COMPARISONS: NATIONAL HIV/AIDS STRATEGY, CARE INITIATIVE AND PROPOSED UPDATES FROM BEYOND AIDS

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2010 STRATEGY	**2013 EXECUTIVE ORDER: CARE CONTINUUM INITIATIVE**	**SOME KEY PROPOSED ADDITIONS TO NATIONAL STRATEGY FOR 2015**
REDUCING NEW INFECTIONS • Focus prevention efforts in heavily concentrated HIV areas (MSM, IDU, blk/hsp, geographic) -Target resources appropriately -Ensure efforts are culturally sensitive -Couple HIV screening with substance treatment programs -Develop new tools to ensure accountability of recipients of public funds • Expand efforts with a combination of EBM approaches -Government agencies should fund projects to demonstrate which combo of interventions produce improved outcomes/greatest impact -Support existing surveillance activities -Expand access to prevention methods with greatest potential to impact high-risk populations -Support HIV positive persons in avoiding transmission to others • Education of population -Increase outreach through traditional and networked media -Promote age-appropriate prevention education • <u>Specific Targets</u>: *-By 2015, lower the annual number of new infections by 25 percent (from 56,300 to 42,225).* *-Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV).* *-By 2015, increase from 79 percent to 90 percent the percentage of people living with HIV who know*	**REDUCING NEW INFECTIONS** <u>Section 1: Policy</u> • USPSTF recommendation for screening of all individuals ages 15 to 65 for HIV • HHS guidelines for ARV agents recommends treatment to all adolescents and adults diagnosed with HIV • ACA implementation expanding access to preventive services (HIV testing) and no exclusion from coverage based on pre-existing conditions (HIV). • Prioritize addressing the continuum of HIV care in the implementation of the National Strategy • <u>Projects</u>: *-Focusing on prevention interventions that work: CDC and its partners are pursuing a High-Impact Prevention approach to reducing new HIV infections. This approach is using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas to increase the impact of HIV prevention efforts.*	**REDUCING NEW INFECTIONS** • Post-test counseling and information, including measures to avoid transmission, should be provided at testing sites to all persons testing positive, with invitations or referrals for further follow-up counseling provided, especially for those who cannot emotionally process full information when results are presented. Referral sources for prompt evaluation and care should be discussed. • Post-test information on measures to avoid infection (e.g., condoms, with option of PrEP if they are unlikely to be used), with availability of counseling, referrals, and repeat screening based on risk, should be offered at publicly funded testing sites to all persons testing negative who can be accessed for such services (amended 11/30/14; USPHS, 2014). • Estimated duration of infection, based on history and laboratory assays (Laeyendecker, 2013), should be utilized to guide the timeframe for initial partner tracing. • HIV reporting and other surveillance activities should be universally recognized as an integral and essential component of prevention. All legal and institutional barriers to the use of reporting data for prevention purposes should be eliminated. • Laboratory reporting of positive tests to the local public health agency should trigger automatic, prompt, and routine initial outreach services, consistently and adequately funded in all local jurisdictions nationwide. This outreach should assure that the following linkages, services, and referrals take place, should be provided for all individuals confirmed as testing positive, and/or to the providers of those tested

their serostatus (from 948,000 to 1,080,000 people).		under the providers' care: 1) Linkage to care by healthcare providers who are knowledgeable about HIV management and prevention, if not already arranged. 2) Counseling on measures to prevent transmission, if not already provided, including the importance of viral suppression, safe sexual practices, informing of partners; and for drug users, non-sharing of "works," access to clean needles, and drug treatment. 3) Initial partner services by disease intervention or other public health specialists, or by properly trained healthcare personnel as permitted by law, to identify likely source partners and the most recently exposed partners, including confidential notification and opt-out testing of possibly exposed individuals. • Partners who test HIV positive should be provided with all of the same counseling and care services of the source patients. Those who test HIV negative should be counseled on condom use, with option of PrEP (e.g., until patient's viral load becomes undetectable, if exposure will be ongoing). • Partners who are injection drug users should be counseled on disinfection and non-sharing of "works"; screening for hepatitis B and C, non-sharing of "works," access to clean needles, and drug treatment. • Risk assessment and effective prevention messages (e.g., on condoms, with option of PrEP if condoms are unlikely to be used) should be offered at publicly funded testing sites to all persons testing negative who can be accessed for such services, with availability of counseling, referrals, and repeat screening based on risk. • Sera from recently exposed and high-risk persons testing negative, whose new-onset infection might be missed by

