VIRGINIA DEPARTMENT OF HEALTH

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BACKGROUND

As of December 31, 2012, there were 24,720 people, known to be living with a diagnosis of HIV disease in Virginia, at a prevalence rate of 305.3 per 100,000 population. Approximately half of this population had progressed to the AIDS stage of the disease. Both case counts and rates of HIV disease diagnoses have increased among young adults ages 20-24, from a rate of 24.2 per 100,000 in 2007 to 30.6 in 2011. Black and Latino communities in Virginia are disproportionately impacted by HIV. Blacks represent 20% of Virginia's population; however, they account for 60% of new HIV diagnoses. While the infection rate among Whites was 5 per 100,000 in 2012, it was triple that among Latinos. More than 80% of the diagnoses occurred among men, of whom 70% reported a transmission risk of male-to-male sexual contact. From 2007 to 2011, young Black, non-Latino men who have sex with men (MSM) experienced an increase of 125% in new diagnoses of HIV disease. While more than 80% of the newly diagnosed HIV cases between 2006 and 2010 were linked to care, only 55% had evidence of care in 2011.

Social Determinants of Health (SDH) impacting the disproportionate impact of HIV on Blacks and Latinos in Virginia include the 10 factors that make up the Virginia Department of Health, Office of Minority Health and Health Equity, Health Opportunity Index (HOI). Of these 10 factors, lower educational levels, lower household income, high population density and lack of racial diversity can be correlated with higher rates of HIV. In Virginia, the geographic census tracks with the lowest HOI scores correspond closely with disproportionate burden of HIV and AIDS. Additionally, both the Black and Latino communities experience a higher rate of incarceration. According to the Bureau of Justice Statistics for 2007, the incarceration rate in Virginia per 100,000 population was 96 for Whites, 487 for Hispanics, and 2,331 for Blacks. Homelessness contributes to recidivism and gaps in care among the formerly-incarcerated HIV-positive population.

These SDH, in addition to high levels of stigma, continue to affect both retention in care rates and utilization of testing services in Virginia. Anecdotal reports from members of the gay men of color advisory committee, as well as from individuals located for re-engagement to medical care, suggest that negative perceptions of initial medical visits and concerns about confidentiality (especially in rural areas of the state) prevent many young men from staying engaged in care. In 2012, NASTAD's stigma survey revealed that Virginia had one of the highest rates of HIV-related stigma among all respondents.

USE SURVEILLANCE DATA AND DATA SYSTEMS TO IMPROVE CARE AND PREVENTION

The project will establish a care markers database that contains all available indicators of medical care for HIV-positive persons to include dates of HIV positive tests (including first and most recent), CD4 counts, viral loads,

evidence of Anti-Retroviral Therapy (ART) and medical visits. This database, developed with funding from both CAPUS and a HRSA Special Projects of National Significance Systems Linkages grant, will provide information for assessing the HIV Care Continuum for Virginia, as well as for providing data to organizations in the community on a client's care status. Out-of-care lists will be developed and shared with medical providers and patient navigators, who will feedback updated data on linkage and re-engagement efforts for these clients. At least two laboratory facilities (LF) electronic HIV laboratory reports (ELRs) will be imported into the respective HIV data systems using lab import functionalities. The ELR data will assist with more timely assessment of care marker data, as paper-based data has created a lag time of up to 12 months, which can hinder efforts to improve linkage and retention.

INCREASE HIV TESTING, LINKAGE TO, RETENTION IN, AND RE-ENGAGEMENT WITH CARE, TREATMENT, AND PREVENTION

The project will perform 35,000 additional HIV tests among Blacks and Latinos, ages 18-64 and living in the targeted Virginia communities, over the three-year project period, distributed as such: 5,000 tests in year one, 10,000 tests in year two, and 20,000 tests in year three. In order to reach this population, the Division of Disease Prevention (DDP) targeted funding for HIV testing efforts to census tracts where at least 30 percent of the population was Black or Latino, and where at least 20 percent of the population was living beneath the federal poverty level as of the 2011 American Community Survey. These selection criteria were used to prioritize sites for community-based, as well as pharmacy-based HIV testing. DDP will convene monthly technical assistance calls for CAPUS testing contractors using the model already established by the Community HIV Testing program.

In addition to the testing strategy to reach Blacks and Latinos, DDP will begin implementation of a new rapid-rapid testing algorithm with two test sites to immediately identify and refer individuals with presumptive positive HIV diagnoses identified by any HIV testing program into HIV medical care. The basis for the rapid-rapid algorithm is the Clinical and Laboratory Standards Institute's document M53A, and will entail the use of two sequential, orthogonal rapid HIV tests to provide a presumptive HIV-positive diagnosis. Using the rapid-rapid test technology, the length of time needed to link a newly diagnosed HIV-positive person in medical care will decrease, as the test counselor will be able to make an immediate referral to care.

