHIV. This does not yet have a "home" or ownership. It

will require infrastructure and funding to implement and would be an excellent project for grant applications.

Additional Recommendations

- 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.

Meaningful Involvement of People Living with HIV/AIDS or at Risk for HIV/AIDS

Key Objective

- *Ensure that people living with HIV (PLWHIV) and those at highest risk for HIV 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.*

Highest Priority Recommendations for 2017-2018

- *Ensure that Fulton BOH 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.*

Current Status

Fulton BOH HIPP has access to multiple advisory committees that include PLWHIV in addition to the federally mandated Jurisdictional Prevention Planning Group (JPPG), some of whose members are PLWHIV. The HIPP staff held a meeting to inform the community about current funding awards and the requirements of the upcoming CDC HIPP funding opportunity PS18-1801.

We encourage the health department to include the community, especially PLWHIV beyond those on its staff, in a meaningful way throughout the planning for the PS18-1801 application, including the design of programs it intends to propose to meet the grant requirements. In addition, since GA DPH may be the recipient of some or all of the funding from this award, we encourage the state to include the community, especially PLWHIV beyond those on its staff, in discussions and planning for this grant proposal. Both health departments should educate all staff on the Denver Principles and their implications for the planning and implementation of HIV programs, and include PLWHIV in training and orientation for new staff. The Intercultural Awareness Subcommittee's work focuses on soliciting feedback from PLWHIV receiving services at agencies and clinics in Fulton County. All agencies should solicit feedback from PLWHIV who receive their services, and hire PLWHIV when possible.

When the new Fulton Advisory Committee convenes, it should ensure that PLWHIV are well represented. The Task Force will assist this effort by providing recommendations to the Board of Commissioners for new appointees.

Additional Recommendations

- Create funded leadership opportunities for PLWHIV.
- Create funded speakers' bureau of PLWHIV.

Structural Issues Affecting Fulton County Government, Including Fulton BOH

Key Objective

- *Address issues that impede optimal functioning by Fulton BOH*

Highest Priority Recommendations for 2017-2018

- *Ensure transparency regarding the use of federal, state, and county funds impacting HIV, STIs, viral hepatitis, and TB by Fulton BOH.*
- *Improve Program Collaboration and System Integration among HIV, STI, viral hepatitis, and TB programs for prevention and care at FULTON BOH.*
- *Ensure that structural changes affecting Communicable Diseases and Ryan White programs at Fulton BOH 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 Fulton BOH.*
- *Evaluate and address contracting processes that impede timely implementation of HIV, STI, viral hepatitis, and TB initiatives at Fulton BOH.*

Current Status

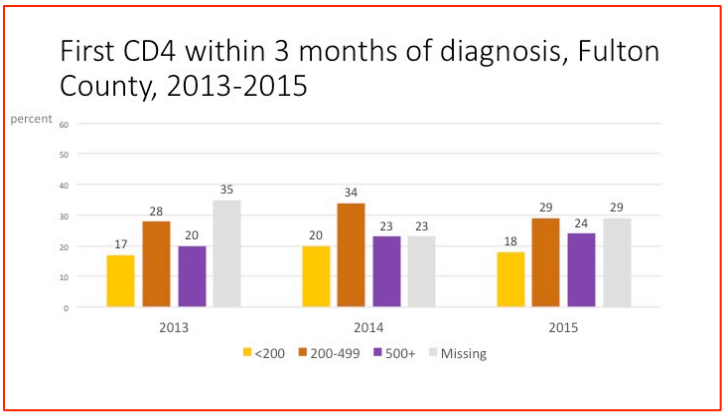
Since the Task Force's inception, the performance of the health department has improved and there is no longer any evidence that large sums of money are mismanaged in its HIPP program. Transparency provided by the Task Force has allowed the HIV community, citizens, and elected officials to rebuild trust in the agency. The new Health Director will be working under the Commissioner of Public Health and the new Fulton Board of Health, and new operating systems will be created over that next year that are likely to further improve functioning of the organization. Under the old governance, contracting issues have not been resolved, and CBO contracts continue to be late, risking the inability to expend allocated funds as planned. Hiring issues have not been resolved, and the HIPP Director position remains interim after 10 months of vacancy. The new Advisory Committee should set up a schedule for regular reporting to the Committee from the agency in order to understand whether grant deliverables and funding remain on track. Better communications and transparency will go a long way toward repairing damaged relationships with the community that began years before the current administration joined the agency.

Testing

Key Objectives

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

Based on methodology developed by CDC, the rate of undiagnosed HIV infection in Georgia is thought to be 16.6% (13.1-19.9%), with that of gay and bisexual men higher. We estimate that approximately 2981 persons in Fulton County are living with HIV but not aware of their status. The proportion of newly diagnosed persons found to have advanced disease (stage 3, AIDS) within 3 months of diagnosis has remained stable between 2013 and 2015. Both case finding efforts, and HIV incidence impact the percent of persons diagnosed late. As a result it is difficult to interpret change in this measure over time.



Ideally, however, no one should have AIDS at the time of diagnosis. Early diagnosis is associated with less likelihood of death or disease progression and early treatment offers the opportunity to live a normal and healthy life span without transmitting the virus. Data suggest that 30% of new infections are from PLWHIV who are unaware of their status. [Skarbinski, 2015]

Routine Opt-Out HIV Testing

In 2006, CDC produced a guidance recommending that HIV screening should be offered to all persons ages 13 to 64 who are being seen in health care settings, regardless of the reason. [Branson, 2006] This guidance was prompted by data showing that many people had made multiple visits to health care settings prior to being diagnosed with HIV, but had never been offered a test, resulting in late diagnosis and missed opportunities for treatment and decreasing HIV transmission. In 2013, the United States Preventative Services Task Force (USPSTF) gave HIV screening an "A" rating for persons ages 15 to 65, indicating that Medicare and Medicaid would reimburse for the testing. [Moyer, 2013] Fulton County government has the obligation - and opportunity - to ensure that health care delivered in facilities supported by county funds is in keeping with the highest standards of care as recommended by federal guidelines, in this case, CDC and USPSTF recommendations for HIV testing.

Highest Priority Recommendations for 2017-2018

- *POLICY: BOC should require that patients receiving healthcare (including behavioral health) through facilities supported by Fulton County funds receive routine opt-out HIV screening in compliance with CDC and USPSTF recommendations. Facilities should include:*
    - *Fulton County Board of Health outpatient clinics*
    - *Facilities contracted through the Fulton-DeKalb Hospital Authority*
    - *Facilities contracted to provide behavioral health and substance use treatment*
    - *Facilities contracted to provide medical services in Fulton County jails*
  - *BOC should require language in vendor contracts for behavioral health and correctional medicine to ensure that routine opt-out testing is implemented according to CDC guidelines; process measures and outcomes are regularly reported to Fulton BOH; and penalties for contract noncompliance are specified and enforced.*
- *Create data systems for monitoring, evaluation, and reporting on routine opt-out testing sites.*

Current Status

Fulton BOH identified opt-out HIV screening at its clinics as one of its key 2017 priorities. Individuals presenting for STI screening at the Fulton Sexual Health clinic routinely are offered HIV testing. In addition, Neighborhood Union (with HEALing Center) already has contractual language for HIV testing in place as of 2017. This center resides in The Bluff, a high HIV prevalence neighborhood and zip code. Neighborhood clinics at North Fulton, College Park, and Adamsville are targeted for opt-out HIV testing integration in 2017. Sexual health services also will expand to Adamsville.

At present, it is not possible to monitor numbers of tests offered and seropositivity at these clinics. Data collection methodology and systems are needed to ensure that this screening is monitored and is meeting objectives.

It should be a high priority to ensure that persons who are having blood drawn for any reason receive opt-out HIV screening using their blood sample. Likewise, all persons who present for sexually transmitted infection (STI), tuberculosis (TB), or viral hepatitis screening at any site in Fulton County should be offered HIV screening, including the use of rapid HIV tests if no blood is being drawn. Processes must be established for the care of persons testing positive, such that they are linked to a medical visit within 3 days and to other supportive services as needed. Individuals testing negative should be offered education about pre-exposure prophylaxis and post-exposure prophylaxis in addition to condoms and instructions for proper use.

Routine opt-out testing is performed at the Grady Hospital Emergency Department, with funding from Gilead Sciences' FOCUS project, Fulton County HIPP, and Grady. The program is now expanding to patients seen at other Grady ambulatory care departments, including neighborhood clinics, with a pilot project on the inpatient hospital service. Grady is our major safety net hospital that serves a low-income population, many of whom may be at risk for HIV. Full implementation of opt-out testing throughout this system could have major impact on decreasing the proportion of PLWHIV but not aware of it.

In 2016, Fulton County's Board of Commissioners voted to outsource county behavioral health and substance use treatment services to private vendors. At present, there is no requirement that county-funded behavioral health providers offer HIV testing to their clients. To ensure that persons receiving mental health and substance use treatment services using county funds are also offered HIV screening, the BOC should require that all contracts to private vendors require that routine opt-out HIV testing will be offered, along with reporting requirements and a written plan for rapid linkage to care for persons who are newly diagnosed or who are previously diagnosed but currently out of care. The current expectation is that the vendor selection process is nearing completion at the time of this report, to be announced in August 2017, with contract finalization in January 2018. This is a critical item for follow up by the new Advisory Committee. Mental health and substance use disorders are common among people with HIV, and persons with these conditions may be at higher risk for HIV acquisition. In addition, persons with these concurrent conditions are at risk for treatment non-adherence and are at higher risk for falling out of care. These populations are often hard to reach and may require more intensive services.

Offering routine opt-out HIV testing in Fulton County jails has proven to be a high impact intervention. During the year ending in 2014, an HIV jail testing program funded by Gilead FOCUS found that HIV seroprevalence was 2.13%, and 89 persons were newly diagnosed out of 17,035 persons tested. [Spaulding, 2015] In 2016, 3,685 tests were done, identifying 39 new positives (1.1%). There is now a new vendor for medical services for the Fulton County jails. Because of Task Force recommendations, language was included in the contract for provision of routine opt-out testing upon entry to jails. Rapid tests are necessary in this setting because the length of jail stays may be short and it is crucial to have results before release. The current contract does not contain specific HIV testing reporting requirements that would allow adequate monitoring and evaluation of whether this testing is occurring as required, or how medical evaluation while incarcerated and linkage to care upon release are being handled. In the future, these requirements should be included, along with penalties for noncompliance.

Additional Recommendations

- Expand routine opt-out screening at
  - Federally Qualified Health Centers and Community Health Centers
  - Substance use and mental health treatment facilities not under Fulton County's authority
  - Internal Medicine, Family Practice, and OB-Gyn private practices.
  - Urgent care clinics

Several Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs) have fully or partially implemented routine opt-out HIV screening. Southside Healthcare has been funded by the Gilead FOCUS project for several years. Mercy Care began its opt-out testing with a FOCUS grant but now is funded by HIPP. The Georgia AETC [GAETC] has worked with these two FQHCs on staff trainings to help non-HIV physicians be more comfortable with HIV testing and counseling, and with managing HIV care. GAETC also collaborates with The Health Initiative to help expand their LGBTQ-focused trainings for Community Health Centers and other programs to include education on the routinization of HIV testing in the primary care setting in accordance with CDC guidelines.