		even the best antigen/antibody methods, should be submitted for pooled viral load testing. • Community HIV education for the general population, and that targeted to high-risk populations, should be focused on specific public health objectives: 1) Including HIV screening with HIV education as the entry point for newly discovered HIV infections into the HIV continuum of care; as well as the trigger for initial partner services, which in turn may identify early HIV cases or prevent them. 2) Combined or coordinated screening for HIV, other STDs, and viral hepatitis. 3) Promoting safe behavior that can prevent not only HIV but other STDs and bloodborne pathogens as well. ○ State legislation/ regulations should be sought as needed to require laboratories to report aggregate numbers of negative tests done, in order to permit surveillance of overall testing and positivity rates.
INCREASING ACCESS TO CARE AND IMPROVING OUTCOMES • Increase linkage to care at dx -Co-location of testing and care facilities -Promote collaboration among providers -Providers should ensure that eligible HIV-positive persons have ARV access • Increase #/diversity of providers rendering HIV care -Federal agencies to develop strategies to encourage providers in relevant specialty areas to provide HIV services (i.e., MH, PC, Addictions med) -Federal agencies to engage providers/professional societies on current HIV screening/care guidelines • Support co-morbid health conditions and social needs for those living with HIV -Enhance assessment tools to increase access to	**INCREASING ACCESS TO CARE AND IMPROVING OUTCOMES** <u>Section 2: HIV Care Continuum Initiative</u> • Initiative overseen by Director of ONAP to: -Promote expansion of testing and service delivery -Encourage innovative approaches to barriers to care -Use of Federal resources on evidence-based interventions <u>Projects</u>: • *Supporting research to improve outcomes along the HIV care continuum:* *- The National Institutes of Health (NIH) has expanded its investment in research to address gaps and opportunities in the HIV care*	**INCREASING ACCESS TO CARE AND IMPROVING OUTCOMES** • Surveillance of the demographics of recent new positives and evolving transmission patterns, as well as well as risk behavioral surveillance data (e.g., NHBS) if available, should guide the targeting of future screening and risk behavior reduction efforts. • Treatment adherence should be monitored, with simplification or adjustment of regimens as needed. • Detectable viral loads reported by laboratories should be tracked in state public health surveillance systems, brought to the attention of providers when levels remain elevated or tests are missed, compared with reported infections to determine suppression rates, and correlated with transmission patterns.

non-medical support services -Develop metrics to effectively measure health outcomes -Consider additional efforts to support housing assistance to promote initiation/adherence to tx • <u>Specific Targets</u>: *-By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).* *-By 2015,increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73 percent to 80 percent (or 237,924 people in continuous care to 260,739 people in continuous care).* *-By 2015, increase the number of Ryan White clients with permanent housing from 82 percent to 86 percent (from 434,000 to 455,800 people). (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.)*	*continuum. Highlights include investigations of the effectiveness of methods to identify HIV-infected people earlier and to link them to care; community-level interventions to expand HIV testing and treatment; interventions to improve HIV outcomes among substance users; and evaluation of innovative network approaches for HIV testing and referral for uninfected persons in the correctional system.* *• Supporting innovation to link and engage persons living with HIV into care:* *- Funded through the Secretary's Minority AIDS Initiative Fund, the Care and Prevention of HIV in the United States demonstration project is underway in eight states and is designed to reduce HIV-related morbidity, mortality, and related health disparities among racial and ethnic minorities.*	• Barriers to initial linkage in care should be reduced. • Referral sources for prompt evaluation and care should be discussed with all persons testing positive. • Prompt offering/initiation of antiretroviral treatment, and assurance of continuous treatment availability, should be available. • Referral services should be available to specialists, support groups, ADAP, case management cross-trained in prevention, substance abuse treatment, mental health services, housing assistance, prevention with positives, and other programs (historically funded by the Ryan White CARE Act) as appropriate. • Transportation assistance should be available to patients having difficulty with initial linkage or return to treatment facilities, or with access to referral specialists. • Providers should monitor for and address antiretroviral medication adverse effects. • Federal grants and other public funding for care and case management should hold recipients accountable for monitoring of viral loads.
REDUCING HIV HEALTH DISPARITIES • Reduce HIV-related mortality in communities with high risk of HIV infection -Improve access to regular VL and CD4 testing •Adopt community-level approaches to reduce infection rate in high-risk communities -Establish pilot programs using community models -Track community VL to address areas of high HIV incidence -Improve prevention of HIV related co-morbidities (STIs, HepB/C), not only HIV prevention in high-risk groups • Reduce stigma/discrimination associated with HIV	**REDUCING HIV HEALTH DISPARITIES** Section 1: Policy • HHS guidelines for ARV agents recommends treatment to all adolescents and adults diagnosed with HIV	**REDUCING HIV HEALTH DISPARITIES** • Training should be made widely available to providers, on universal screening recommendations and their culturally competent implementation. • Treatment facilities should be made available in neighborhoods populated by disadvantaged, high-risk population groups. • Active community outreach to patients missing appointments, and closely tracked referrals to new sources of care for those who require a change in provider. • Patients whose viral loads are not fully suppressed should be provided with special intensive assistance, both medical