The project will also request proposals for, and will launch a pharmacy-based HIV testing program, which will enhance opportunities for testing in non-stigmatizing settings in areas not served or underserved by CBOs. The pharmacy contractor selected will be integrated into the network of CBOs performing community-based HIV testing, for the purpose of making active referrals to confirmatory testing for individuals who are found to be preliminary positive. DDP staff will work directly with the pharmacy testing contractor in orienting pharmacy testing site staff to the CBOs and Disease Intervention Specialists working in their jurisdiction.

Uptake of HIV testing in at least 25 clinical sites, including Expanded HIV Testing sites will be encouraged through distribution of "Ask Me About the Test" conversation starter materials to clinicians and other clinic staff. These will entail waiting room print materials co-branded with the Greater Than AIDS campaign, as well

as buttons, lapel pins, and print brochures that encourage patients to ask their provider for an HIV test. DDP will work with the Department of Health's Clinical Liaison and Expanded HIV Testing Coordinator to market the campaign to local health departments and other clinical sites. Evaluation data from the "Ask Me About the Test" campaign will be shared with other jurisdictions that have implemented similar campaigns in the past.

The project will implement a Social Network Strategy (SNS) to identify individuals at high-risk for HIV infection and to engage them in HIV testing and counseling services. SNS promotes and increases HIV testing through targeted efforts. The project will use SNS to target HIV-positive individuals or high-risk negative individuals to be enlisted as recruiters. Once enlisted, these individuals recruit members of their social, sexual, or drug-use networks who may be at very high risk for HIV infection to get tested.

ENHANCE PATIENT NAVIGATION

Contracts will be established with at least five HIV care sites throughout the Northern, Northwest, and Eastern regions to fund a Community Health Worker (CHW) to provide patient navigation services, including linkage to, retention in, and re-engagement in care, prevention education, and medication assistance/adherence counseling. CHWs will provide linkage, retention, re-engagement in care, education, and/or medication assistance/adherence counseling services to at least 150 Black and Latino HIV-positive clients in the Northern, Eastern, and Northwest regions of Virginia. Additionally, there will be an increase in the show rate for scheduled HIV appointments by 15% over a baseline rate (to be determined) at participating HIV care sites.

Using the Coordination of Care and Services Agreement (CCSA) and Active Referral Protocol for Disease Intervention Specialists (DIS), the project will ensure that at least 75% of the DIS provide active referrals to care for persons newly diagnosed with HIV. This will be accomplished through the use of the CCSA itself, as well as logs and the continuing technical assistance Polycom conference calls already used by the Field Operations Services unit in managing the DIS. Through training in the Active Referral protocol and active relationship-building facilitated by DDP, DIS will develop working relationships with the HIV patient navigators already funded in their health district by CAPUS or other funding streams. This will enhance the patient navigation system by creating a mutually-aware network of linkage and retention workers, which will provide a smoother transition for newly-diagnosed clients to link to and remain in care. Requirements for linkages to care will be incorporated into memoranda of agreement with health districts for DIS activities.

ADDRESS SOCIAL AND STRUCTURAL FACTORS DIRECTLY AFFECTING HIV TESTING, LINKAGE TO, RETENTION IN, AND RE-ENGAGEMENT WITH CARE, TREATMENT, AND PREVENTION

The Virginia CAPUS project will analyze HIV testing facilities' location and HIV disease burden data alongside social determinants of health datasets to improve understanding of target populations for use in planning HIV testing, linkage to care and re-engagement in care activities. In addition, the Virginia-specific Act Against AIDS: Greater Than AIDS campaign components for Blacks will be launched in at least two health regions of the state. In the second and third years of the project, Testing Makes Us Stronger will be launched on social networking sites and smartphone technology to address HIV testing and care in targeted messages to Black

and Latino MSM. Furthermore, a pilot temporary housing program will be established for HIV-positive persons being released from incarceration. This pilot will work in conjunction with an existing state program that provides case management for HIV-positive individuals released from incarceration. The housing pilot will track clinical indicators along the continuum of care, as well as rates of recidivism, employment and housing status upon completion of the six-month housing period.

FUND COMMUNITY-BASED ORGANIZATIONS USING A MINIMUM 25% OF TOTAL AWARD

Approximately 53% of CAPUS funds will be directed to CBOs during the three year period. Activities conducted by CBOs will include: community and pharmacy-based rapid HIV testing, confirmatory HIV testing, linkage to, retention and re-engagement in HIV medical care, implementation of Social Networking Strategy, prevention education, treatment adherence counseling, and provision of temporary housing. CBOs will also conduct other activities as needs are identified.