Key Implementation Issues for Routine Opt-Out HIV Testing

- Staff training: Provide training to facility staff to institute routine opt-out HIV screening within their facilities. This should include implementing intercultural awareness programs to decrease stigma and increase customer satisfaction.
- Linkage to care: Establish rapid linkage to care mechanisms for facilities instituting routine opt-out HIV screening.

Targeted Testing

As our data on prevalent and new diagnoses demonstrate, the HIV epidemic in Fulton County, and metropolitan Atlanta, is a concentrated one, disproportionately affecting African Americans, especially young gay and bisexual men, transgender women, and cis-gender women, as well as gay and bisexual men of other races and ethnicities. In addition, the highest rates of HIV infection are geographically clustered. Unlike opt-out testing, which is designed to reach a general population, targeted testing is designed to reach those at highest risk of acquiring HIV. Therefore it is crucial that demographics and geographic testing data be routinely analyzed, and targeting adjusted to ensure that the most likely to be affected populations are reached.

Highest Priority Recommendations for 2017-2018

- *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 techniques.*
  - *HIPP-funded entities can be required to participate in collaborative planning, while non-funded entities, including research studies that offer testing, should be approached and invited to participate.*
  - *Create a metro-wide geomapping group that will produce monthly or quarterly maps of HIV testing activities, new HIV diagnoses, newly diagnosed acute HIV infections, and prevalence at testing sites, to facilitate targeting of HIV testing and prevention services toward high prevalence geographic areas.*
  - *CDC should be engaged and asked to require data sharing by directly funded CBOs and coordination with HIV testing programs funded through HIPP.*

- *Seek ongoing input from disproportionately affected populations, including PLWHIV, regarding best venues and approaches for HIV testing.*

City of Atlanta (Fulton/DeKalb) High Impact HIV Prevention Program
2017 Jan 1-Jun 30

Count of Risk Category (NHM&E Data Tables)			
	Negative	*Positive*	*Grand Total*
Heterosexual	10,641	46	10,687
IDU	34	1	35
MSM	1,118	68	1,186
MSM/IDU	10	1	11
Other Risk Category	261		261
Unknown Risk Category	1,606	22	1,628
Grand Total	13,670	138	13,808

Count of Gender Group (NHM&E Data Tables)			
	Negative	*Positive*	*Grand Total*
Declined	12		12
Female	7,062	31	7,093
Male	6,542	107	6,649
Not Asked	2		2
Transgender FTM	16		16
Transgender MTF	36		36
Grand Total	13,670	138	13,808

	Health Care Setting	*Non-Health Care Setting*	*Grand Total*
Other (specify)	42	1,625	1,667
PS12-1201 - Category A	8,080	1,563	9,643
PS12-1201 - Category B	889	1,609	2,498
Grand Total	9,011	4,797	13,808

Source: Fulton County instance of EvaluationWeb pulled 26 July 2017.

NOTE: HIV status (new/prev) of reactives must be confirmed. Not included are 10,516 Aggregate tests.

Current Status

Preliminary Data on HIPP HIV testing from 1/1/2017 to 6/26/17 are presented below. For this time period, 13,808 tests were performed, yielding 138 positives (1.0% seropositivity). Analysis of whether these are newly diagnosed or previously diagnosed persons is pending at this time. Of tests performed, 1,297 (8.7%) were Men who have Sex with Men (MSM) or MSM/IDU and 6.1% tested positive. Seroprevalence was 0.4% among females and 1.6% among males. A total of 9,011 (65%) tests were conducted in healthcare settings. There was a substantial delay in contract awards in 2017, partially associated with the timing of funding receipt from CDC and county procurement rules; issues around RFQ release and award decisions; as well as ongoing structural delays in contract completion using county procurement systems. Whether this will affect 2017 testing outcomes cannot be evaluated at this time. Compared with 2016, at mid-year, fewer tests have been conducted by funded sites, under both Category A (31.6% of 2016 totals) and Category B (23.2% of 2016 totals). However, it is unclear whether these metrics are predictive of outcome. Progress should be closely monitored and adjustments made during the remainder of the year to ensure program success.

HIPP 1/1/2016 to 12/31/2016

In 2017, HIPP exceeded its testing deliverables, with 68,553 tests, or 104% of its target. Of these tests, 27,278 were in routine opt-out settings that did not collect client-level data (9.275 in county jails; 18,003 in Grady's Emergency Department) and therefore are not included in demographic analyses. Of remaining tests, 30,528 were Category A (routine testing) and 10,757 were Category B (targeted testing). The highest rate of new diagnoses in all categories was for Black MSM, ages 20-29 ranging from 2.1-5.7%. Under Category A, 927 men (29% of total Category A) received routine testing, but only 342 men (11% of total Category B) received targeted testing, illustrating a missed opportunity to direct the bulk of testing toward the highest risk demographics. Under Category A, 4,445 Black females, ages 30-49 were tested yielding a 0.2% seropositivity rate. No new positives were identified among 1,348 tested under Category B. [Appendix B.]

HIPP data show that targeting of testing toward populations at highest risk could be improved. A collaborative planning system, with regular and frequent meetings among funded and non-funded agencies, is needed to reduce duplication of testing and to ensure that disproportionately affected populations receive the highest levels of attention. These efforts should include coordination of mobile

testing units, including those of Fulton BOH, Someone Cares, AIDS Healthcare Foundation, Mercy Care, and other local entities that perform mobile HIV testing. Geomapping, which will be required in the upcoming CDC funding opportunity PS18-1801, should be incorporated. Multiple entities have expertise and interest in geomapping, including Emory's Rollins School of Public Health, the GA DPH, and the Atlanta Regional Commission. If geomapping expertise is not available through Fulton BOH, these experts should be consulted to assist. Importantly PLWHIV and other disproportionately affected populations should always be at the planning table to advise about strategies. In addition, structural changes are needed to the procurement and contracting process (see Government).

Additional Recommendations

- Offer HIV screening at pharmacies and urgent care centers in areas of high HIV prevalence as defined by geomapping.
- 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.
- 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, and solicit feedback from recipients of partner service interventions about their experience.
- 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.

Walgreens has collaborated with Greater than AIDS at a national level to offer HIV testing at selected pharmacies across the nation. These tests are available for free during collaborative testing events, in which Fulton County has previously participated. Future collaborations should be directed by geomapping of highest prevalence locations.

Ensuring that partner service personnel receive intercultural awareness and customer satisfaction training is essential to the success of the program and the wellbeing of clients. (See Intercultural Awareness) Partner services can be an important source of education, outreach, and screening when done in a supportive manner.

Implementation Issues

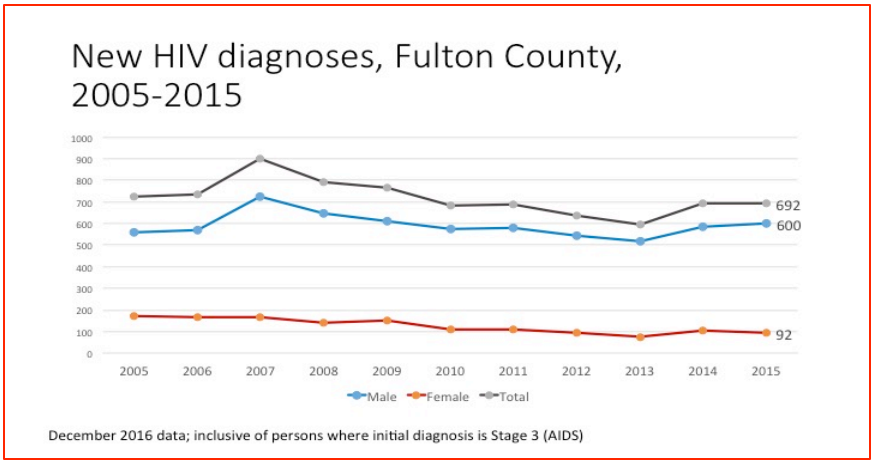
- Standardize protocols among agencies conducting HIV testing and counseling.
- Develop client feedback mechanisms to obtain information about their experience with funded providers.
- Require initial and ongoing intercultural awareness training for all employees of agencies receiving funding for HIV or STI testing, including a program evaluation component.

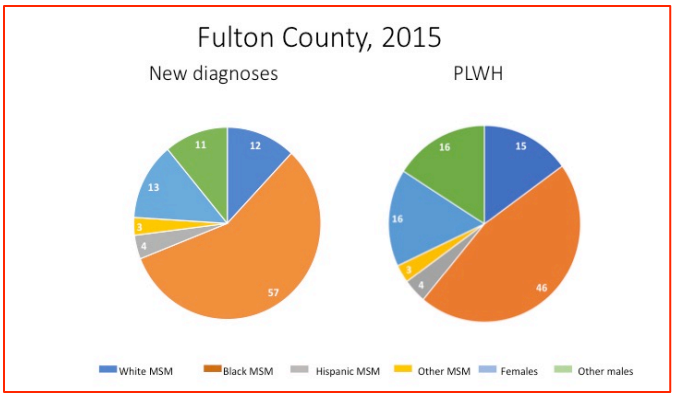
Prevention

Key Objectives

- *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)*

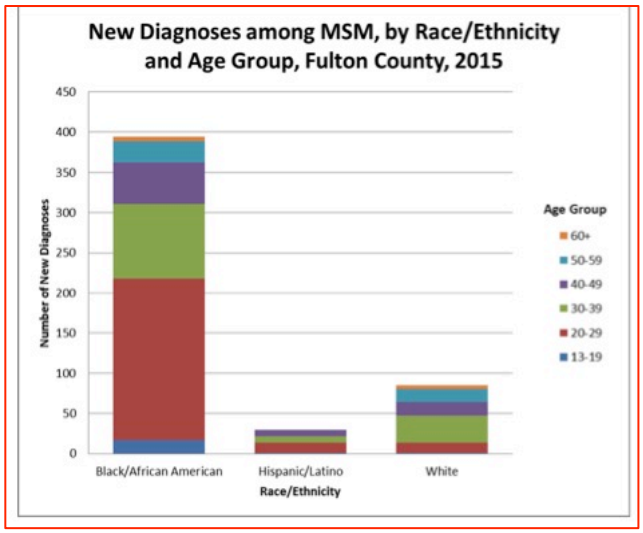
We now have tools that could prevent over 99% of new HIV infections, even without a vaccine. The most powerful tool probably is antiretroviral treatment for all persons with HIV, regardless of CD4 count, as recommended by guidelines of the Department of Health and Human Services, the International Antiviral Society USA, and the World Health Organization. Recent research has shown that persons who have suppressed "undetectable" virus on effective treatment are highly unlikely to transmit HIV. Public health entities around the country and the world have endorsed the slogan: "Undetectable = Untransmittable" or "U=U." Effective antiretroviral treatment is addressed under Care and Treatment, below. For persons at high risk of acquiring HIV, preexposure prophylaxis (PrEP) with Truvada® is up to 99% effective when taken daily. And for people who have experienced a high risk exposure, a month of postexposure prophylaxis (PEP) is highly effective. Yet PrEP and PEP are not routinely available to all who need them. Pregnant women with HIV can reduce their risk of giving birth to an infant with HIV to less than 1% by taking antiretroviral therapy throughout pregnancy and treating the infant after birth. For persons who inject drugs, Syringe Services Programs (SSPs), previously called "needle exchanges," are highly effective in curbing the spread of HIV, as was recently shown in an HIV outbreak among persons using injectable opioids in Scott County, Indiana.





Current Status

Data from 2015 show no decline in the numbers of new HIV diagnoses in Fulton County, with 692 persons testing positive for the first time. Of these, 600 were men. Trend analysis since 2005 shows the number of newly diagnosed women decreasing. The upswing in 2007 is thought to have been associated with changes in HIV reporting methodology rather than a dramatic upswing in new diagnoses. Recent transmission appears concentrated among black gay and bisexual men, (Men who have Sex with Men, or MSM), as they represent 57% of new diagnoses but only 46% of all PLWHIV. More than half of newly diagnosed Black gay and bisexual men



were under 30 years old, compared with 20% of white gay and bisexual men.

PrEP

Highest Priority Recommendations for 2017-2018

- *Ensure access to PrEP for eligible persons at high risk of HIV infection.*
  - *Ensure adequate staffing for the Fulton BOH PrEP Clinic.*
    - *The Board of Commissioners should approve Fulton BOH's proposal for increased staffing to provide PrEP through its Sexual Health clinic and on its mobile units.*
  - *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.*
    - *Established PrEP clinics should explore partnerships with CBOs capable of HIV and STI testing and collecting safety specimens for PrEP monitoring.*
  - *Develop data collection systems for monitoring PrEP uptake.*
- *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 non-HIV care providers in Fulton County.*

Current Status

PrEP is highly effective but implementation has been slow. CDC estimates that approximately 1.2 million persons could benefit from PrEP who are not currently receiving it. [MMWR, 2015] The number of people in need of PrEP and the number receiving PrEP in Fulton County is not known. There has, however, been progress in increasing the number of access points for PrEP in Fulton County. Fulton BOH officially opened its PrEP Clinic in February 2016, and other PrEP clinics are open at Empowerment Resources Center (ERC), Positive Impact Health Centers (PIHC), and Someone Cares. Absolute Care has been prescribing PrEP since 2012 and has a large cohort of active PrEP patients. In addition, AID Atlanta provides a limited PrEP clinic and there are many private doctors who routinely prescribe PrEP and can be found on the PrEP Locator webpage (preplocator.org). Fulton plans to begin PrEP follow up visits at Adamsville in October 2017. GA DPH published its downloadable PrEP Toolkit on the GA CAPUS website in September 2016 (https://www.gacapus.com/r/wp-content/uploads/2017/03/PrEP-Toolkit-2017.pdf). Morehouse College Student Health is working to begin a PrEP clinic on campus. More access points are needed for uninsured patients and those whose insurance will not cover fully cover PrEP.

Opportunities for education about PrEP in the community and among non-HIV care providers have increased, but more needs to be done. A directory of PrEP providers is available through preplocator.org and through the GA CAPUS Resource Hub but both of these need to be regularly updated and community awareness raised about their existence. Wide-ranging ongoing community education programs are still needed.

Spotlight on PrEP

Status of Current PrEP Clinics

Clinic	Date Opened	Number Served	Who Qualifies	2017-2018 Plans
Fulton BOH	2/2016 (10/16 pilot)	2016 -340 2017 -55	No insurance restrictions	Expand services; possible mobile unit if funded

Absolute Care	Began prescribing 2012; formal guidelines 2014	450 (to 6/2017;250-300 active)	Insured patients; uninsured on sliding scale	Increase to 1000 active patients; possibly telemed
ERC	2015	1859 "access to" PEP/PrEP services	Able to afford; meet CDC criteria	
PIHC	2016	100+	All	Expanding high risk client numbers
Someone Cares	10/2016	137 MSM, 2 women	No insurance restrictions	Increase by 50% by end 2017; 250 pts in 2018

Outcomes

Fulton: 205 lost to follow up (35% no longer interested in PrEP; 30% difficulty with appointments; 12% side effect concerns); Reaching 79% gay and bisexual men; 68% Black, 8% Hispanic/Latino; 49% ages 20-29.

Challenges faced by existing clinics:

- Absolute Care: Capacity to serve more people and ability to reach those at highest risk
- ERC: Client medication adherence; lack of awareness of services
- Fulton: Loss to follow up, clinic capacity and lack of funding
- PIHC: Funding; Reaching more high-risk populations
- Someone Cares: Missed appointments; fear of Truvada side effects; not wanting to take a pill everyday

Additional Recommendations

- Encourage Grady Health System to create PrEP access in its neighborhood health centers
- Encourage PrEP prescription by OB-Gyn, Internal Medicine, and Family Practice providers.
- Investigate opportunities for PrEP funding, including foundations, community fundraising, and government grants
- Collaborate with pharmacies that plan to establish PrEP clinics in Fulton County and metro Atlanta.

Grady's neighborhood health centers may be ideal settings for PrEP access, depending on geographic location and population served. Partnerships should be explored. Expansion of PrEP prescribing in the private practice community is also needed.

Funding is the recurring challenge that seems universal. Sites should consider collaborations that could attract major multi-year funding. Sustainability always becomes an issue, so exploring sources of sustainable funds is crucial.

Walgreens has established PrEP clinics across the country and is currently exploring a plan to roll out clinics in metro Atlanta. They have expressed willingness to collaborate with public health in marketing campaigns to publicize other PrEP clinics for persons without insurance.

PEP

Key Objective

- *Ensure access to PEP for eligible persons following occupational or non-occupational exposure to HIV.*

Highest Priority Recommendations for 2017-2018

- *Increase awareness and knowledge of PEP among care providers in Fulton County, especially those in emergency departments, urgent care settings, and private practices.*

- *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. Include a directory of PEP access points and PEP educational resources for clients.*
- *Conduct ongoing education, including cultural competency training for Grady Emergency Department staff, and those of other Emergency Departments to encourage prescribing of PEP.*

Current Status

PEP is not well known by individuals or care providers outside of HIV circles. Individuals with insurance who are established with a private doctor knowledgeable about PEP can often get a prescription over the phone when in need. Industry co-pay cards can be used for PEP with private insurance in most circumstances. Generally PEP can be obtained through emergency departments, but access to medications may be challenging for those without insurance. Because it is an "on demand" treatment, access points are often needed after regular clinic hours. Ryan White clinics are legislatively prohibited from prescribing for persons without HIV, and ADAP currently cannot provide Truvada® for PrEP. The GA CAPUS Resource Hub is an ideal site for a repository of PEP resources for providers and a directory of PEP access points and PEP education for clients.

It is unknown how many PEP prescriptions are written annually in Fulton County. It is possible that some information on this might be gleaned from analysis of the state Medicaid database under a collaborative arrangement between Medicaid and the DPH HIV Epidemiology Division. Grady's Emergency Department has a protocol in place for prescribing PEP.

Additional Recommendations

- Educate the community about the difference between PrEP and PEP, including how and when to access PEP.
- Share protocol and computerized order set templates for use in hospital emergency departments.

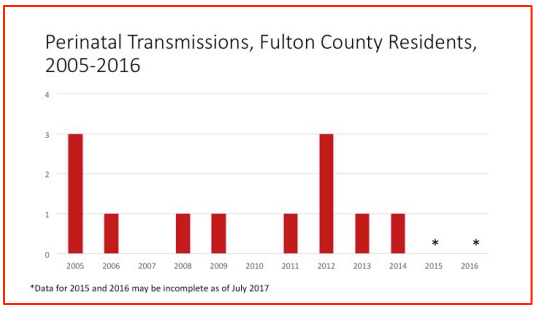
Perinatal Transmission

Key Objective

- *Eliminate perinatal transmission in Fulton County.*

Highest Priority Recommendations for 2017-2018

- *Expand capacity of perinatal staffing at Fulton BOH in order to provide comprehensive perinatal prevention services for pregnant women with HIV.*
- *Establish a designated perinatal team at DPH to provide comprehensive prevention services for pregnant women with HIV, and to enhance coordination between state and county.*
- *Explore expanding the HIV Health Information Exchange to identify out of care pregnant women with HIV when they present for obstetric care at Grady.*



Current Status

It is encouraging that no transmissions have been verified as yet among Fulton County residents in 2015 and 2016. Since 2005 there have been zero to 3 mother-child transmissions annually among Fulton county residents. Although no transmissions have yet been documented for 2015 or 2016, delays in diagnosis and in case finding can result in delayed identification. Both Fulton BOH and

GA DPH are concerned about adequate capacity to fully address perinatal transmissions, although they plan to address the issues differently. Fulton sees the need for increased overall capacity, while DPH prefers a dedicated perinatal team.

Expanding the use of the HIV Health Information Exchange to allow identification of pregnant women who are out of care at the time that they present for prenatal care or for delivery could have high impact. There is no excuse for a single baby ever again to be born with HIV to a resident of Fulton County.

Additional Recommendations

- 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.

Prevention for People Who Inject Drugs

Key Objectives

- *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 the State of Georgia.*
  - *POLICY: Request that the Board of Commissioners include support for state legislation to clarify current law.*

Highest Priority Recommendations for 2017-2018

- *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 the State of 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 Fulton's HIPP services through its mobile units.*
- *Explore providing syringe services programs for PLWHIV through Ryan White clinics.*

Current Status

The Task Force worked with Fulton's BOC to unanimously pass a resolution recognizing syringe services programs as a legitimate medical intervention for the prevention of HIV, hepatitis B and C, and bloodborne infections. A bill using much of Fulton's language was introduced in the state legislature, but did not pass during the 2017 session. Support for this bill should be part of Fulton County's legislative agenda when it returns for consideration in 2018.

At present, Atlanta Harm Reduction Coalition is the only syringe service program provider in Fulton County. Expansion of SSPs is needed to address the opioid and crystal methamphetamine crises in the county. Every cluster of injectors is an HIV and hepatitis C epidemic waiting to happen. Just ask Indiana.

Additional Recommendations

- 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.
- 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 substance use disorders. [See cross cutting issues]

Condom Distribution

Key Objective

- *Increase the number of condoms distributed to persons with HIV and high-risk seronegatives to 3.5 million units per year.*

Highest Priority Recommendations for 2017-2018

- *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.*

Current Status

Condom distribution has increased every year under the HIPP grant. Assuming a continued increase in 2017, an increase to 3.5 million in 2018 should be achievable. Lubricant should always be provided with condoms.

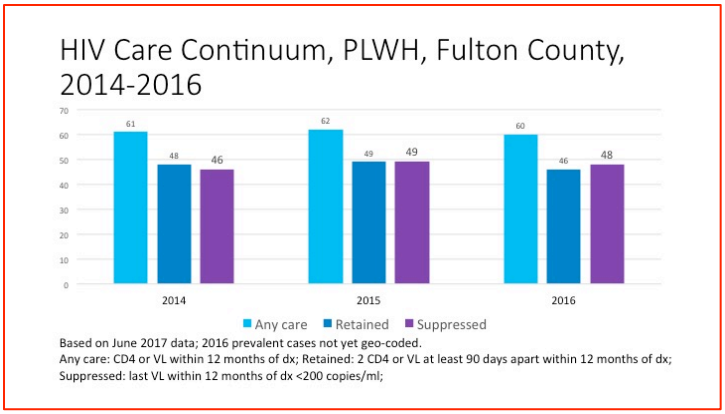
HIPP Condom Distribution Objectives and Annual Targets

	Year 1	Year 2	Year 3	Year 4	Year 5	Cumulative Total
Targets	921,000	1,633,338	1,991,147	2,170,068	2,348,956	9,564,509
Actual	577,402	2,069,900	2,978,458	2,439,562	2,761,942	10,827,234
Percent	62%	126.7%	149%	112.4%	117.58%	113.2%

Care and Treatment

The Care Continuum

The goal of HIV treatment, optimal health for a normal life span, can only be achieved by maintaining viral suppression. In addition, individuals with "undetectable" virus do not transmit HIV to others. Viral suppression, however, depends on a cascade of steps, each of which must be successfully negotiated in order to achieve continuous viral suppression. This cascade is called the care continuum. Ideally, no person would become HIV positive, however, those who do acquire HIV would be diagnosed soon after infection, rapidly linked to care and started on antiretroviral therapy, remain consistently in care and on treatment, and achieve continuous viral suppression. The reality, however, falls far from this goal. The Task Force has set the following care continuum goals for 2020.



- *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%.*
  - *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*

Current Status

This graph shows care continuum outcomes among diagnosed persons living with HIV in 2014, 2015, and 2016. Viral suppression increased from 46 to 49% between 2014 and 2015. Because data for 2016 have not yet been geocoded, 2016 findings are preliminary. It is anticipated that the percent virally suppressed will increase as persons are properly assigned geographically. The care continuum for newly diagnosed persons shows that the proportion virally suppressed increased from 51% to 57% and the proportion virally suppressed among those with any care (at least one visit) increased from 72% to 78% between 2013 and 2015. Some of this increase likely reflects implementation of the 2012 treatment guidelines recommending ART for all persons with HIV.

Linkage to Care

All persons newly diagnosed with HIV should be immediately linked to care and offered HIV treatment. While the National HIV/AIDS Strategy goal is to link newly diagnosed persons to care within 30 days, the Task Force has taken a bolder stance by stating that a medical visit – not just linkage to the front door of a facility – should be facilitated within 3 days of diagnosis (same day is preferable, if diagnosed within a care facility.) Therefore the primary linkage goal for 2016 was to begin to initiate Rapid Entry mechanisms at care facilities. This process has now begun with robust efforts. As efforts have begun, new challenges have emerged.

Highest Priority Recommendations for 2017-2018

- *Continue to implement Rapid Entry pathways at Ryan White clinics to ensure an initial medical visit for newly diagnosed patients within 3 days of diagnosis.*
  - *Eliminate barriers to patient entry at Ryan White clinics, including implementation of data sharing among Part A Ryan White clinics.*
  - *Create and implement data collection systems to allow measurement and evaluation of Rapid Entry systems, including rates of retention and viral suppression.*
- *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.*
  - Request that the Board of Commissioners approve Fulton BOH's request for additional staffing for intensive navigation services.

Spotlight on Rapid Entry

What Is Rapid Entry?

Rapid entry is defined differentially in different contexts but is rooted in the concept of "test-and-treat" with immediate ART offered to patients at the time of their diagnosis (or presentation to clinic). Historically, after an HIV diagnosis, the CD4 count was assessed and a decision was made to initiate or defer therapy based on the results. In the past few years several landmark studies have conclusively shown that initiation of ART independent of CD4 count is ideal and guidelines now recommend treatment for all who are infected and viremic. (INSIGHT START, 2015; TEMPRANO ANRS, 2015) Nevertheless, it may take weeks to months for a patient to successfully enroll in a treatment program and start ART. More recently, studies conducted in San Francisco, South Africa and Haiti have demonstrated that offering antiretroviral therapy at a patient's first presentation to care, ideally on the same day as diagnosis, decreases time to viral suppression and improves retention in care. (Koenig S, 2016; Pilcher CD, 2016; Rosen S, 2016) In the United States, and in particular in Fulton County, the development of a systematic process to secure an HIV provider appointment and initiate ART is both complex and challenging for most HIV care centers due to enrollment requirements into Ryan White Part Programs and individual clinics/health systems in addition to the need to secure a payer source for medications. In an effort to decrease these system barriers, changes have been implemented across Fulton County to make rapid entry a reality. Table 1 outlines the types of changes that were made at health system and individual clinic levels across Fulton County in order to facilitate getting patients into care and offered ART within 72 hours of diagnosis (or first touch with the clinic).

LEVEL OF THE HEALTH SYSTEM	ACTION
Ryan White Part A Recipient	Change of CD4 count criteria for entry into HIV care in the Atlanta AMA
Ryan White Part A Recipient & Hospital System	Grace period of 30 days to present full financial documentation for clinic enrollment
Hospital System & Clinic	Re-arranging templates and provider schedules to accommodate appointments scheduled w/in 72 hours
Pharmacy	Manual applications for Pharmaceutical Assistance Programs for ART
Clinic	Loosen PPD requirement for entry; rely on WHO active TB screen
Clinic	Education on safe ART initiation with limited clinical data
Clinic/Field	Peer counselors to assist patients with obtaining missing documentation for full enrollment in Ryan White

Preliminary Data Summary from Ryan White Part A Rapid Entry Clinics

Reporting Period 10/1/16-6/30/17 Source: Ryan White Part A CAREWare

The tables below indicate the aggregate numbers of persons receiving rapid entry services funded under the Ryan White Part A Rapid Entry Pilot.

Client Composition

Client	# Clients	Percent
Newly Diagnosed	115	43.40%
Newly Enrolled	103	38.87%
Re-enrolled	35	13.21%
Unknown Diagnosed Date	12	4.53%
Total	265	100.00%

* Newly Diagnosed: Clients diagnosed between 7/1/2016-6/30/2017
* Newly Enrolled: Clients enrolled between 7/1/2016-6/30/2017 but diagnosed prior to 7/1/2016
* Re-enrolled: Clients diagnosed and/or enrolled prior to 07/1/2016

Service Utilization

Service Category	# Clients	# Units/Visits
Outpatient Ambulatory Health Services	227	425
Non-Medical Case Management	112	248
Medical Transportation	22	107
Referral for HealthCare and Support	30	55

*Clients who received rapid entry services between 10/01/2016 – 06/30/2017

The Ryan White Part A Recipient has taken bold steps to implement the Task Force's recommendation for rapid entry of newly diagnosed and reengaging patients. Going forward, it will be important to continue to support these efforts, to incorporate lessons learned, to collect data in a standardized manner across sites that are implementing rapid entry without pilot funds, and to analyze outcome data for retention and viral suppression. Rapid entry should be seen as a work in progress, with as many lessons learned as successes. Clinics are to be congratulated on wrestling with the innumerable challenges that come with fundamental shifts in operating methodologies.

Summary of Clinics Implementing Rapid Entry

Clinic	Date Opened	Number Served	Who Qualifies	2017-2018 Plans
Fulton BOH	4/2016	102 newly diagnosed	Persons newly diagnosed in the STI clinic; all at NU	Expand to shelter clients, whether newly dx or not
Fulton/HEALing Ctr, Neighborhood Union	3/2017	10	All	Expand capacity, referral partners
AIDS Healthcare Foundation - Midtown	12/2016	19 by 6/30/17	Newly diagnosed or prior care and not on meds	Add post-incarceration as qualifier; work on efficiency; more pt education; funding for outreach worker/navigator; cover only 1st 14 days in order to serve more pts
AIDS Healthcare Foundation - Lithonia	10/2016	49 by 6/30/17	Newly diagnosed or prior care and not on meds	
Grady IDP	5/16/2016	230 by 9/15/16	New to IDP clinic	Revising qualifying criteria; build retention teams
Positive Impact Health Centers	11/2016	121 as of 5/2017 58% new dx 42% reengaging	Newly diagnosed or reengaging	Continue to refine SOPs; seek funding
VAMC ID Clinic	12/2016	15	Newly diagnosed	Increase outreach; improve services

Outcomes

Fulton: Of 102 newly diagnosed persons, 29 accepted rapid entry services and 27 received same day ART.

Grady IDP: Of 131 patients enrolled by 7/31/16 38% saw a medical provider within 72 h and the median time was 5 days. The median time to viral suppression was 33 days.

PIHC: Outcomes: 26% saw medical provider within 72 h and 88% of those were prescribed ART during the visit; 47% saw a medical provider within 14 days. 9% have not seen a provider. Overall 91% were prescribed ART.

Challenges

AHF: Handling the unpredictable; flexibility with scheduling; ADAP enrollment; patients lack housing, food, finances, mental health resources, transportation; stigma.

Fulton: Lack of funding for expansion, especially to mobile unit, and for navigators. Proposal sent to Board of Commissioners and pending.

Grady IDP: Volume; flexibility in scheduling; access to immediate ART especially when lacking all required enrollment documentation; retention in care

PIHC: New SOP and system level changes; Staff time to complete pharma and ADAP applications; Cost of new patient labs is high; Provider availability to see patients – need to designate provider slots for RE; comorbidities SU/MH, homelessness; Patient readiness; Capacity (funding and human resources)

Additional Recommendations

- Evaluate synergies between allowable CDC HIPP and Ryan White activities to maximize linkage resources and decrease duplication of effort.

Implementation Issues

- The Ryan White Part A Recipient Office will need to obtain HIPAA Business Associate agreements from Ryan White Part A clinics to allow data sharing.
- Modify patient intake documents to include a patient release allowing sharing of information among Ryan White clinics.

The Ryan White Part A Recipient Office plans to implement data sharing procedures. To do so, it must obtain Business Associate agreements with each Ryan White Part A clinic, to ensure compliance with HIPAA regulations, and each Ryan White client will need to give individual permission for sharing. This will be accomplished through modifying intake documents and consents that are signed upon clinic enrollment and at recertification. This process should be complete by the end of 2017.

Retention in Care and Reengagement in Care

Retention in care refers to attendance at clinic visits at regular intervals; poor retention in care is associated with poor outcomes with regard to viral suppression, morbidity and mortality. Retention in care remains Fulton County's (and America's) most elusive step of the care continuum. We have randomized control trial evidence demonstrating the role of strengths based case management for linkage to care (ARTAS), yet we have no definitive intervention to improve retention in care.[Gardner LI, 2005] Retention in care is challenging because it requires engagement over time which may be interrupted by many of the issues discussed in the *Social Determinants* section of this report. Stigma and discrimination, difficult-to-navigate health systems, transportation issues, mental illness, substance abuse, unstable housing, food insecurity and simply being younger in age all contribute to poor retention in care within Fulton County. A few interventions have demonstrated some level of improved retention in care, such as interactive Care Coordination teams with patient navigation, medical and nonmedical case management and coaching [Irvine MK, 2015]; Enhanced Personal Contacts in clinics [Gardner LI, 2014]; data-to-care and electronic health record alerts. [Robbins GK, 2012; Bove JM, 2015]

Improving retention in care in Fulton Co. will take a multipronged approach through implementation of existing evidenced based interventions, restructuring health systems and clinic processes to be more patient centered and more broadly tackling the upstream social determinants of health, stigma and discrimination to encourage patients to regularly access care. In addition, continued research is needed to develop effective interventions to improve retention in care.

Reengagement is more challenging than initial linkage to care. Individuals who have dropped out of care do not do so at random, and tend to be those who have challenging life circumstances, including lack of transportation, lack of paid sick leave, changes in health insurance (if insured), and concurrent unaddressed substance use and mental health disorders. In addition, our health system makes it difficult to return to care because of our many requirements place the burden of documentation on the patient, who often is impeded in meeting requirements for the same reasons they have fallen out of care.
While essential for personal health, reengagement in care is also a public health issue. Persons who are out of care do not have continuous access to HIV treatment that keeps their virus undetectable, which lowers the risk of transmitting HIV to near zero.

Key Objectives

- *Increase the number of people continuously retained in care to 90% of those diagnosed.*
- *Decrease the number of persons who are out of care by 50%.*
- *Reengage individuals identified as out of care within 3 days of contact.*

Highest Priority Recommendations for 2017-2018

- *Create a Retention and Reengagement Task Force to investigate and propose best practices for retention and reengagement, and allocate additional Ryan White Part A funding to retention and reengagement.*
- *Increase intercultural awareness 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.*
- *Use patient navigators to assist with retention for vulnerable populations, especially those previously lost to care. Identify patients at high risk for loss to follow up and design individualized retention plans.*
  - *The Board of Commissioners should approve Fulton BOH's request for additional staffing for intensive navigation services.*
- *Simplify and synchronize Ryan White, ADAP, and HICP recertification procedures to alleviate undue burden on patients, and to ensure that documents are submitted in advance of necessary clinic recertifications, prescription refills and insurance renewals.*
- *Evaluate and improve clinic wait times.*

Current Status

Care continuum data show rates of retention in care of 57-58% overall, but less in Blacks, youth, and person who inject drugs. People who are not retained in care are at high risk for progression to AIDS, and death. Because they do not have continuous access to ART, they also experience viral rebound and are again able to transmit HIV to others, thus fueling the epidemic. It is estimated that 60% of new infections are from people who are diagnosed but who have fallen out of care. [Skarbinski, 2015] Therefore, retention and reengagement are two of our most challenging problems. Stakeholders, including PLWHIV, have been adamant that more concentrated efforts are needed to assist PLWHIV to stay in care or to reengage in care after an interruption in care. The Task Force recommends that Ryan

White Part A Recipient Office should create a Retention and Reengagement Task Force to propose the best approaches to these issues, including structural changes, intensive case management and provision of other support such as navigation services. In addition, we recommend that Ryan White Part A consider allocating additional funding to retention and reengagement efforts, perhaps including the formation of a centralized retention and reengagement team, or creating such teams at large clinics that currently are understaffed for such efforts. The Ryan White Part A Recipient Office has the authority to create such a Task Force, and has agreed to do so.

In every Task Force community listening session, stigma and lack of intercultural awareness were mentioned as factors that make it difficult and uncomfortable for some PLWHIV to remain in care. As mentioned, the Intercultural Awareness Subcommittee is currently implementing a pilot survey to assess provider and consumer perspectives about these issues within several Ryan White clinics.

Repetitive paperwork, often involving similar qualification measures, creates a barrier to continuous care access and places undue burden on patients and clinic staff in completing applications for Ryan White enrollment or recertification, ADAP, and HICP. It is hoped that an ADAP working group (see Viral Suppression) will addressed these issues.

The Ryan White Part A Recipient Office is in the process of conducting and analyzing a survey of clinic wait times. Results are expected this year.

Additional Recommendations

- Follow up on missed visits during the same day to assess reason, need for medication refills, and to reschedule.
- 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).
- Provide reminders for visits and medication refills, including use of online platforms for streamlined client communications (Google Boomerang, Mailchimp).
- Institute and evaluate reengagement strategies using surveillance data to improve care reengagement. 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.
  - Expand the HIV HIE to encompass the entire county.
- 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 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 mechanisms for eliciting patient feedback on reengagement process, including a stigmatization assessment metric [see Cross Cutting]

Implementation Issues

- A proposal for funding allocation for intensive Retention and Reengagement support will be made to the Priorities Committee of the Ryan White Part A Planning Council in August.

- Results from the Part A wait time survey should be shared with the new Retention and Reengagement Task Force, as well as with all Part A Ryan White clinics.

The Priorities Committee of the Metro Atlanta HIV Health Services Council (also called the Ryan White Part A Planning Council) has the authority to make allocations for intensive retention and reengagement support. Task Force members from several Ryan White clinics (including PLWHIV) will present this request to the Priorities Committee at its next meeting in August. The full Planning Council must approve recommendations of the Priorities Committee.

Viral Suppression

Key Objectives

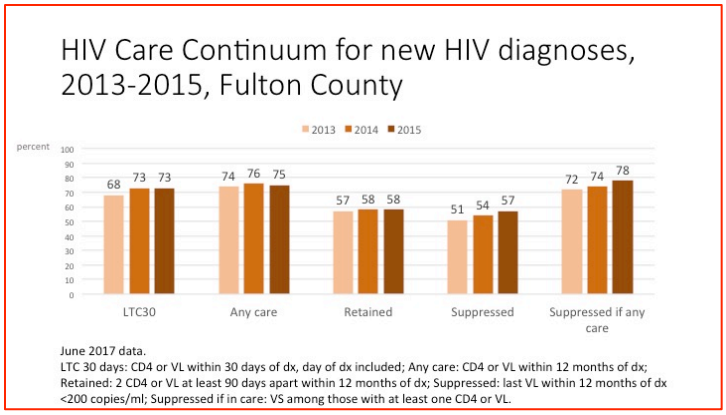
- *Increase the proportion of persons with diagnosed HIV who achieve HIV RNA levels <200 c/mL to 80% (NHAS Indicator 6).*
  - *Increase the proportion of persons with diagnosed HIV who achieve continuous HIV RNA levels <200 c/mL to 80%.*
  - *Decrease the time from HIV diagnosis or reengagement in care to viral suppression to an average (mean) of 6 months*

Highest Priority Recommendations for 2017-2018

- *Create systems that facilitate immediate access to ART for newly diagnosed persons or individuals reengaging in care.*
- *Convene an ADAP Working Group consisting of DPH ADAP staff, HIV care providers, and PLWHIV to troubleshoot emerging issues and address systems issues that create barriers to continuous access to ART.*
  - *Optimize drug delivery systems to ensure patients have consistent access to antiretroviral therapy and other critical therapies.*
  - *Expedite enrollment in HICP for eligible patients to enhance access to medical care and ART through health insurance. [see Cross cutting]*
  - *Expedite submission and processing of ADAP applications, and track turnaround times and reasons for delays in processing.*
  - *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.*
- *POLICY: Advocate against adverse drug tiering, quantity limits and prior authorization imposed by insurance companies.*
- *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.*

Viral suppression, otherwise known as becoming "undetectable", means that the level of HIV virus in the blood is below the limit of detection by our current blood tests. It does not mean the virus is eradicated from the body, because virus will rebound back to detectable levels after interruption in treatment in those patients with viral suppression. Viral suppression is the ultimate goal of being on ART as this allows the immune system to recover to more normal levels and decreases the risk of morbidity and mortality for individual patients. Furthermore, while undetectable, patients cannot transmit HIV to others, prompting the slogan, Undetectable=Untransmittable or U=U. [Cohen, 2016] Therefore viral

suppression is the most critical step for both individual patient health and our community's public health. In addition to both achieving and maintaining viral suppression, the time to achieve viral suppression becomes important as the shorter the period of time with detectable virus, the lower the likelihood of further immune systems decline and HIV transmission.

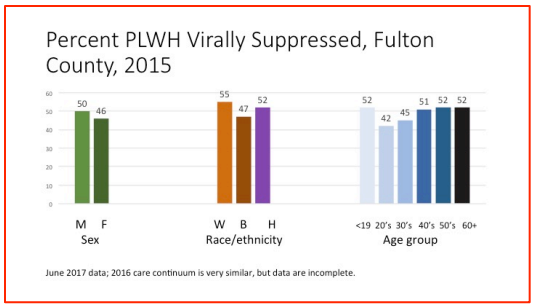


Current Status

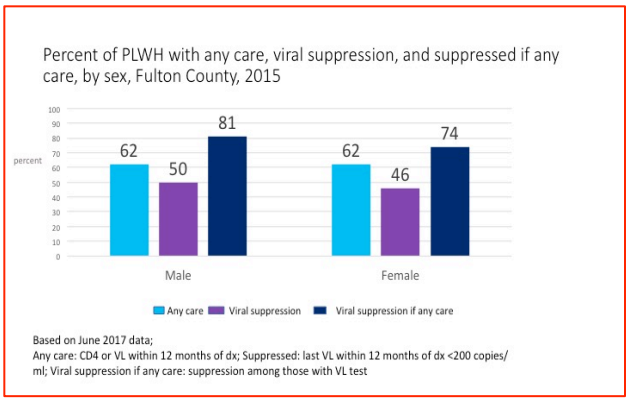
There are many metrics for measuring viral suppression, and they all tell different stories. The figure below lists some of those measures. The proportion of diagnosed PLWH achieving viral suppression in 2015 varied by sex (lower in women), by race/ethnicity (lower in Blacks and Hispanics), and by age group (lower in persons in their 20's and 30's). The care continuum for men and women living with HIV shows that while the same proportion of men and women received any care (at least one lab) in 2015, a lower proportion of women receiving care achieved viral suppression. Comparing Blacks to Whites shows that a higher proportion of Blacks received any care (at least one visit), but a lower proportion of those receiving care achieved viral suppression. Overall viral suppression among diagnosed PLWH increases with age, from 42% among those 13-19 to 52% among those 60 and older. Among persons with at least one visit, the proportion achieving suppression also increased by age, from 58% among those 13-19 to 86% among those 60 and older (not shown).

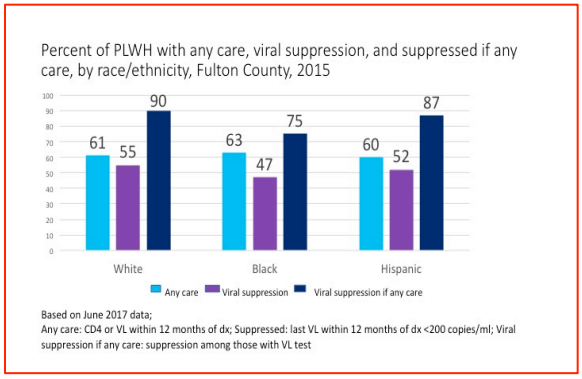
Viral Suppression Measures

Measure	Result	Comment
VS among persons living with HIV	49% (2016)	
VS among persons retained in care	83% (2016)	
VS among persons diagnosed in most recent year	57% (2015)	
VS within 6 months of diagnosis	49% (2015)	33% within 3 months
VS within 6 months of re-engagement in care	48% (2016)	Re-engaged: person with lab after gap of 14 months or more
Continuous VS among PLWH	85% (2015 -> 2016)	Among persons suppressed in 2015, percent still suppressed in 2016 (persons moving to another county in 2016 excluded)



The care continuum for newly diagnosed persons shows that the proportion virally suppressed increased from 51% to 57% and the proportion virally suppressed





among those with any care (at least one visit) increased from 72% to 78% between 2013 and 2015. Some of this increase likely reflects implementation of the 2012 treatment guidelines recommending ART for all persons with HIV. These increases were also seen among men and women. Women tended to be more likely to have a visit, but among those with any care, a lower proportion achieved viral suppression. These increases also were seen among Blacks and Whites. However, a lower proportion of Blacks had any care, and a lower proportion of those with any care achieved viral suppression. Thirty three percent of newly diagnosed persons achieved viral suppression by 3 months, and 49% by 6 months.

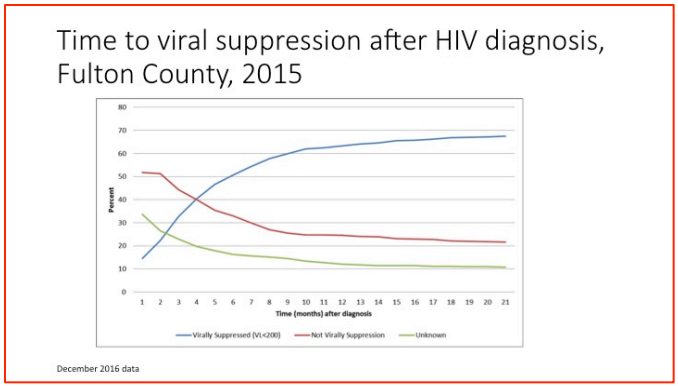
Additional Recommendations

- 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 social/recognition events to recognize achieving undetectable viral load.
- 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.

Quality of Care

Key Objectives

- *Reduce the AIDS-related death rate among persons by at least 33%.*



- *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.
- *Improve linkage to mental health and substance use treatment programs within one month of assessment. [see Cross cutting]*
- *Ensure that patients coinfected with HIV/HCV receive HCV treatment.*

Current Status

Mortality data are lagging behind for 2017 and will not be available until later this year. Care quality is monitored by chart reviews but results are not released to the community. There are no mechanisms in place for measuring time to linkage to mental health and substance use treatment programs. Each clinical program should be evaluated to determine the number of patients with HCV and their rates of referral for curative therapy. Adequate ADAP funding should be sought to cover the cost of HCV cure for all coinfected PLWHIV.

Social Determinants of Health

Housing

Key Objective

- *Address suboptimal housing such that <5% of people with HIV are unstably housed.*

Addressing social determinants will be key to ending the epidemic. It is estimated that over 10,000 PLWHIV in Metro Atlanta are in need of stable housing. Housing is healthcare for PLWHIV and prevention for those at risk of contracting it. Without stable housing, PLWHIV are less likely to be engaged in the medical care they need to stay healthy and prevent transmission to others. As such, the federal government allocates resources specifically to alleviate homelessness among people living with HIV in the form of Housing Opportunities for People with AIDS (HOPWA) funding to highly impacted states and cities across the United States. While the City of Atlanta manages the metro Atlanta region's HOPWA grant, a substantial part of the burden of both HIV/AIDS cases and homelessness reside in Fulton County. It is vital that Fulton County leadership remains actively involved in ending homelessness among PLWHIV and advocating for resources to house people who may be at high risk for contracting HIV.

Highest Priority Recommendations for 2017-2018

- *Adopt and enforce a "Housing First" approach in all HOPWA contracts.*
  - *The HOPWA office should develop a plan for enforcement of contract obligations.*
  - *The HOPWA office should develop a transparent and accessible mechanism for reporting contract violations by housing providers*
- *Convene HOPWA technical assistance to educate on "Housing First" and elements of HOPWA contracts.*
  - *Convene HOPWA providers for mandatory technical assistance, as above.*
  - *Provide technical assistance for CBOs and the HIV care community about housing regulations and requirements.*
- *Create an online resource portal for HOPWA 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.*
- *Expedite the process for contract development and execution.*

Current Status

The "Housing First" approach involves immediately connecting people experiencing homelessness into housing regardless of their willingness to engage in other kinds of support services like substance abuse recovery, healthcare or other programs. To resolve chronic homelessness as a root cause of many subsequent health, mental health and substance abuse issues, "Housing First" programs are championed by The US Department of Housing and Urban Development. "Housing First" programs place no unnecessary barriers or conditions upon people seeking housing and are intended to lead to permanent supportive housing. People with HIV and other chronic health conditions may benefit more than others from "Housing First" because housing has proven instrumental to maintaining long-term health behaviors like regular doctor visits and medicine adherence.

City of Atlanta HOPWA has embraced the "Housing First" approach. As of this year, all new HOPWA contracts now contain the following language relevant to HOPWA's "Housing First" approach:

- Contractor will not use HOPWA funds to pay for drug and/or criminal background screenings; this is not an eligible cost or HOPWA requirement.
- Contractor will ensure occupancy does not drop below 90% capacity.
- Contractor shall ensure that no fee, except rent, will be charged, of any housing or services provided in whole or in part from this contract.
- Contractors agree to use the Housing First model, by reducing barriers to housing, and not discharging or evicting clients from permanent housing except in the most egregious of situations.
- Contractor may not use arrest records as a basis to deny admission to housing and criminal background screenings must comply with civil rights laws.

How these contract obligations will be enforced is a critical issue that remains unresolved. The Task Force recommends that the HOPWA office address enforcement as a high priority, including the creation of a transparent and well-publicized mechanism for reporting alleged contract violations.

The HOPWA office plans to implement technical assistance programs for housing providers (mandatory) and for community organizations and HIV healthcare providers in September 2017. It also has committed to begin the process of developing an online resource portal on the City of Atlanta's Office of Grants Management website by the end of 2017. Additionally, the HOPWA office plans to develop a needs assessment tool to better understand the housing needs of PLWHIV during the fourth quarter of 2017.

The HOPWA office has begun to expedite contracts by asking awardees to develop work plans before funding is available to disburse, so that contracts can be developed and moved into the queue for approval quickly once the City receives the final award. Further work is needed to understand the bottlenecks in the approval process that impede timely contract execution. Just as Ryan White Part A has negotiated a streamlined contract execution process with the Fulton Board of Commissioners, it may be possible for HOPWA to simplify its approval processes for federal funds.

A 2016 *Strategy* objective "Standardize rules and applications across all housing providers" has been met. The application process is now standard across housing providers seeking HOPWA funding, and the standardization of rules for HOPWA funding has been achieved through contract language updates described above.

Additional Recommendations

- Implement a centralized online repository for documents needed to qualify for services and ensure that service providers and CBOs interacting with 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.
  - Explore feasibility of ClientTrack, the Homeless Continuum of Care's chosen Homeless Management Information System (HMIS) database, interfacing with Ryan White CAREWare and explore the HIPAA barriers to data sharing.
- Advocate for public housing from a public health messaging standpoint, emphasizing the need for long-term housing as method of reducing the HIV burden on the most impacted communities.

Because of the complexity of achieving a technical interface with CAREWare and resolving the HIPAA barriers to doing so, the important work of creating a central repository of documents to expedite qualification for housing services will take time to achieve, and it is not anticipated that this will be completed in 2018. The process, however, must begin now in order to ensure execution within the next 2 to 3 years. The Ryan White Part A Recipient Office already has begun to explore the use of Part A CAREWare document data sharing to expedite qualification for Ryan White eligibility. Interface with CAREWare needs exploration, once an HMIS system is chosen for HOPWA, and HIPAA barriers to data sharing between Ryan White clinics and HOPWA need to be studied.

Education

Key Objective

- *Increase health literacy regarding HIV prevention and treatment, including implementing evidence-based sex and sexuality education in schools.*

Highest Priority Recommendations for 2017-2018

- *Implement evidence-based comprehensive sex and sexuality education for youth in Fulton County and City of Atlanta schools.*

Current Status

Excellent progress has been made on this recommendation over the past year. The Task Force has a member who sits on the Atlanta Public Schools (APS) Human Growth and Development Advisory Committee (HGDC), a group that advises the Board of Education on its sexual health curricula. The Task Force volunteered to review the FLASH curriculum, which is being considered for adoption, and to make corrections where necessary and recommendations for improvement. A working group of 11 people was formed, representing a variety of disciplines including adult and pediatric medicine (Infectious Diseases and Internal Medicine), HIV prevention, program evaluation, health education, sexual health, and law. The group reviewed curriculum for elementary, middle, and high school levels with a focus on medical and scientific accuracy, stigmatizing and discriminatory language, and significant omissions. The group produced a 16 page narrative report and an extensive spreadsheet detailing their findings. The chair of the committed expressed gratitude on behalf of APS and said that all of the working group's findings were being incorporated into the curriculum. Copies of the report were provided to G-CAPP, the regional technical assistance group for FLASH and the FLASH curriculum leaders. APS is moving rapidly toward a comprehensive, scientifically accurate, sexual health curriculum. The upcoming challenge will be to achieve the same outcomes with the Fulton County School System.

Additional Recommendations

- 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 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.

Criminal Justice: Policing, Courts, and Incarceration

Key Objectives

- Ensure that police, courts, and jails in Fulton County and the City of Atlanta respect the rights and dignity of PLWHIV and LGBT individuals and are educated on intercultural awareness and basic HIV knowledge.

- Eliminate policies or actions that stigmatize incarcerated people with HIV.

Highest Priority Recommendations for 2017-2018

- *Work with APD to incorporate HIV education, trauma-informed practices, and intercultural competency training into courses at the Police Academy and provide HIV education, training on trauma-informed practices, and intercultural 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.*
- *Work with Atlanta Municipal and Fulton County courts to expand 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.*
- *Provide evidence-based sexual health and HIV prevention and treatment education, education on HIV criminalization, and HIV prevention resources for incarcerated persons.*
- *Expand pre-release planning for HIV positive inmates at Fulton County and Atlanta City Jails.*
- *Ensure that incarcerated persons receive HIV treatment according to current DHHS Antiretroviral Guidelines.*
- *POLICY: Offer routine opt-out HIV testing upon entry at Fulton County jails. [See Testing]*
- *POLICY: Provide access to condoms for all incarcerated persons.*

Current Status

The Atlanta Police Department has had LGBT liaison positions for many years. Following a high profile case involving discrimination against LGBT individuals, it expanded its intercultural awareness training program. In addition, APD should ensure that all officers and staff receive education about HIV prevention and treatment. Fulton County Sheriff's Department should implement intercultural awareness training and HIV education for all of its officers and staff. Medical care for incarcerated persons should be of the highest caliber. Opt-out testing should routinely be available at jails in Fulton County and the City of Atlanta.

Additional Recommendations

- Collaborate with APD and Fulton County Sheriff's Department to conduct an anti-stigma campaign within their departments.
- 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.
- POLICY: Provide access to condoms for all incarcerated persons.

Stigma

Key Objectives

- *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

Highest Priority Recommendations for 2017-2018

- *POLICY: Reform HIV criminalization laws to align with current HIV science and advance best public health practices for HIV prevention and care.*
- *Create and implement a public awareness campaign across Fulton County and the City of Atlanta 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.*
- *Collaborate with external partners, such as the Center for Civil and Human Rights LGBT Institute, to convene workshops and symposia with national experts and local leaders from faith, business, entertainment, government, and healthcare communities to create a blueprint for attacking stigma.*
- *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)*

Current Status

We share a collective responsibility for addressing and eliminating HIV stigma throughout our community. HIV stigma is the mark of disgrace whether a person is living with HIV or at risk for HIV. This negative mark is rooted in fear of the unknown, lack of knowledge and ignorance. As long as stigma lives within healthcare settings and within the community there will be barriers to accessing medical care for PLWHIV and those at greatest risk for infection.

We have to implement a multifaceted approach as we dispel HIV stigma. Our approach must be centered in community, the service delivery model, and within people living with HIV. Addressing stigma from a community approach begins with anti-stigma campaigns designed with and for Black gay, bisexual, same-gender loving men and transgender-women, and education and advocacy for prevention and treatment options for those disproportionately impacted. Addressing stigma through prevention and treatment services must include delivering interculturally competent, trauma-informed care to all regardless of gender identity, sexual orientation, or ability to pay for services. The work of the Intercultural Awareness Subcommittee advances these recommendations.

Lastly, PLWHIV must dispel stigma by creating self-sustaining networks where HIV disclosure is achievable. As more PLWHIV disclose their HIV status, others also living with HIV are encouraged to engage and stay in care longer, thus benefiting both treatment and prevention.

Additional Recommendations

- 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.

Several topics under Social Determinants of Health have not received as much attention as needed. Assigning working groups for each of the following areas should be a priority for the new Advisory Committee.

Transportation

Key Objectives

- *Reduce unmet need for affordable transportation to HIV and support services.*

Highest Priority Recommendations for 2017-2018

- *Study feasibility of opening satellite clinics in areas with underserved transportation infrastructure.*
- *Use mobile van to provide medical visits to remote locations with inadequate transportation.*
- *POLICY: Advocate for regional transportation solutions in metro Atlanta.*

Current Status

Fulton BOH is attempting to address the obstacles presented by lack of transportation by expanding HIV and sexual health services to neighborhood health centers. Initially they plan to expand routing opt-out HIV testing to several neighborhood centers, beginning with Neighborhood Union. They will expand sexual health services to Adamsville in 2017. In addition, Fulton has two mobile units that it plans to use for clinical visits, given funding for adequate staffing. With adequate staffing, these units will also be able to do PrEP visits.

Additional Recommendations

- Contract with a limited number of transportation vendors to provide transportation for all Ryan White clients.

Food Insecurity

Key Objective

- *Reduce unmet need for access to food and nutritional programs among people with HIV.*

Highest Priority Recommendations for 2017-2018

- *Ensure screening for food insecurity and other nutritional needs 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*

Additional Recommendations

- 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.

Job Training and Readiness

Key Objective

- *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.*

Highest Priority Recommendations for 2017-2018

- *Partner with Job Corps and Atlanta Regional Commission Workforce Development to increase job training opportunities for PLWHIV.*
- *Identify sources of funding to subsidize GED classes for PLWHIV.*
- *Partner with employment agencies to provide temporary employment opportunities for PLWHIV.*

Additional Recommendations

- Create resource portal for clothing banks, job training opportunities, GED classes.
- Create flexible clinic hours to facilitate attendance for those who are employed 9am-5pm.

Passing the Torch: A Letter from the Task Force to the New Fulton HIV/AIDS Prevention, Care, and Policy Advisory Committee

Dear Fulton County HIV/AIDS Prevention, Care and Policy Advisory Committee,

As we close out the work of the Task Force we look with excitement toward the next chapter as the new Advisory Committee leads the charge against HIV/AIDS in Fulton County. We believe this body is critical to bringing a unified, data driven, and community driven approach that will be necessary to end our local epidemic.

Essential to the early success of the Task Force has been the involvement of the community both by being on the Task Force and participating in dozens of listening sessions. We believe it is important to continue the dialogue through frequently holding listening sessions across the county and ensuring even greater meaningful involvement of persons living with HIV and at risk for HIV by including them in leadership roles for the new Committee. Furthermore, we believe there is work to be done to reach even more of our citizens, using novel mechanisms of communication to reach less heard segments of the community and gain broader input.

Critical now, is to remember that the early phases (I, II, and III) of the *Strategy to End AIDS* are principally recommendations and a blueprint. Now it is time to ensure implementation and vigilantly monitor outcomes in order to see a "bend in the curve" of the epidemic. We hope to see the Advisory Committee continue to advocate on behalf of the Fulton County Board of Health and the Georgia Department of Health as they lead the fight against HIV in the county and the state while also advocating for the communities we serve by ensuring transparent and open dialogue.

We are grateful for the opportunity to have worked as a Task Force for the past 30 months toward the betterment of our community, and we look forward to watching the work continue. It will continue to require time-intensive efforts, strong leadership, political will and ultimately a greater financial investment in order to see progress. This is a fight, not just against a virus, but a fight for equality and social justice. We now entrust our *Strategy* and the vision of Ending AIDS in Fulton County to the new Fulton County HIV/AIDS Prevention, Care and Policy Advisory Committee.

In Solidarity,
The Fulton County Task Force on HIV/AIDS

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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/µL 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.

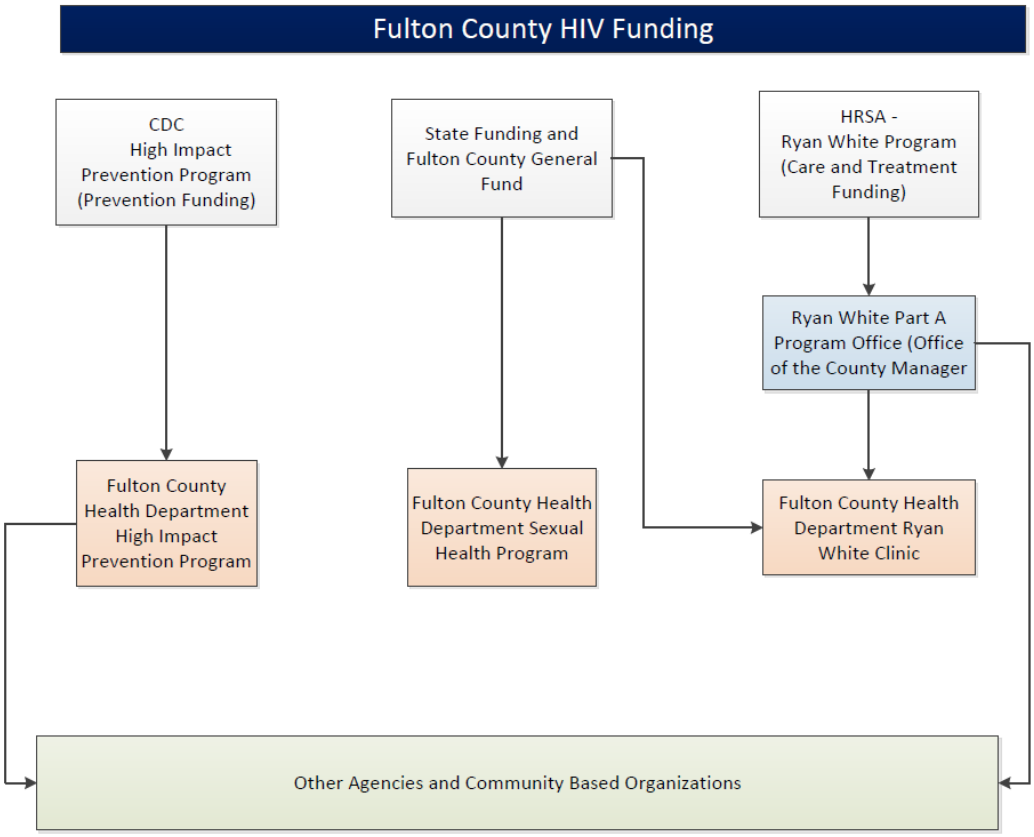
Appendix A: Federal Funding for HIV Services in Fulton County

	Ryan White Part A	High Impact Prevention Program	State Funds	General Fund
Authority	Ryan White HIV/AIDS Treatment Extension Act of 2009 codified through Title XXVI of the Public Health Services Act.	PS12-1201: Comprehensive HIV Prevention Program for Health Departments CDC-RFA-PS12-1201 Catalog of Federal Domestic Assistance Number: 93.940, HIV Prevention Activities For Health Departments	General Assembly	Fulton County Board of Commissioners Fulton County Board of Health
Federal Administration	Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB)	Centers for Disease Control and Prevention (CDC)	-	-
Local Administration	Office of the County Manager	Department of Health & Wellness/Health Department (after July 1, 2017)	Department of Health and Wellness/Board of Health	Department of Health and Wellness/Board of Health
Jurisdiction	Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, Walton	Fulton and DeKalb	Fulton	Fulton
Services	Part A funds must be used to provide core medical and support services for people living with HIV. *See Attachment A for FY17 Service Providers and funding levels.* **Core medical services**: medical case management; medical nutrition therapy; mental health services; oral health; outpatient and ambulatory health services; and, substance abuse. **Support services:** medical transportation, linguistic services, food bank/home delivered meals; legal services, psychosocial support, referrals for health care and other support services, and non-medical case management. Required to spend at least 75% of funds allocated for services on core medical services and no more than 25% on support services.	High Impact HIV Prevention Program aims to decrease new infections, increase access to HIV medical care and improve health outcomes for people living with HIV, reduce HIV-related disparities and health inequities and achieve a more coordinated response. **Required (Category A):** Routine HIV Testing; Linkage to HIV Medical Care; Partner Services; Condom Distribution; Perinatal Transmission Prevention; Jurisdictional Planning Group; Capacity Building; and Program Planning, Monitoring, and Evaluation. **Required (Category B):** Targeted or Expanded testing with a 2.0% Newly Diagnosed positivity rate. Perform Service Integration via simultaneous testing for STIs, and Hepatitis. **Recommended:** Evidence-based Interventions; PrEP; and Social Marketing, Media and Mobilization Required to spend at least 75% of Category A funds and 70% of Category B funds in healthcare settings. Service Integration limited to not greater than 5% of the Category B budget.	Outreach Testing Linkage Pre-exposure prophylaxis (including medical care)	Outreach Testing Linkage Pre-exposure prophylaxis (including medical care)
Administrative & Quality Management (QM) Funding	▪ Not more than 10% may be used for administration and planning council support. ▪ Additionally, up to 5% percent or $3,000,000 whichever is less may be spent on QM. ▪ No more than 10% of service dollars may be used for subrecipient administrative costs.	▪ Administration positions account for 10% of the total HIPP budget.	`	Most administrative costs for all programs are absorbed here.
Community Involvement	**Metropolitan Atlanta HIV Health Services Planning Council** Membership must reflect the local epidemic demographically and include members with specific expertise. At least 33 percent of the members must be consumers of Ryan White HIV/AIDS Program services. Sets funding categories and amounts.	**City of Atlanta (Fulton/DeKalb Counties) Jurisdictional Prevention Planning Group (JPPG)** *Co-chaired by the community and the Health Department, JPPG members must be a resident of Fulton or DeKalb Counties, and/or agency of service located in Fulton or DeKalb Counties.* The maximum number of JPPG members is forty-five (45); there is no minimumnumber. In selecting members for the JPPG or assigning JPPG members to any of its Committees, special emphasis is placed on including representatives of the groups targeted in the Prevention Plan Group, make-up is reflective of the local epidemic. Standing seats for 1502 Grantees and members/employees from the following institutions: Education, Faith, Corrections, Housing, Medical, and Behavioral Health.	No standing community advisory board. We use *ad hoc* advisory committees as needed.	No standing community advisory board. We use *ad hoc* advisory committees as needed.
5 Year Funding History	2017: $25,529,919 2016: $25,023,768 2015: $23,778,777 2014: $22,285,910 2013: $21,483,214	2017: $8,036,968 2016: $8,049,791 2015: $8,472,341 2014: $9,679,545 2013: $6,270,856	2017: $342,635* *STD program budget + PrEP nurse; no specific HIV program budget. State Grant In Aid (GIA) funds are handled differently from general funds, so more or less funding may be available in any given year.	2017: $334,185* 2016: $758,208 2015: $598,806 2014: $630,751 *HIV enhancement funds are being gradually rolled into an overall Sexual Health Program budget starting 2017
Restrictions	▪ Grant funds must be utilized to supplement not supplant funds ▪ Political subdivisions must maintain the level of expenditures by such political subdivisions for HIV-related services at a level that is equal to the preceding fiscal year ▪ Ryan White legislation is "payer of last resort," meaning that funds may not be used for any item or service for which payment has been made, or can reasonably be expected to be made by any other payer. ▪ Ryan White funds may be used for general HIV testing only if there is no other source of funding for HIV testing in the jurisdiction.	▪ Spending is limited to the items included in the grant contract.	None, though state funds do not come to our individual programs the same way as general funds (i.e., the communicable disease administrators do not receive a specific line-item budget for these funds to spend). We currently use these funds for outreach, education, testing, linkage, and PrEP services.	None. STD/HIV funds are moving to one large budget to handle HIV, syphilis, gonorrhea, chlamydia, and other sexually transmitted infections due to the large overlap in individuals. We currently use these funds for outreach, education, testing, linkage, and PrEP services.
Website	www.ryanwhiteatl.org	http://www.standup2hivatl.org		

HIV Prevention and Care Funding - 2017					
Subrecipient Funding Levels and Services					
	Ryan White Part A		High Impact Prevention Program (HIPP) CDC PS12-1201		TOTAL
Subrecipient	**Care & Treatment**	**Services**	**Prevention Funding**	**Services**	**Prevention & Care Funding**
AID Atlanta	$2,031,682	Outpatient/Ambulatory Health Services; Oral Health; Mental Health; Medical Case Management; Non-Medical Case Management; Linguistics; Medical Transportation; Psychosocial Support – Patient Navigation; Referrals for Health Care & Support Service	$83,145	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$2,114,827
AIDS Healthcare Foundation	$776,612	Outpatient/Ambulatory Health Services; Oral Health; Medical Case Management; Linguistics; Medical Transportation; Psychosocial Support – Patient Navigation	$0		$776,612
AIDS Research Consortium of Atlanta	$0		$74,951	HIV Prevention Services: Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$74,951
Aniz	$179,801	Mental Health; Substance Abuse; Non-Medical Case Management; Referrals for Health Care & Support Service; Medical Transportation; Psychosocial Support	$150,000	HIV Prevention Services: Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$329,801
Atlanta Harm Reduction Coalition	$0		$111,650	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$111,650
Atlanta Legal Aid	$106,134	Legal Services	$0		$106,134
Center for Black Women's Wellness	$0		$83,148	HIV Prevention Services: Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$83,148
Center for Pan Asian Community Services	$0		$150,000	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$150,000
Clarke County	$131,702	Outpatient/Ambulatory Health Services; Oral Health; Medical Case Management; Medical Transportation	$0		$131,702

Clayton County	$299,703	Outpatient/Ambulatory Health Services; Oral Health; Medical Transportation; Non-Medical Case Management; Psychosocial Support; Psychosocial Support – Patient Navigation	$0		$299,703
Cobb County	$874,829	Outpatient/Ambulatory Health Services; Oral Health; Mental Health; Medical Case Management; Linguistics; Psychosocial Support – Patient Navigation	$0		$874,829
DeKalb County Board of Health	$812,227	Outpatient/Ambulatory Health Services; Oral Health; Mental Health; Medical Nutrition Therapy; Linguistics; Medical Transportation; Psychosocial Support; Psychosocial Support – Patient Navigation; Medical Case Management through AID Atlanta	$2,036,399	HIV Prevention Program for DeKalb County: Routine Opt-Out HIV Screenings; HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS Linkage to Medical Care and Support Services; Partner Services Interventions for High Risk HIV Negative Persons; Condom Distribution; Education/Outreach.	$2,848,626
Emory Healthcare	$0		$200,490	HIV Prevention Services: DeKalb County Jail - Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$200,490
Emory Midtown	$895,934	Outpatient/Ambulatory Health Services; Medical Transportation; Non-Medical Case Management; Food Bank/Home Delivered Meals	$0		$895,934
Empowerment Resource Center	$0		$150,000	HIV Prevention Services: Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$150,000
Fulton Health & Wellness	$2,867,920	Outpatient/Ambulatory Health Services; Oral Health; Mental Health; Substance Abuse; Medical Nutrition Therapy; Medical Case Management through AID Atlanta; Non-Medical Case Management; Food Bank/Home Delivered Meals; Linguistics; Medical Transportation; Medical Case Management through AID Atlanta; Psychosocial Support – Patient Navigation through AID Atlanta	$3,986,220	Comprehensive HIV Prevention Program for Health Departments for the City of Atlanta Jurisdiction, which includes Fulton and DeKalb Counties. Routine Opt-Out HIV Screenings; HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS Linkage to Medical Care and Support Services; Partner Services Interventions for High Risk HIV Negative Persons; Condom Distribution; Education/Outreach. The total award for 2017 is **$8,036,968**. The funding allocated to DeKalb County Board of Health and other funded agencies listed in this chart has been deducted to avoid duplication.	$6,854,140
Grady Healthcare	$0		$223,464	HIV Prevention Services: Emergency Department and Primary Care Centers - Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$223,464

Grady Infectious Disease Program	$8,546,283	Outpatient/Ambulatory Health Services; Oral Health; Mental Health; Substance Abuse; Medical Nutrition Therapy; Medical Case Management; ; Non-Medical Case Management; Child Care; Linguistics; Medical Transportation; Psychosocial Support	$0		$8,546,283
Here's to Life	$284,095	Substance Abuse; Non-Medical Case Management; Food Bank/Home Delivered Meals; Medical Transportation; Psychosocial Support	$0		$284,095
Mercy Care	$979,218	Outpatient/Ambulatory Health Services; Oral Health; Non-Medical Case Management; Food Bank/Home Delivered Meals	$112,501	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$1,091,719
NAESM	$116,599	Mental Health; Substance Abuse; Non-Medical Case Management; Food Bank/Home Delivered Meals; Medical Transportation	$150,000	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$266,599
Open Hand	$984,429	Medical Nutrition Therapy; Food Bank/Home Delivered Meals	$0		$984,429
Positive Impact Health Centers	$3,423,827	Outpatient/Ambulatory Health Services; Oral Health; Mental Health; Substance Abuse; Medical Case Management; Non-Medical Case Management; Food Bank/Home Delivered Meals; Linguistics; Medical Transportation; Psychosocial Support; Psychosocial Support – Patient Navigation	$150,000	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$3,573,827
Recovery Consultants of Atlanta	$23,591	Medical Transportation; Psychosocial Support	$0		$23,591
Someone Cares	$0		$150,000	HIV Prevention Services: HIV Screenings for persons and geographic locations disproportionately impacted by HIV/AIDS; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$150,000
Southside Medical Center	$0		$225,000	HIV Prevention Services: Routine Opt-Out HIV Screenings; Linkage to Medical Care and Support Services; Interventions for High Risk HIV Negative Persons; Condom Distribution.	$225,000
TOTAL	**$23,334,586**		**$8,036,968**		**$31,371,554**


Fulton County HIV Funding
CDC High Impact Prevention Program (Prevention Funding)
State Funding and Fulton County General Fund
HRSA - Ryan White Program (Care and Treatment Funding)
Ryan White Part A Program Office (Office of the County Manager
Fulton County Health Department High Impact Prevention Program
Fulton County Health Department Sexual Health Program
Fulton County Health Department Ryan White Clinic
Other Agencies and Community Based Organizations

Appendix B: HIPP Data

Data Courtesy Fulton Board of Health, Annual CDC Progress Report, 2016

Category A Data: High Priority Populations

HIGH PRIORITY POPULATIONS TESTED
Category A- Healthcare

(Source: Evaluation Web Data as of 03/24/2017)

Priority Populations*	N	NP	NP PR
Black High-Risk Heterosexual Females, Ages 30-49	4,126	7	0.17%
Black MSM, Ages 20-29	887	47	5.30%
High-Risk Heterosexuals, Ages 13-64	20,871	37	0.18%
Hispanic MSM, Ages 20-49	132	2	1.52%
IDU, Ages 13-64	59	1	1.69%
Transgender MTF	97	4	4.12%
White MSM, Ages 30-39	146	1	0.68%

* Numbers for the priority populations are not mutually exclusive, and some testing events may be counted under more than one priority population
NP= New Positive; NP PR = New Positive Positivity Rate

HIGH PRIORITY POPULATIONS TESTED
Category A- Non-Healthcare

(Source: Evaluation Web Data as of 03/24/2017)

Priority Populations*	N	NP	NP PR
Black High-Risk Heterosexual Females, Ages 30-49	319	3	0.9%
Black MSM, Ages 20-29	48	1	2.1%
High-Risk Heterosexuals, Ages 13-64	2,125	6	0.3%
Hispanic MSM, Ages 20-49	13	0	0.0%
IDU, Ages 13-64	29	0	0.0%
Transgender MTF	6	0	0.0%
White MSM, Ages 30-39	15	0	0.0%

* Numbers for the priority populations are not mutually exclusive, and some testing events may be counted under more than one priority population
NP= New Positive; NP PR = New Positive Positivity Rate

Category B Data: High Priority Populations

HIGH PRIORITY POPULATION TESTING
Category B- Healthcare

(Evaluation Web Data as of 03/24/2017)

Priority Populations*	N	NP	NP PR
Black High-Risk Heterosexual Females, Ages 30-49	342	0	0.0%
Black MSM, Ages 20-29	44	1	2.3%
High-Risk Heterosexuals, Ages 13-64	1,552	3	0.2%
Hispanic MSM, Ages 20-49	10	0	0.0%
IDU, Ages 13-64	40	0	0.0%
Transgender MTF	7	0	0.0%
White MSM, Ages 30-39	8	0	0.0%

* Numbers for the priority populations are not mutually exclusive, and some testing events may be counted under more than one priority population
NP= New Positive; NP PR = New Positive Positivity Rate

HIGH PRIORITY POPULATION TESTING
Category B- Non-Healthcare

(Evaluation Web Data as of 031/24/2017)

Priority Populations*	N	NP	NP PR
Black High-Risk Heterosexual Females, Ages 30-49	1,006	0	0.0%
Black MSM, Ages 20-29	298	17	5.7%
High-Risk Heterosexuals, Ages 13-64	5,760	15	0.3%
Hispanic MSM, Ages 20-49	226	6	2.7%
IDU, Ages 13-64	115	2	1.7%
Transgender MTF	45	2	4.4%
White MSM, Ages 30-39	141	2	1.4%

* Numbers for the priority populations are not mutually exclusive, and some testing events may be counted under more than one priority population
NP= New Positive; NP PR = New Positive Positivity Rate