-Community leadership (i.e., faith-based, businesses, schools) in nonjudgmental practices -Promote public leadership by people with HIV -Encourage state legislatures to review HIV-specific criminal statutes -DOJ and other agencies should enhance/facilitate enforcement of antidiscrimination laws • <u>Specific Targets</u>: *While working to improve access to prevention and care services for all Americans,* *-By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.* *-By 2015, increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.* *-By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.*		and related to adherence, to help achieve undetectable levels. • Special programs to enhance viral suppression should be provided for population groups with the lowest rates, but should involve work directly with individual patients. • Provider training should be increased for culturally competent care (adapting to the local context), identification and treatment of comorbid mental health diagnoses, and concomitant substance use. • Primary care providers who do not treat HIV should be urged to refer all HIV patients to competent providers who do.
COORDINATED NATIONAL RESPONSE • Increase coordination of HIV programs across Federal, state and local government agencies -Feds should increase focus on coordinated planning across agencies -Review methods used to distribute Federal funds and ensure resources go to areas of greatest need -Streamline efforts for grant administration including; standardized data collection, consolidation of announcement and reporting requirements. • Develop improved methods to monitor and report on status of National Strategy implementation -Prioritize and redirect resources to most effective programs (4 criteria identified) -Annual reporting on progress -Encourage States to provide annual reports to ONAP	**COORDINATED NATIONAL RESPONSE** <u>Section 2: HIV Care Continuum Initiative</u> -Coordinate Federal efforts in HIV treatment/prevention <u>Section 3: Care Continuum Working Group</u> • HHS and ONAP as co-chairs in conjunction with DOL, HUD, VA, OMB and others to: -Review efforts from agencies addressing the domestic epidemic and review research on outcomes -Obtain input from stakeholders -Recommend way to further integrate efforts and improve coordination between and within agencies -Provide recs to POTUS at 180d after order and annually	**COORDINATED NATIONAL RESPONSE** • The Centers for Disease Control and Prevention (CDC), and the U.S. Preventive Services Task Force (USPSTF) should maintain, update, and urge universal implementation of the latest recommendations for universal screening of adolescents and adults, and the methods and confirmation algorithms used. • Aggregate laboratory reporting of negative HIV tests, and reporting of all viral RNA, resistance, and.CD4 tests, should be pursued including state legislative/regulatory changes. • CDC should promote surveillance of viral loads, genotypes, and CD4 levels, and should include this service in prevention grants to states. • Federal funding from CDC for surveillance and outreach should be available in all geographic and demographic areas. States should be held accountable, as a condition of funding, for assuring that services are available in all local

and HHS OS	thereafter with ONAP annual report Section 4: General Provisions • Provides necessary wording to protect executive department or agency authority, and the functions of the OMB as it relates to budgetary, administrative or legislative proposals. • Projects: *Standardizing HIV data to improve health outcomes along the care continuum:* *- In June 2013, the Secretary approved plans submitted by nine HHS operating divisions to adopt and* *deploy seven HIV common core indicators and streamline data collection for HIV services grantees.* *HHS offices are working to include these indicators as clinical quality measures in electronic* *health record (EHR) systems beginning in 2016.*	jurisdictions. • Surveillance-driven updating (at least annual) of the targeting of screening and prevention should be a condition for CDC funding. • CDC should survey and monitor distribution of testing sites and testing rates, to optimally serve populations at increased risk. • State legislation/ regulations should be sought as needed to require laboratories to report aggregate numbers of negative tests done, in order to permit surveillance of overall testing and positivity rates. • State legislation/ regulations should be sought to enact laboratory reporting of all viral load, genotype, and CD4 testing regardless of results, in those states not yet providing this.○ • Prevention with Positives components should be provided through collaboration of providers and supportive HIV/AIDS services with Ryan White funding, including accessible condom distribution; screening and treatment of other STDs, hepatitis B and C, and tuberculosis; prevention of mother-to-child transmission; reproductive health care; and referral to other services as needs arise during care • The U.S. Preventive Services Task Force, CMS, and other appropriate agencies should review preventive services needed by HIV positive persons, so that these can become benefits under the Affordable Care Act. • HRSA should include monitoring and follow-up of detectable viral loads in the funding and accountability of HIV treatment funding. • HRSA, in cooperation with CDC and NIH, should assure that recommendations for treatment of all infected persons are widely disseminated and promoted to patients and providers, as the standard of care. • HRSA should require cross-training of Ryan White case managers to provide prevention case management, including

NHAS goals and targets acquired from: http://www.whitehouse.gov/files/documents/nhas-implementation.pdf	*Care Continuum Sections acquired from:* http://www.gpo.gov/fdsys/pkg/FR-2013-07-18/pdf/2013-17478.pdf *Care Continuum projects planned acquired from:* http://aids.gov/federal-resources/national-hiv-aids-strategy/hiv-care-continuum-initiative-fact-sheet.pdf	ongoing counseling on maintenance of condom use, treatment adherence, and other measures to prevent transmission. • Coverage of treatment through the ADAP program should be maintained for persons with HIV who are not covered by Affordable Care Act, and for any treatments not covered by ACA exchange plans. • All possible efforts should be pursued to extend prevention and treatment services provided through the Ryan White CARE Act as benefits of both Medicaid and the ACA exchanges. • Ancillary measures provided by the Ryan White program should be maintained for persons and for services not covered by the Affordable Care Act (e.g., support groups, socio-economic assistance, and case management). *PrEP Guidelines acquired from:* http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf