GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Enhanced Comprehensive HIV Prevention Plan (ECHPP)
For the Atlanta Metropolitan Statistical Area

Submitted:
May 6, 2011

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I. INTRODUCTION

The Atlanta-Sandy Springs-Marietta Metropolitan Statistical Area (Atlanta MSA) is a 28-county jurisdiction located in the north and northwest region of the state of Georgia. Widely known as the home of the growing central city of Atlanta, the Atlanta MSA continues to struggle with inner city issues within the confines of a largely rural state. Among the struggles that loom large is the ongoing fight against HIV/AIDS. Ranked 5th among the top 12 Metropolitan Statistical Areas for cumulative AIDS cases in 2007, the Atlanta MSA bares a disproportionate burden of the state of Georgia's HIV/AIDS morbidity. More specifically, approximately two thirds of all newly diagnosed cases in Georgia can be found within the Atlanta MSA. Fulton and DeKalb counties alone account for over 50% of newly infected cases. The Georgia Department of Community Health (Georgia DCH) recognizes the importance of allocating and leveraging resources based on need. To this end, the Atlanta MSA Enhanced Comprehensive HIV Prevention Plan (ECHPP) will focus on the following 5 counties that collectively account for 60% of the state's total HIV/AIDS morbidity; Fulton, DeKalb, Cobb-Douglas, Clayton and Gwinnett counties respectively.

Efforts to address the HIV/AIDS epidemic in the Atlanta MSA must take into consideration a confluence of factors including the current demographic make-up of the jurisdiction, socio-economic trends, existing services and related structural and environmental factors that impact the efficacy of HIV services and related outcomes.

The overarching goals of the Atlanta MSA ECHPP are consistent with that of the President's National HIV/AIDS Strategy 1) To reduce new infections 2) Increase access to care and improve health outcomes for people living with HIV/AIDS (PLWHA) 3) Reduce HIV related disparities and 4) Ensure a more coordinated response. In support of Georgia's efforts to meet these goals, the Georgia Department of Community Health, HIV Unit and key stakeholders from multiple sectors around the Atlanta MSA embarked on a comprehensive (albeit aggressive) assessment and planning process. The result was a substantive assessment of the scale, scope and reach of "required" interventions followed by a discussion of "recommended" interventions related to the current continuum of HIV prevention and care services in the Atlanta MSA (figure A). The information garnered from the assessment phase (situational analysis) informed the development of intervention specific goals and objectives (the planning phase) that will drive Georgia's coordinated HIV prevention and care activities in the Atlanta MSA moving forward.

Overview of the Atlanta MSA

The Atlanta Metropolitan Statistical Area is the eighth largest metropolitan area in the United States. Home to the central city of Atlanta (the capital of Georgia) the Atlanta MSA consists of 28 counties which span the entire northern third of the state. The estimated population of the Atlanta MSA in 2008 was 5,376,285 persons. The budding metropolis of the Southeastern United States, Atlanta's growth reached epic proportions in the 1990's. A city of perpetual dichotomies one must only travel 40 minutes in either direction before the prominent skyline is replaced with a rural landscape of an old world agrarian community.

The U.S. Census report for 2008 documented 421,570 residents in the Atlanta city limits. Of that number 236,220 (56%) identified as African-American (Black). Unfortunately, recent estimates indicate that 9% of all Atlanta families live below the federal poverty line. As compelling is the number of Black families reported to live below the federal poverty line (over 18%). The majority of these families are headed by single females, an ongoing reminder of the plethora of social-ecological disparities plaguing Atlanta's African American community. Black female heads of households with children have the highest poverty rates (36%) with a high proportion concentrated in the census tracts that coincide within the metropolitan area of Atlanta and HIV disease epicenters (U.S. Census Bureau, 2008).

HIV and related risk behaviors in the Atlanta MSA

In a study conducted by the Emory University Center for AIDS Research (CFAR) in 2009, investigators Hixson, Omer, del Rio, and Frew found that the HIV epidemic in metropolitan Atlanta is concentrated primarily in an area consisting of 157 census tracts centralized in the downtown area. Research indicated that this centralized HIV cluster consisted of 105 census tracts from Fulton County and 52 census tracts from DeKalb County. This cluster did not contain census tracts from either Clayton or Gwinnett counties. The area of the cluster was 466 square kilometers (approximately 180 square miles), and includes many of the areas identified by DCH HIV Surveillance as "High Risk".

The HIV prevalence rate in this area exceeds 1.34% and is compatible with the World Health Organization's description of an "epidemic". Epidemic status is assigned to any area with a rate that exceeds one percent. Forty-two percent (42%, N=11) of HIV service providers (i.e., ASO/CBOs) in Atlanta were also located in this cluster. Tracts in the cluster were associated with higher levels of poverty, higher density of African-Americans in the general population and a high prevalence of behaviors that increased the risk of HIV exposure. These risk factors include injection drug use, men having sex with men, and men having sex with men and IV drug use.

A graphic representation of the cumulative cases of HIV infection in Georgia by Public Health Districts in 2007 is shown in Figure 1. Figure 2 shows newly diagnosed HIV infections (not AIDS) by gender that occurred in Georgia in 2007. Additional information regarding the HIV epidemic and breakdown of HIV cases in Georgia can be found in the section for tables, graphs, and charts starting on page 43.

Figure 1: Cumulative Cases of HIV Infection (not AIDS) by Public Health District in Georgia, 2007

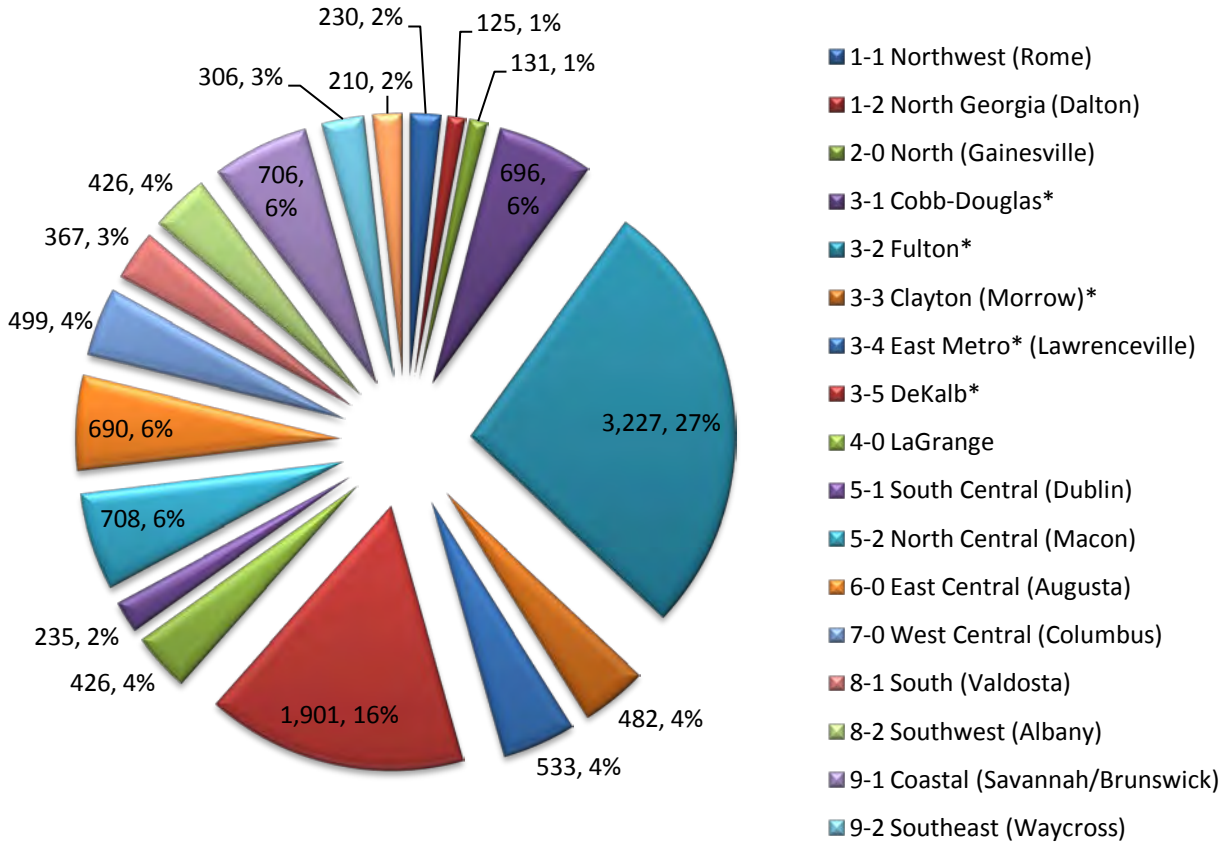
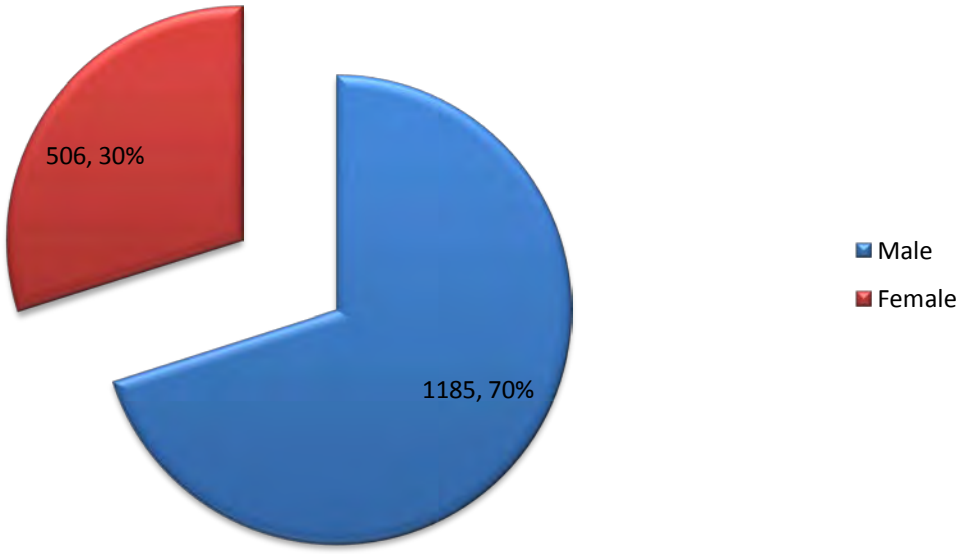


Figure 2: Cases of Newly Diagnosed HIV (non AIDS) by Gender in Georgia, 2007



II. REQUIRED INTERVENTIONS, INCLUDING SITUATIONAL ANALYSIS, GOAL SETTING, RATIONALES, AND OBJECTIVES

In this section, Georgia DCH describes the results of the situational analysis and goal setting process based on feedback received from key stakeholders, the 2009 – 2013 Georgia Comprehensive HIV Prevention Plan, and other key documents and resources. It is organized by intervention or public health strategy and discusses the current scope, scale and impact of the fourteen required interventions in the funding announcement, followed by four recommended interventions selected by Georgia DCH and key stakeholders involved in this process.

In addition, this section addresses potential opportunities for maximizing the impact of selected interventions in an effort address and support, directly or indirectly, priorities listed in the National HIV/AIDS Strategy for the United States; specifically, to (1) reduce new HIV infections; (2) reduce HIV-related health disparities, and (3) increase access to care and improve health outcomes for HIV positive individuals. Throughout the ECHPP planning process, efforts were focused on assessing the current environment and identifying the optimal combination of prevention, care, and treatment activities in an effort to maximize outcomes and leverage resources.

Sources of information used to develop goals and strategies within this plan include HIV/AIDS surveillance data for Georgia, the Georgia Epidemiological Profile, key informant interviews, qualitative and research studies, key stakeholder input from focus groups and other group processes, secondary data reports, and a collection of related literature and scientific publications.

Intervention 1 (Required): Routine, opt-out screening for HIV in clinical settings

Situational Analysis

Opt-out testing in clinical settings is not being conducted by all service providers in the Atlanta MSA largely due to a lack of awareness of Georgia House Bill 429, which, in short, requires physicians and health care providers to test pregnant women for HIV unless she specifically declines. Georgia DCH will continue to explore opportunities to build the capacity of clinical sites to provide routine opt-out screening for HIV using the CDC revised recommendation. More specifically, via technical assistance, Georgia DCH will provide information on Georgia House Bill 429, opt-out testing strategies, and other recommendations to clinical sites that are not providing opt-out screening for HIV consistently or effectively.

In 2009, Georgia DCH allocated $590,000 to three facilities in the Atlanta MSA in support of routine opt-out screening for HIV in clinical settings. Fulton County Department of Health and Wellness (FCDHW) received $100,000 for testing under the expanded testing initiative and $60,000 for African American MSM testing initiatives. DeKalb County Board of Health received

$50,000 for general testing. Grady Hospital received $380,000 for testing under the expanded testing initiative. Currently there are no other funding sources to support this intervention. State funded HIV tests in clinical settings yielded a 1.6 percent sero-positivity rate. A cost analysis of the 2009 statewide funding allocation revealed a significant discrepancy in the cost per test and cost per positive patient identified. More specifically, the Metro hospital cost per test was $66.78 resulting in a $2,730.99 cost per positive patient identified in comparison to the non-metro cost per test of $98.71 resulting in $24,614.55 cost per positive patient identified. The non-metro hospital was not cost effective, yielding very few positive cases.

Key informant feedback indicated ongoing concerns regarding physicians and medical providers in the Atlanta MSA's overall awareness of opt-out testing as a best clinical practice. Medical providers on our key informant panel stated that, based on their experience, not enough primary care providers were implementing opt-out testing in clinical settings. Issues relative to both "capacity and comfort level" are barriers to large scale implementation of this intervention. In a number of instances, it was noted that individuals with co-morbidities (e.g. tuberculosis and/or other sexually transmitted diseases) are not consistently being offered opt-out testing in clinical settings throughout the Atlanta MSA.

Feedback from key informants spoke to a number of systemic barriers including:

- Lack of test kits for non-health department providers
- Burden of additional reporting requirements specifically in busy clinical environments
- Availability of technical assistance for non-health department clinical staff
- Lack of a simple algorithm for providers to follow

In the Atlanta MSA, no additional funding is available to support this intervention beyond the $590,000 in CDC funds previously mentioned.

Goal Setting

Goal 1.1: Increase the provision of routine opt-out screening for HIV by clinical sites in the Atlanta MSA.

The National HIV/AIDS Strategy that this goal addresses is (#1) Reduce new infections. The goals lead to the identification of new positives subsequently resulting in a reduction in risk behaviors.

> Strategy 1.1.A: Develop and implement capacity building strategies around routine opt-out screening for HIV in clinical settings that target service providers in the Atlanta MSA.
>
> Strategy 1.1.B: Partner or collaborate with service providers in clinical settings (e.g. hospitals, health departments, colleges, etc.) to implement new or expand existing HIV testing initiatives in the Atlanta MSA.
>
> Strategy 1.1.C: Select, develop, and make available a comprehensive toolkit of information, talking points, and other materials that describes or provides strategies or

recommendations regarding the provision of routine opt-out screening for HIV in clinical settings.

Strategy 1.1.D: Target and recruit for technical assistance and capacity building services at least four professional associations, organizations, or networks for medical service providers (e.g. Southern Regional Hospital; DeKalb Medical Center; Georgia Chapter – American Academy of Pediatrics; American College of Obstetricians and Gynecologist; Georgia Academy of Family Physicians; etc.) that provide HIV-related services (e.g. HIV screening) to populations at high risk for HIV infection or transmission.

Strategy 1.1.E: Provide sites in clinical settings with resources (e.g. rapid HIV test kits) that will increase the provision of routine opt-out screening for HIV.

Objective 1.1.1: By September 2011, Georgia DCH will provide at least one technical assistance training about routine opt-out screening for HIV to reach a minimum of 10 individuals or service providers.

Data sources: Georgia DCH training calendar; attendance sheets; CBA/TA training records and reports; participant evaluations

Funding source: CDC (i.e. ECHPP)

Objective 1.1.2: By September 2011, increase from 3 to 5 the number of service providers in the Atlanta MSA that receive funding from Georgia DCH to provide routine opt-out screening.

Data sources: Georgia DCH contracts, monthly progress reports from grantees

Funding source: CDC (i.e. ECHPP), Georgia DCH (i.e. Test GA Initiative)

Objective 1.1.3: By September 2011, increase from 600 to 900 the number of routine opt-out screening for HIV conducted monthly by service providers in clinical settings in the Atlanta MSA for a total of 3600 by the end of the planning grant period.

Data sources: Georgia DCH contracts; monthly progress reports from grantees

Funding source: CDC (i.e. ECHPP)

Rationale

Concurrent with Georgia's Comprehensive HIV Prevention Plan and feedback received during stakeholder meetings for ECHPP, opt-out testing will give providers an opportunity to identify, treat, and/or link to care persons (particularly pregnant women) who may not know their HIV status. Providing effective technical assistance and capacity building services are identified strategies that will raise awareness of Georgia House Bill 429 and increase the capacity of private and public service providers to implement strategies for opt-out screening for HIV.

Implementing these strategies will likely contribute to the increase of the overall number of physicians and health care providers who test pregnant women for HIV unless she specifically declines.

Intervention 2 (Required): HIV testing in non-clinical settings to identify undiagnosed HIV infection

Situational Analysis

Although in 2009, Georgia DCH did not fund any agencies to conduct HIV testing in non-clinical settings to identify undiagnosed HIV infected persons, a number of agencies and providers in the Atlanta MSA leveraged other funding sources in support of non-clinical HIV testing efforts. In support of these efforts, Georgia DCH allocated $200,000 to purchase OraQuick Rapid Test kits to assist funded agencies and District Health Departments with their HIV testing efforts. An additional $400,000 was allocated to support confirmatory testing and screening at the Chatham County Laboratory, the laboratory selected to process confirmatory HIV tests administered by agencies statewide, including those in the Atlanta MSA. Figure 3 shows the HIV testing outcomes for agencies that received health department funding in support of other (non-testing) HIV prevention services in 2009.

Figure 3: HIV Testing Outcomes for Georgia HD-funded (non-clinical) agencies, 2009

	Total Tests	Total Positive	Sero-positivity
Gender			
Male	29619	770	2.60%
Female	28763	128	0.45%
Transgender M2F	220	7	3.18%
Transgender F2M	9	0	0.00%
Missing	68	0	0.00%
Gender Total	**58679**	**905**	**1.54%**
Age			
Less Than 13	176	2	1.14%
13-18	3289	16	0.49%
19-24	16329	261	1.60%
25-34	18225	318	1.74%
35-44	10508	162	1.54%
45+	10152	146	1.44%
Age Total	**58679**	**905**	**1.54%**
Race			
American Indian / Alaskan Native	189	1	0.53%
Black	44805	744	1.66%
White	9493	98	1.03%
Native Hawaiian / Pacific Islander	2025	41	2.02%
Asian	625	1	0.16%
More Than One Race	0	0	-
Don't Know	1542	20	1.30%
Race Total	**58679**	**905**	**1.54%**
Ethnicity			
Hispanic / Latino	4068	48	1.18%
Not Hispanic / Latino	53656	845	1.57%
Declined/ Don't Know	955	12	1.26%
Ethnicity Total	**58679**	**905**	**1.54%**
Transmission Category			
White MSM		77	
Black MSM		434	
NH/PI MSM		3	
Unknown Race MSM		7	
IDU		8	
Heterosexual		239	
NIR/NRR		133	
Transgender		4	
Transmission Total		**905**	

Under the transmission category, data for total test kits and sero-positivity rates are unavailable because such categorization of data was not required for reporting prior to June 2010. However, as of June 2010, agencies receiving health department funding is now required to

report transmission categories for individuals tested. To ensure compliancy, Georgia DCH provides a range of technical assistance regarding reporting requirements, e.g. training, instructional documents, assistance via teleconferences, and other forms and means of information.

There are five agencies within the Atlanta MSA that receive Health Resources and Services Administration (HRSA) funding to provide HIV counseling and testing services. A number of these agencies provide intermittent HIV testing in non-clinical settings. According to the HIV Unit's counseling and testing database, there are over 200 counseling and testing sites in the Atlanta MSA. Given the high concentration and diversity of testing sites in the Atlanta MSA, barriers related to client access to HIV CTS are reduced. The availability of sustained health department funded non-clinical HIV testing will likely improve HIV testing outcomes as the capacity of prevention partners to reach high risk populations where they live, work, and worship increases.

As of September 2010, Georgia DCH increased the amount of funds available to purchase test kits from $200,000 to $700,000. This increase considers recently funded non-clinical sites in the Atlanta MSA including eight community based organizations (CBO) and three historically black colleges and universities (HBCUs). For each of these sites, Georgia DCH will support the purchase of test kits and cover the cost of confirmatory testing. Funding for non-clinical sites will be used to support HIV testing with test counselors, social marketing, and promotional testing events. Ten CBOs were funded at $40,000 per agency for a total of $400,000 and seven HBCUs were funded at $30,000 per school for a total of $210,000.

Feedback from key informants during interviews and focus groups indicated that a number of community stakeholders felt that the health department lacked the capacity to meet the training needs of providers because of the low number of trainings scheduled for service providers. Georgia DCH has taken steps to increase the availability of trainings and reverse the perception of community stakeholders by hiring new employees in March 2011 for the HIV Unit to assist with and facilitate technical assistance and trainings related to interventions, CTS, and linkage to care.

Goal Setting

Goal 2.1: Increase the number of HIV tests conducted at non-clinical sites in areas with high concentrations of HIV the Atlanta MSA.

The National HIV/AIDS Strategies that these goals address are (#1) reduce new infections and (#2) reduce health disparities. The goals will lead to the identification of new positives subsequently resulting in a reduction in risk behaviors, as well as enable HIV testing where racial and minorities live, work, play, and worship.

> Strategy 2.1.A: Identify and partner or collaborate with local agencies, businesses, and/or service providers in the Atlanta MSA to develop new or strengthen existing HIV testing initiatives to identify undiagnosed HIV infections.

Strategy 2.1.B: Provide technical assistance or capacity building services to services providers that enhance HIV testing at nonclinical sites (e.g. CTR training, HIV testing strategies that target social networks, etc.) in areas with HIV concentrations of HIV infection in the Atlanta MSA.

Strategy 2.1.C: Utilize HIV testing and prevention campaigns, such as GreaterThan.org and Taking Control, to encourage and involve community stakeholders in hosting HIV testing efforts and activities.

Strategy 2.1.D: Provide service providers with resources (e.g. rapid HIV test kits) to increase their provision of HIV testing at nonclinical sites with high concentrations of HIV.

Objective 2.1.1: By September 2011, Georgia DCH will provide at least three training courses related to HIV counseling, testing, and referral (CTR) to reach a minimum of 60 individuals or service providers.

Data sources: Georgia DCH training calendar; attendance sheets; CBA/TA training records and reports; participant evaluations

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Test Georgia Initiative)

Objective 2.1.2: By September 2011, increase from 17 to 20 the number of service providers in the Atlanta MSA funded by Georgia DCH to provide HIV testing at nonclinical sites in areas with high concentrations of HIV.

Data sources: Georgia DCH contracts

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Expanded HIV Testing Initiative)

Objective 2.1.3: By January 2012, increase from 12,100 to 15,000 the number of HIV tests provided by nonclinical services providers in the Atlanta MSA that are funded by Georgia DCH.

Data sources: Georgia DCH contracts; HIV testing and surveillance data; monthly progress reports from grantees

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Test Georgia Initiative)

Rationale

The absence of agencies funded to conduct HIV testing in non-clinical settings greatly hindered the capacity of providers to offer these services in the Atlanta MSA. By funding agencies to provide HIV testing in non-clinical settings and by providing comprehensive, standardized and sustained HIV counseling and testing training and technical assistance to agencies that provide

HIV testing in non-clinical settings, Georgia DCH greatly increases the likelihood of targeted testing initiatives in disease epi-centers throughout the Atlanta MSA.

Intervention 3 (Required): Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection

Situational Analysis

In 2009, Georgia DCH allocated $10,000 for the purchase of condoms in support of statewide HIV prevention efforts. Although dispensed to organizations and agencies that provide HIV-related services to individuals who are HIV positive or at high risk for HIV infection, information specific to the volume of condoms provided to HIV positive individuals and individuals at highest risk in the Atlanta MSA is currently unavailable. Given the disparate morbidity in the Atlanta MSA, Georgia DCH acknowledges the definitive need to develop strategies for providing condoms to HIV positive persons (both in and out of care) in the Atlanta MSA. Currently, agencies in the Atlanta MSA that provide case management services to HIV positive clients are not required by Georgia DCH to offer condoms to clients during scheduled appointments. Also, according to feedback received from key stakeholders in the Atlanta MSA, condoms are dispensed by physicians, nurses, and other medical and health care professionals in Infectious Disease clinics inconsistently due to a lack of funding to address the issues of low supply and higher demand. Such issues (i.e. funding, low supply, and lack of availability to meet demand and needs) are ongoing barriers to condom distribution, which also makes standard operating procedures for condom distribution as a standard of care in Infectious Disease clinics difficult to achieve.

The impact of existing condom distribution methods in the Atlanta MSA is difficult to assess. Data collection and evaluation strategies vary across agencies in the Atlanta MSA. As varied is the breadth of information requested by those agencies that receive other sources or support to dispense condoms to individuals who are HIV positive or at high risk for HIV infection. Additional data will be needed to ascertain reach and overall effectiveness of the current condom distribution levels targeting HIV positive persons and persons at highest risk of acquiring HIV in the Atlanta MSA.

Surveillance data of specific zip codes in the Atlanta MSA indicate that there are disease epi-centers in regions of the Atlanta MSA where condom distribution will likely have greater efficacy at reaching HIV positive persons and persons at highest risk of acquiring HIV. From January to November of 2010, records show 230 cases of condoms (230,000 condoms) were shipped to community based organizations statewide. Of this number, 88% (approximately 202,000) were distributed to 12 metro Atlanta community-based organizations that provide HIV-related services (e.g. prevention, care, or treatment) to high risk individuals. This allocation of condoms is one of the first in a series of steps to ensure that condoms are readily available to HIV positive and high risk HIV negative individuals throughout the Atlanta MSA. Another step

taken is that Georgia DCH will keep track of how many cases of condoms are distributed to specific agencies or areas in the Atlanta MSA.

Key informant feedback has indicated that Grady's Infectious Disease Program (Grady IDP) is in urgent need of more condoms for distribution. Grady IDP is a local agency in the Atlanta MSA that provides HIV-related services to HIV positive individuals, including those lost to care. Grady IDP has a client tracking systems that link HIV positive persons to care. This population is a priority for ensuring they receive condoms. In addition, Grady IDP provides medical services to HIV positive persons, including to adolescent clients. Stakeholders emphasized the importance of offering specific types and brands of condoms to encourage client use, mostly by those populations at greatest risk (e.g. African American men). The National Health Behavioral Risk Factor Surveillance Survey (NHBRFSS) indicated that the Atlanta MSA has a low level of access to free condoms.

Goal Setting

Goal 3.1: Increase the number of condoms distributed in the Atlanta MSA with high concentrations of HIV.

The National HIV/AIDS Strategies that these goals address are (#1) reduce new infections; (#2) reduce health disparities; and (#3) increase access to care / improve health outcomes for people living with HIV disease. Availability of condoms increase the likelihood that condoms will be used subsequently reducing transmission encounters.

> Strategy 3.1.A: Develop a request and tracking system to keep account and records of condom distributed by Georgia DCH.
>
> Strategy 3.1.B: Identify and provide resources (e.g. condoms or funding to purchase condoms) to organizations and event organizers in the Atlanta MSA to reach HIV positive persons and persons at highest risk for HIV infection.
>
> Strategy 3.1.C: Identify and recruit businesses (e.g. bars/clubs, event/party promoters, restaurants, gyms, retail, etc.) located in the Atlanta MSA with high concentrations of HIV or persons who are at high risk of HIV infection to participate in Georgia DCH's Business Response to AIDS / Labor Response to AIDS (BRTA/LRTA) program.
>
> Strategy 3.1.D: Develop and implement a brand marketing strategy for condoms distributed by Georgia DCH.

Objective 3.1.1: By September 2011, Georgia DCH will provide 50,000 condoms to service providers located in areas with high concentrations of HIV in the Atlanta MSA.

Data sources: Distribution and tracking system

Funding sources: CDC (i.e. ECHPP)

Objective 3.1.2: By September 2011, 10 local businesses will participate in BRTA / LRTA activities and distribute a minimum of 20,000 condoms.

Data sources: Distribution and tracking system; BRTA / LRTA event records; sponsorship; MOAs

Funding sources: CDC (i.e. ECHPP)

Objective 3.2.3: By January 2012, Georgia DCH will have created at least one brand marketing strategy to distribute a minimum of 100,000 condoms in the Atlanta MSA and areas with high concentrations of HIV.

Data sources: Distribution and tracking system; brand marketing plan / proposal

Funding sources: CDC (i.e. ECHPP)

Rationale

Increasing condom distribution by organizations that provide HIV-related services to HIV positive clients and clients at high risk for acquiring HIV will increase accessibility for condoms by populations at highest risk of transmitting or acquiring HIV. Based on feedback from key stakeholders and information in the Georgia Comprehensive HIV Prevention Plan, the availability of free and cultural acceptable condoms are needs among HIV positive persons and those at highest risk of acquiring HIV.

Intervention 4 (Required): Provision of Post-Exposure Prophylaxis to populations at greatest risk

Situational Analysis

Currently, there are no community-based organizations or agencies that receive funding to specifically provide post-exposure prophylaxis (PEP) to populations affected by HIV. No funding allocation was made in the absence of a clear guidance on broader scale implementation of PEP above and beyond traditional use in hospital settings.

Goal Setting

Goal 4.1: Increase the provision of post-exposure prophylaxis (PEP) by HIV service providers (e.g. health departments, public or private medical providers, healthcare organizations or clinical or non-clinical service providers) in the Atlanta MSA.

The National HIV/AIDS Strategies that these goals address are (#1) reduce new infections and (#3) increase access to care / improve health outcomes for people living with HIV disease. Increase awareness among providers may promote the use of PEP subsequently decreasing new infections.

Strategy 4.1.A: Develop and distribute to service providers in the Atlanta MSA a brochure with information about PEP.

Strategy 4.1.B: Identify at least two service providers in the Atlanta MSA that will receive referrals from health providers to provide PEP services to individuals recently exposed to HIV.

Strategy 4.1.C: Encourage and support service providers in the Atlanta MSA to develop memorandum of agreements with organizations that provide PEP services to refer individuals recently exposed to HIV.

Objective 4.1.1: By September 2011, Georgia DCH will distribute information regarding PEP to all Georgia DCH-funded service providers in the Atlanta MSA.

Data Source: Evidence of information brochure / materials about PEP; a distribution list

Funding Source: CDC (i.e. ECHPP)

Objective 4.1.2: By January 2012, Georgia DCH will partner with a minimum of two medical associations to present PEP to medical providers.

Data Source: Medical conference agenda

Funding Source: CDC (i.e. ECHPP)

Rationale
With no current policy regarding the provision of PEP to populations at greatest risk for HIV infection or transmission, there is limited structured information being shared to HIV service providers in the Atlanta MSA regarding PEP. Providing technical assistance to address is issue will likely increase the likelihood and number of organizations in the Atlanta MSA that provide PEP.

Intervention 5 (Required): Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment

Situational Analysis
Internal to Georgia DCH
There are existing internal infrastructure weaknesses that make it difficult for Georgia DCH to optimize HIV prevention, care, and treatment activities and related services that target HIV positive persons and people at high risk of acquiring HIV in the Atlanta MSA. Georgia DCH has prioritized efforts to address internal weaknesses, including the restructuring of the HIV

Prevention Team. Specially, Georgia DCH is considering and implementing internal strategies that address issues and concerns related to staff (e.g. turnover, furloughs, and vacancies), the organizational chart (i.e. internal hierarchy, program staff structure, and roles/responsibilities), and policies (e.g. reviewing and reinforcing existing policies or institutionalizing new policies). Existing infrastructure challenges can limit the ability of the Georgia DCH to respond promptly and consistently to the growing capacity building and technical assistance needs of CBOs and service providers that provide HIV-related services in the Atlanta MSA (e.g. provision of technical assistance workshops, such as HIV CTR training courses). Because of a somewhat lengthy screening, interviewing, and hiring process for new staff with necessary knowledge, skills, and abilities, such transitions can leave key personnel or staff positions vacant for an extended period of time, which forces leadership to concentrate on addressing gaps in staff positions as well as the general adverse impact caused by critical vacancies in Georgia DCH. Georgia DCH also faced state mandated furloughs and other related human resource control that adds to the challenges of staff retention.

According to feedback received from key community stakeholders and partners, Georiga DCH's procurement requirements and processes as well as its internal infrastructure are perceived as barriers and weaknesses to the dissemination of Georgia DCH resources (e.g. funding) to community partners, especially in a timely manner. Similarly, Georgia DCH recognizes that ongoing macro-level changes at different levels within Georgia DCH make establishing and maintaining an efficient procurement system extremely difficult. As an administrator of resources available to community partners, Georgia DCH will take steps to reduce barriers and increase accessibility of available resources to agencies that provide services to targeted populations.

Georgia DCH will not only develop strategies to better respond to the growing CBA and technical assistance needs of agencies in the Atlanta MSA, but also Georgia DCH will work closely with internal human resource teams and systems to develop strategies that are expected to improve staff retention and expertise. Georgia DCH will also work with internal departments and team (e.g. human resources) to improve the procurement process for disseminating Georgia DCH resources (e.g. funding) to community partners.

Georgia DCH will continue current efforts to overcome challenges aforementioned as well as develop new strategies when opportunities exist. So far, Georgia DCH has hired new staff members and has made changes to its internal infrastructure format, which, according to feedback received from community partners, has shown promise regarding the provision of quality of prevention services. More specifically, community partners have acknowledged a more inclusive, responsive Prevention Team with regards to technical assistance, communication, provision of critical information that may affect their organization's programs or program expectations. In addition, the new infrastructure has allowed leadership within the Prevention Team to fully utilize knowledge, skills and abilities of new and existing team members as evidenced by the "Taking Control" MSM initiative (established September 2010), the Greater than AIDS campaign (established December 2010), and the Sistas Organizing to Survive initiative (established March 2011).

External to Georgia DCH
Current GA law categorizes hypodermic needles as paraphernalia, which is a common barrier to implementing programs and activities that address the prevention, care, and treatment needs of people who inject drugs, including those who are HIV positive. There is one agency in the Atlanta MSA that currently conducts needle exchange activities (i.e. Atlanta Harm Reduction). This organization is able to conduct needle exchange activities in communities frequented by Intravenous Drug Users (IDUs) under the guise of a "medical use" clause in the existing laws. This medical use clause offers an opportunity to provide badly needed needle exchange services to clients, but the current law in Georgia greatly impedes the overall reach of effective needle exchange services and programs throughout the Atlanta MSA.

Goal Setting
Goal 5.1: Improve and strengthen environmental factors (e.g. existing structures, policies, and regulations) to optimize HIV prevention, care, and treatment efforts in the Atlanta MSA.

The National HIV/AIDS Strategies that these goals address are (#1) reduce new infections; (#2) reduce health disparities, and (#3) increase access to care / improve health outcomes for people living with HIV. Improved infrastructure that will support needle exchange opportunities in high risk and targeted communities in the Atlanta MSA will likely reduce HIV infection/transmission rates caused by injection drug use.

Strategy 5.1.A: Develop criteria to screen and approve CTR trainings conducted or provided by community partners (e.g. CBOs and other service providers) in the Atlanta MSA.

Strategy 5.1.B: Continue to update and release Georgia DCH training calendar for capacity building trainings and workshops for service providers in the Atlanta MSA, including CTR trainings approved by Georgia DCH.

Strategy 5.1.C: Based on a regional training model developed by Georgia DCH, identify and maintain a registry of community partners with state approved CTR trainers.

Strategy 5.1.D: Inform and make recommendations to policymakers and other public administrators about needle exchange programs effective at reducing HIV transmission.

Objective 5.1.1: By September 2011, Georgia DCH will have screened and approved three community-based organizations in the Atlanta MSA to provide CTR training.

Data sources: Criteria checklist to approve CTR training; screening and approval documentation

Funding source: CDC (i.e. ECHPP)

Objective 5.1.2: By September 2011, Georgia DCH will conduct a minimum of three CTR trainings in the Atlanta MSA to reach 60 individuals.

Data sources: Training calendar; CTR training enrollment; participant evaluations; training certificates

Funding source: CDC (i.e. ECHPP); Georgia DCH (i.e. Test GA Initiative)

Objective 5.1.3: By January 2012, Georgia DCH will have conducted a community forum about needle exchange program to reach 25 individuals.

Data sources: Announcements; attendance and event records; participant evaluations

Funding source: CDC (i.e ECHPP)

Rationale

Georgia DCH understands and recognizes that turnover rates exist within CBOs and other community partners that provide HIV services, including HIV testing. Taking into account internal challenges that are priorities for Georgia DCH and external opportunities with community partners, Georgia DCH plans to increase the availability and accessibility of CTR trainings in the Atlanta MSA by developing criteria to screen and approve CTR trainings provided by CBOs and community partners. CBOs and community partners will have the flexibility to add more targeted or specific elements of the CTR training that are unique to its jurisdiction or target audience (e.g. downtown residents, homeless persons, college students, etc.). By executing these strategies and activities, Georgia DCH expects to increase the number of CTR trainings in the Atlanta MSA and decrease or eliminate waitlists for CTR trainings. Other expectations include increases in the number of HIV test conducted by service providers, increase in the number of HIV positive people who linked to care.

Also, lawmakers, public administrators, and other community stakeholders who are informed about needle exchange programs that reduce HIV infection and the implications of existing paraphernalia laws in Georgia are able to make or support recommendations and decisions that improves HIV prevention efforts or activities that use needle exchange. By doing so, Georgia DCH and community partners will be able to strengthen targeted HIV testing and prevention activities to reach injection drug users, their partners, and those who are at high risk for HIV infection.

Intervention 6 (Required): Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care

Situational Analysis

Ryan White Part A funded health departments and local community-based organizations provide a continuum of care (i.e. medical and support services) for people living with HIV disease. These funded organizations each have written policies and procedures regarding linkage to care, treatment and prevention for individuals who are HIV positive, whether newly diagnosed or known status, but are not enrolled in or accessing primary care or treatment services. Organizations that provide services included in the continuum of care to people in the Atlanta MSA include Fulton County Department of Health and Wellness (FCDHW), DeKalb County Board of Health (DCBH), Cobb/Douglas Board of Health (CDBH), Clarke County Board of Health (CCBH), AID Atlanta, AID Gwinnett, Positive Impact, and Saint Joseph Mercy Care.

Ryan White Part A funding is provided by Health Resources Services Administration (HRSA) to provide care and treatment options and services to people with HIV disease. Georgia DCH recognizes this as an opportunity to develop a standardized training or method to provide technical assistance on policies and procedures regarding linkage to care for individuals newly diagnosed with HIV infection. Currently, organizations in the Atlanta MSA providing linkage to care services are responsible for ensuring that their respective staff members are trained and held accountable for adhering to their perspective organization's policies and standard operating procedures.

There are ten Ryan White Part A funded sites that provide primary care and treatment services in the Atlanta MSA. Additional HIV Care funding for people living with HIV or AIDS (PLWHA) is available in the form of Ryan White Parts C and D funding sources (i.e. funding for ambulatory medical services, outpatient HIV early intervention services, and family-centered primary medical care). Continuum of care services are held to rigid quality standards and in the absence of a structured, fully integrated linkage to care system, identifying and tracking HIV positive persons who are not enrolled in primary care is very difficult.

The need to establish a structured linkage to care/lost to care system (primarily in the Atlanta MSA) is a high priority for Georgia DCH. In March 2011, a Linkage to Care Coordinator was hired and will be responsible for collaborating and partnering with other Georgia DCH program staff members and external community partners, including those providing public health services and those who have access to populations in areas with HIV concentrations, to develop a seamless linkage to care system and strategies for finding and providing assistance to help strengthen the medical adherence capacity of patients lost to care.

During focus groups and other process meetings related to this strategy, community stakeholders identified a number of factors that reinforce the need and importance of activities that effectively assist HIV positive persons with accessing and receiving continuum of care services (i.e. linkage to care activities) as opposed to referring an individuals to services with minimal activities to determine if the person accessed the services as intended (e.g. referral activities). Focus group participants suggested that certain documents and eligibility requirements that are necessary for linkage to care services is uniquely challenging for HIV positive individuals previously incarcerated. Furthermore, stakeholders highlighted that some steps, procedures, and other related courses of action necessary or required by some service

providers to link newly diagnosed HIV positive persons to continuum of care services are complex, which, in some cases, makes general linkage to care activities difficult for some providers and discouraging for some clients. Focus group participants also highlighted and discussed a "denial period," particularly among clients in younger age groups, that often exists for clients who learned their HIV positive status for the first time. According to participants, having dedicated staff persons responsible for following up with clients as they adjust to their new HIV status and health status only also reinforces the importance of an effective linkage system.

Recommendations from stakeholders included the need for an "active" linkage to care system, particularly for youth, in the Atlanta MSA. Providers suggested that dropout rates from educational systems (e.g. high schools) among youth in the Atlanta MSA contributes to the difficulty in reaching some youth at high risk of HIV infection or who are HIV positive and unaware of their status or are not enrolled in continuum of care services. They recommended that the HIV CTR training course provided by Georgia DCH includes strategies for linkage to care.

Starting in November 2010, Georgia DCH also began the process of supporting and funding innovative approaches that are based on the Antiretroviral Treatment Access Study (ARTAS), which is a prevention model for linkage to care services. For example, Georgia DCH identified Grady IDP and three African American churches in the Atlanta MSA that have a high percentage of African American gay men who are members as having the capacity to implement linkage to care services for people who are HIV positive or at high risk of acquiring HIV disease. Based on the HIV epidemiological profile for Georgia (including the Atlanta MSA), Georgia's Comprehensive HIV Prevention Plan, and feedback from key stakeholders and community members, Georgia DCH initiated this effort to responded to and focus on the prioritized population of African American gay men as well as the prioritized strategy of linkage to care activities.

Goal Setting

Goal 6.1: Increase the number of individuals in the Atlanta MSA linked to care, treatment, and prevention services who are newly diagnosed or who are HIV positive, but not enrolled in primary care.

The National HIV/AIDS Strategies that these goals address are (#2) reduce health disparities and (#3) increase access to care / improve health outcomes for people living with HIV. Linkage to care systems will ensure that those populations that bear disproportionate burden of the disease are properly transitioned to HIV care services.

> Strategy 6.1.A: Develop and execute contract with Grady's Infectious Disease Program (Grady IDP) to provide patient recovery and retention services for clients lost to care in the Atlanta MSA.

Strategy 6.1.B: Develop and execute contracts with faith-based organizations in areas with high concentrations of HIV in the Atlanta MSA to reach and ensure that persons testing HIV positive are successfully linked to the continuum of care services (e.g. medical care and treatment, case management, and HIV prevention services.

Strategy 6.1.C: Partner or collaborate with Grady IDP and faith-based organizations to implement Antiretroviral Treatment Access Study (ARTAS) linage to HIV care intervention for persons who have recently tested positive or have returned to care after a period of missed appointments.

Strategy 6.1.D: Update Georgia DCH HIV CTR training protocol and other related training materials (e.g. participant manuals) to include a linkage to care training component.

Strategy 6.1.E: Provide technical assistance or capacity building services to ensure service providers that receive funds from Georgia DCH implement linkage to care activities.

Objective 6.1.1: By September 2011, Georgia DCH will execute four contracts for service providers in the Atlanta MSA to provide linkage to care activities (e.g. ARTAS).

Data sources: Georgia DCH contracts

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Expanded HIV Testing Initiative)

Objective 6.1.2: By September 2011, Georgia DCH will have updated its HIV CTR training protocol and materials to include a component on linkage to care.

Data sources: CTR training protocol and materials

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Expanded HIV Testing Initiative)

Objective 6.1.3: By January 2012, organizations funded by Georgia DCH to provide linkage to care services in the Atlanta MSA will link 100% of newly HIV diagnosed persons to continuum of care services.

Data sources: Monthly progress reports from grantees

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Expanded HIV Testing Initiative)

Rationale

The integration of active and effective linkage to care systems for newly HIV diagnosed individuals and for HIV positive individuals who do not access medical care or treatment that improve health outcomes and prevent transmission of HIV are crucial processes and activities

that are expected to improve HIV care outcomes. Although attempts to link HIV positive individuals to the continuum of care services currently exist, mostly are implemented in the form of a referral among a network of service providers and other health organizations in the Atlanta MSA. Based on recommendations from key stakeholders as well as opportunities to strengthen existing referral networks, a stronger and more structured, fully integrated linkage to care system is necessary to more effectively link persons newly diagnosed with HIV into care and treatment opportunities and services.

Intervention 7 (Required): Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons

Situational Analysis

The Grady Infectious Disease Program (Grady IDP) is currently the only service provider actively implementing strategies and activities, such as Client Tracking (i.e. a program that contacts clients via phone call or via USPS mail to re-enroll into primary care services), that target clients who are considered or described as being "lost to care" or "lost to follow-up" (i.e. HIV positive clients who are not actively seeking to or currently enrolled in primary care or treatment services) in the Atlanta MSA. The issue of high drop-out rates among clients in HIV care clinics continues to plague providers. For example, the absence of staff to conduct case finding or client engagement activities presents a major challenge to a service provider's ability to offer effective service options. To help assess and understand existing issues and challenges, the AIDS Alliance is in the process of launching and conducting a comprehensive study that will identify weaknesses in the provision of HIV care that makes it difficult for service providers to implement, manage, or make available to target populations needed HIV prevention, care, and/or treatment services in the Atlanta MSA.

The African American Outreach Initiative (AAOI) is an annual event and conference that is supported and lead by a network of partnering organizations within the Atlanta MSA that targets HIV positive African Americans. Recent conference themes have focused on individuals lost to care and the importance of accessing services in the continuum of care. The conference uses a peer engagement models to raise awareness among HIV positive persons. Given the disproportionate impact of HIV on the African American community in the Atlanta MSA, efforts to engage PLWHA lost to care (especially HIV positive African Americans and areas with highest rates of infections in the Atlanta MSA) should be fully leveraged.

Goal Setting

Goal 7.1**:** Increase the number of service providers that implement interventions or strategies that promote or support retention or engagement activities for HIV positive persons linked to care in the Atlanta MSA.

The National HIV/AIDS Strategy that these goals address is (#3) increase access to care / improve health care outcomes for people living with HIV disease. Retention or reengagement in care greatly increases the likelihood of favorable care outcomes.

Strategy 7.1.A: Georgia DCH will develop retention and engagement guidance documents that will be provided to service providers in the Atlanta MSA (e.g. Taking Control).

Strategy 7.1.B: Identify and recruit service providers in the Atlanta MSA that provide services to HIV positive persons to receive technical assistance or capacity building services to implement interventions or strategies promoting retention or engagement activities for HIV positive persons linked to care.

Strategy 7.1.C: Schedule trainings or provide technical assistance and capacity building services regarding interventions or strategies promoting retention or engagement activities for HIV positive persons linked to care to service providers in the Atlanta MSA.

Strategy 7.1.D: Establish a collaborative system between HIV prevention and care providers in the Atlanta MSA that addresses retention and re-engagement in care and treatment options for HIV positive persons.

Strategy 7.1.E: Identify state-funded HIV Care providers with developed policies with clearly defined retention and re-engagement strategies with the purpose of assisting HIV positive person to actively seek and continue to access HIV-related services.

Strategy 7.1.F: Establish a baseline of the number of service providers in the Atlanta MSA that implement interventions or strategies promoting retention in or engagement in care for HIV positive persons.

Objective 7.1.1: By September 2011, Georgia DCH will schedule and conduct at least one technical assistance training in the Atlanta MSA about implementing interventions or strategies that promote retention or engagement activities for HIV positive persons linked to care reaching 10 individuals.

Data sources: Training calendar; participant attendance records; training evaluations and participant feedback

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Expanded HIV Testing Initiative)

Objective 7.1.2: By January 2012, Georgia DCH will partner or collaborate with other service providers to conduct two Taking Control events in the Atlanta MSA reaching 30 people.

Data sources: Taking Control event records; participant feedback and evaluation

Funding source: CDC (i.e. ECHPP)

Objective 7.1.3: By January 2012, at least ten HIV positive persons currently not in care are identified at Taking Control events and are linked or reengaged in primary or continuum of care services.

Data sources: Taking Control event records

Funding sources: CDC (i.e. ECHPP); Georgia DCH (i.e. Expanded HIV Testing Initiative)

Rationale

Efforts to retain clients in care services will serve to improve the efficacy of care services for HIV positive clients. By training, partnering, and collaborating with other service providers in the Atlanta MSA, Georgia DCH expects that people who are reached during events, such as Taking Control and the African American Outreach Initiative, will be enrolled or reengaged in primary or continuum of care services.

Intervention 8 (Required): Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons

Situational Analysis

As a standard operating procedure (SOP), all Ryan White Part A funded primary care sites in the Atlanta MSA are required to document the antiretroviral medications (ARV) provided to clients in the patient's medical chart or service file as well as into the CAREWare database, a data management application provided by Ryan White funding administrators. The patient's chart or file should also reflect any opportunistic infection (OI) medications that the patient is taking. All Ryan White Part A funded primary care sites are also contractually obligated to follow public health strategies (PHS) guidelines. Based on progress and evaluation reports as well as comments from contract monitors, all ten organizations in the Atlanta MSA that receive Ryan White Part A funding to provide primary care are currently in compliance with these requirements.

By monitoring treatment standards and adherence to guidelines, the HIV Care program has successfully established and maintained quality care standards, which include, but is not limited to, requiring service providers to maintain appropriate and complete charts for clients, requiring clients and providers to review and ensure clients' eligibility for program services, mandating funded organizations to submit ongoing progress and evaluation reports, and ensuring that funded organizations receive technical assistance that overcome program weaknesses or challenges and take advantage of program strengths or opportunities. Program

integration efforts have resulted in the identification of opportunities for collaboration and service integration throughout the prevention-care continuum.

Georgia DCH's AIDS Drugs Assistance Program (ADAP) currently has about 1,420 people on its waiting list as of the end of April 2011. Of these, about 68 percent (or 966) people reside in the Atlanta MSA. Those wait listed for HIV medications do not have access to medications via private insurance, Medicare, Medicaid, ADAP, patient assistance programs (PAP), pre-existing condition insurance program (PCIP), or health insurance continuation program (HICP).

Goal Setting

Goal 8.1: Georgia DCH will update current policies and procedures to increase the accessibility and provision of antiretroviral treatment in accordance with current treatment guidelines for HIV positive persons.

The National HIV/AIDS Strategy that this goal addresses is (#3) increase access to care / improve health outcomes for people living with HIV disease. Maintaining and finding opportunities to strengthen existing quality management practices will ensure that HIV positive clients receive the best possible care services for people living with HIV disease.

Strategy 8.1.A: Review and update the current policies and procedures for Georgia DCH ADAP program to transition individuals from the current waiting list for ADAP to the high risk health insurance pool.

Strategy 8.1.B: Reduce the number of people on the ADAP waiting list by developing and adopting a process system that will allow Georgia DCH to utilize Ryan White state match funds to cover Pre-existing Condition Insurance Plan (PCIP) premiums.

Strategy 8.1.C: Schedule and provide technical assistance trainings and consultations to service providers regarding new or revised Georgia DCH policies and procedures around the ADAP and PCIP programs and goals.

Objective 8.1.1: By July 2011, Georgia DCH will have revised and implemented policies and procedures that will allow it to use Ryan White State Match funds to cover Pre-existing Condition Health Insurance Plan premiums for those in high risk health insurance pools.

Data sources: ADAP records, Ryan White State Match program records

Funding sources: CDC (i.e. ECHPP); Ryan White State Match funds

Objective 8.1.2: By September 2011, Georgia DCH will have conducted at least one technical assistance training about revised ADAP procedures and policies to reach at least five ADAP enrollment sites in the Atlanta MSA.

Data sources: Training calendars; training enrollment; participant evaluations; training certificates

Funding sources: CDC (i.e. ECHPP); Ryan White State Match funds

Objective 8.1.3: By January 2011, Georgia DCH will have decreased the number of individuals on the ADAP waiting list by 50 percent.

Data sources: ADAP waiting list

Funding sources: CDC (i.e. ECHPP); Ryan White State Match funds

Rationale
Current efforts have been successful in ensuring the delivery of antiretroviral treatment services in accordance with established guidelines. Maintenance of existing service levels requires no additional resources and meets the existing need.

Intervention 9 (Required): Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons

Situational Analysis
All primary care and medical case management sites in the Atlanta MSA have written procedures in place to promote adherence to antiretroviral medications. In 2009, ten primary care sites and the Ryan White Part A funded centralized case management site were all funded to conduct interventions or strategies (e.g. case management, self management, support services, medical services, and counseling services) to promote adherence to antiretroviral medications for HIV positive persons. Each agency conducted meetings with their case managers and adherence monitoring team to discuss and ensure client readiness as well as to address known or identified barriers that may make compliancy difficult. In 2009, approximately 9,704 PLWHA in metro-Atlanta received some form of service that promoted or assisted client with adherence to antiretroviral medications. In addition, approximately 3,157 PLWHA received medical adherence beyond standard clinical care. This shows the willingness among service providers to identify strategies to promote adherence while also addressing other individual client needs (e.g. assistance with accessing other services, such as housing or substance abuse).

Goal Setting
Goal 9.1: Service providers in the Atlanta MSA will continue to implement interventions or strategies that promote adherence of antiretroviral medications among HIV positive persons.

The National HIV/AIDS Strategy this goal will address is (#3) increase access to care / improve health outcomes for people living with HIV disease. Taking advantage of opportunities to

strengthen existing quality management practices will ensure that HIV positive clients receive the best possible care services for people living with HIV disease.

Strategy 9.1.A: Identify existing interventions or strategies implemented by service providers in the Atlanta MSA that promote adherence of antiretroviral medications among HIV positive persons.

Strategy 9.1.B: Provide ongoing monitoring and evaluation of HIV care services and related outcomes to ensure service providers continue to comply with promoting adherence of antiretroviral medications.

Strategy 9.1.C: Provide technical assistance and capacity building services to service providers in the Atlanta MSA regarding interventions or strategies that promote adherence of antiretroviral medications among HIV positive persons.

Strategy 9.1.D: Provide information or technical assistance to CBOs funded to provide HIV prevention interventions to HIV positive persons (e.g. Comprehensive Risk Counseling and Services [CRCS]) to ensure compliancy with client enrollment into drug assistance programs.

Strategy 9.1.E: Explore opportunities that can help reduce or remove challenges and barriers that keep clients from accessing or adhering to antiretroviral medications (e.g. steps or procedures for screening or recertifying clients' eligibility).

Objective 9.1.1: By September 2011, service providers in the Atlanta MSA will be able to demonstrate they are implementing interventions or strategies that promote adherence of antiretroviral medications among HIV positive persons.

Data sources: Monthly progress reports from grantees

Funding sources: CDC (i.e. ECHPP); HRSA

Objective 9.1.2: By January 2012, Georgia DCH will have facilitated a focus group with service providers in the Atlanta MSA to create recommendations for promoting adherence to antiretroviral medications for HIV positive persons.

Data sources: Focus group meeting reports; participant attendance

Funding sources: CDC (i.e. ECHPP)

Rationale

Current quality assurance practices (e.g. client and provider feedback and recommendations, as well as information obtained from program progress and evaluation reports) encourage and ensure adherence to antiretroviral medications for HIV positive persons. However, Georgia

DCH will continue to monitor quality assurance practices and take advantage of those opportunities that are most cost-effective, efficient, and likely to produce desired outcomes.

Intervention 10 (Required): Implement STD screening according to current guidelines for HIV-positive persons

Situational Analysis

Health departments in Georgia, including the Atlanta MSA, follow Georgia's Nurse Protocols for the provision of STD Screening and Treatment. Although efforts are made to ensure that screening and treatment services are administered in accordance with 2006 STD treatment Guidelines, barriers, such as staff turnover in critical positions, reduce the capacity of health departments, making adherence monitoring difficult (and in most cases impossible). A number of community-based organizations in the Atlanta MSA that provide HIV prevention services have demonstrated an interest in offering STD screening services. The percent of HIV/Syphilis co-morbidity (40 percent) has encouraged prevention providers to increase their capacity or expand their services to provide STD screening for clients. Key informants have indicated that STD screening for HIV positive clients in the Atlanta MSA has proven cost prohibitive. In addition, the complexity of data collection and reporting systems only serve to exacerbate already challenging data collection and reporting systems.

Goal Setting

Goal 10.1: Increase the number of community-based organizations that have the capacity to provide STD screening services to HIV-positive persons or to those who are at highest risk of acquiring HIV disease in the Atlanta MSA.

The National HIV/AIDS Strategies that this goal addresses are (#1) reduce new infections and (#2) reduce health disparities. Increased STD screening can lead to the identification and treatment of STD infections that, if left untreated, can likely increase HIV transmission, especially among racial and ethnic minorities, populations that bare a disproportionate burden of HIV and STDs.

> Strategy 10.1.A: Identify HIV-related service providers in the Atlanta MSA that have the potential to also provide STD screening services to HIV positive persons or to those who are at highest risk of acquiring HIV.
>
> Strategy 10.1.B: Select or identify information, resources, materials, and other tools (e.g. CLIA-waived STD screening tests, existing policies regarding STD screening) regarding the provision of STD screening in clinical or non-clinical settings in the Atlanta MSA.
>
> Strategy 10.1.C: Provide technical assistance and capacity building services regarding STD screening services to service providers in the Atlanta MSA.

Strategy 10.1.D: Identify and take advantage of opportunities that will allow organizations providing HIV programs and those providing STD programs to work collaboratively or in partnership and leverage resources.

Objective 10.1.1: By September 2011, Georgia DCH will conduct at least one technical assistance activity for service providers in the Atlanta MSA to increase their capacity to provide STD screening services in the Atlanta MSA.

Data sources: Training calendar; training attendance sheets

Funding sources: CDC (i.e. ECHPP)

Objective 10.1.2: By September 2011, Georgia DCH will have partnered with 3 HBCUs (i.e. Clark Atlanta University, Morehouse College, and Spelman College) to implement activities (e.g. Greater Than AIDS campaign) that will reach at least 50 individuals to screen for HIV and other STDs (e.g. gonorrhea and Chlamydia).

Data sources: Georgia DCH contracts; monthly progress reports; and feedback from students.

Funding sources: CDC (i.e. ECHPP)

Objective 10.1.3: By January 2012, service providers who receive technical assistance or resources from Georgia DCH will provide STD screening to HIV-positive persons or to those who are at highest risk of acquiring HIV disease in the Atlanta MSA.

Data source: STD management information systems (e.g. SENDSS)

Funding source: CDC (i.e. ECHPP)

Rationale

By identifying opportunities (e.g. CLIA-waived STD screening tests that can be provided in non-clinical settings) to increase the number of community-based organizations that integrate HIV/STD testing services, including those funded by health department, Georgia DCH may leverage resources for STD screening to providers and increase the frequency of combined HIV/STD testing encounters.

Efforts to monitor and ensure quality integrated partner services systems across infectious disease programs should also enhance the overall efficacy of partner services. Quality partner services in the Atlanta MSA should also improve the accessibility and provision of HIV-related prevention and care services.

Intervention 11 (Required): Implement prevention of perinatal transmission for HIV-positive persons

Situational Analysis

The Georgia DCH Perinatal HIV Prevention Program adheres to the written policies and procedures of the Medical Guidelines for the Care of HIV-Infected Adults and Adolescents (June 2005) for perinatal prevention and treatment. In addition, the Perinatal HIV program also adheres to the guidelines of the Department of Health and Human Services' (DHHS) Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission, Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States (updated May 24, 2010). These policies and guidelines function as the framework for preventing perinatal transmission in the Atlanta MSA.

In 2009, Georgia DCH funded the following Perinatal HIV prevention initiatives:

- Via contract with Healthy Mothers/Healthy Babies' Powerline Program, provide referral information on HIV testing sites and other perinatal/infant-related services
- Via contract with Georgia Academy of Family Physicians, surveyed physicians' knowledge of (1) the Georgia HIV Pregnancy Screening Act of 2007 and provided continuing medical education lectures on rapid HIV testing; (2) Georgia's HIV Pregnancy Screening Act that addresses universal opt-out HIV screening of pregnant women; and (3) medical management of pregnant patients with HIV or AIDS and their infants
- Via partnership with the Georgia OB/GYN Society, raise awareness of perinatal HIV transmission in Georgia among community members (e.g. women, African Americans, etc.) and service providers (e.g. physicians, medical offices / clinics, etc.)

Perinatal prevention activities were conducted by two Ryan White Part D programs and three funded agencies. Georgia DCH allocated approximately $242,000 in CDC prevention funds to implement statewide prevention activities. The percentage of funds used solely in the Atlanta MSA could not be determined.

According to the most recent data from the Georgia Pregnancy Risk Assessment Monitoring System (PRAMS), 119,105 (79%) pregnant women were tested for HIV in 2007. The system is currently unable to determine how many of the pregnant women tested in 2007 were newly diagnosed with HIV.

Challenges related to the internal capacity of the Georgia DCH to conduct chart reviews proves an ongoing barrier to the overall effectiveness of the program. In addition, the absence of additional funding (i.e. funding sources other than from CDC) to support perinatal HIV prevention efforts remains a barrier.

There were nine reported perinatal HIV cases by exposure category in the state of Georgia in 2009, according to the HIV Surveillance Unit data thru June 30, 2010. Of these cases, 5 occurred in the Atlanta MSA.

There is a concerted effort to increase awareness among providers regarding the laws associated with perinatal HIV screening. The addition of a Perinatal Advisory Group, to provide strategic guidance and direction to the perinatal projects and function as key informants in the development of strategic plan for perinatal prevention activities has proven to be a valuable resource. Providers also reported continuous issues related to the complexity and rigorous reporting requirements of funders. Key informant feedback indicated that Perinatal prevention efforts should continue to emphasize provider engagement activities.

Goal Setting

Goal 11.1: Increase the capacity of service providers in the Atlanta MSA to link to care or provide perinatal HIV prevention services to HIV positive women who are pregnant in the Altanta MSA.

The Nationals HIV/AIDS Strategy that this goal addresses is (1) reduce new infections. Perinatal transmission rates car be greatly reduced if opt-out screening strategies are employed with expected mothers.

Strategy 11.1.A: Collaborate with the Georgia Chapter of American Academy of Pediatrics to develop an education and training plan for pediatrician providers on perinatal and pediatric HIV transmission prevention.

Strategy 11.1.B: Provide resources (e.g. information about perinatal HIV prevention) to service providers in the Atlanta MSA.

Strategy 11.1.C: Provide resources (e.g. information about perinatal HIV prevention) to communities to assist with community mobilization of African American women.

Strategy 11.1.D: Coordinate partner engagement activities across infectious disease programs in the Atlanta MSA.

Strategy 11.1.E: Collaborate with the STD Unit at Georgia DCH to develop HIV/STD training and materials for pediatricians.

Strategy 11.1.E: Provide linkage to care training and assistance to service providers in the Atlanta MSA who screen pregnant women for HIV.

Strategy 11.1.F: Conduct bimonthly Perinatal HIV Advisory Council meetings to address and provide strategic guidance and direction to perinatal projects. The council consists of representatives from infectious disease programs across the Atlanta MSA and other areas in Georgia.

Strategy 11.1.G: Participate in the Ryan White Part B Quality Management (QM) Program's quarterly meeting to ensure measures are incorporated to improve the

quality of health care and supportive services to HIV infected pregnant women to reduce the risk of perinatal transmission.

Objective 11.1.1: By September 2011, Georgia DCH will launch perinatal social marketing campaign, *1 Test, 2 Lives, 3rd Trimester*, for providers in the Atlanta MSA to promote a 2nd test for high risk pregnant women.

Data sources: Distribution list of social marketing materials

Funding sources: CDC (i.e. ECHPP)

Objective 11.1.2: By January 2012, Georgia DCH will launch, "Ask for the Test" campaign to promote and encourage women an HIV test from their obstetrician.

Data sources: Number of social marketing materials distributed, number of presentations to promote "Ask for the Test" campaign

Funding source: CDC (i.e. ECHPP)

Rationale
Information garnered from the Perinatal Advisory Group indicates the challenges associated with provider engagement. Employing a coordinated engagement strategy across infectious disease programs will likely increase the impact of engagement efforts and ensures that programs are not vying for the attention of providers.

Intervention 12 (Required): Implement ongoing partner services for HIV-positive persons

Situational Analysis
Within the Atlanta MSA, partner services activities are conducted by Disease Intervention Specialist (DIS) and Communicable Disease Specialist (CDS). Historically, partner services have been considered a function of the STD program and were carried out in adherence to CDC's recommendations for Partner Services Programs for HIV, Syphilis, Gonorrhea and Chlamydia Infection. Technical assistance, such as cultural sensitivity and training on implementation procedures and guidelines, is provided to CDS and DIS staff to ensure quality standards are adhered and enforced. There is approximately 20 fulltime CDS/DIS staff working in the metro Atlanta area. Health departments in the metro Atlanta area are considered a training ground for CDC CDS/DIS staff. In addition, there are seven CDC employees who function as CDS/DIS throughout the Atlanta MSA. Partner services activities present a clear opportunity for system integration recognizing that the core work (regardless of funding source) is consistent. In 2009, Georgia DCH allocated $399,338 for partner services in the Atlanta MSA.

In 2009, there were 843 confirmed HIV positive individuals identified in the Atlanta MSA. Partner services activities resulted to the identification of 1,187 partners of which 487 received HIV testing services. Of that number, 96 were newly identified (and confirmed) positive persons for HIV infection.

There is a concerted effort among infectious disease programs to identify opportunities to fully optimize the work of CDS/DIS. Efforts are underway to assess the CDS staffing needs of all Health Districts to ensure that staffing and other resources are allocated to reflect the burden of disease. In addition, many providers are unaware of the availability of partner services provided by health departments, but key informants agree that increased awareness does not equate to increased capacity to meet emergent needs. Stakeholder feedback has indicated that providers need a mechanism to be able to treat uninsured partners of patients. In addition, partner services is seen as another opportunity to engage and inform service providers in the Atlanta MSA. The need for ongoing training and capacity building services focused on the delivery of partner services was a recurring theme among key informants. Lastly, partner services providers identified the need for better integration of partner services into the existing counseling and testing service continuum.

Goal Setting

Goal 12.1: Strengthen the capacity of current CDS/DIS staff to provide ongoing partner services to HIV positive persons.

The National HIV/AIDS Strategy that this goal address is (#1) reduce new infections. Partner services increases the likelihood that individuals unaware of their HIV risk will receive screening and treatment opportunities.

> Strategy 12.1.A: Conduct assessment of CDS staff in metro area to determine case load and/or need to increase the number of CDS workers.
>
> Strategy 12.1.B: Schedule trainings or provide technical assistance and capacity building services regarding partner services to CDS/DIS staff members in the Atlanta MSA.
>
> Strategy 12.1.C: Distribute information and materials that promote partner services to service providers in clinical and non-clinical settings in the Atlanta MSA.
>
> Strategy 12.1.D: Partner or collaborate with the STD Unit at Georgia DCH to leverage resources and increase the provision of partner services.

Objective 12.1.1: By September 2010, 100 percent of CDS/DIS staff at Georgia DCH serving HIV positive persons in the Atlanta MSA will receive technical assistance or capacity building services (e.g. training or refresher course) regarding partner services.

Data sources: Training calendar; training enrollment; participant evaluations; training certificates

Funding sources: CDC (i.e. ECHPP)

Objective 12.1.2: By January 2012, all CDS/DIS staff at Georgia DCH (i.e. HIV and STD Units) will reach 1,800 partners of HIV-positive persons in the Atlanta MSA to provide them with partner services.

Data source: Partner counseling and referral services records; monthly progress reports from grantees

Funding source: CDC (i.e. ECHPP)

Objective 12.1.3: By January 2012, 80 percent of the partners reported by HIV positive persons will be reached through partner counseling and referral services (PCRS).

Data sources: PCRS records

Funding sources: CDC (i.e. ECHPP)

Objective 12.1.4: By January 2012, 75 percent of the partners reached through partner counseling and referral services (PCRS) will be screened and tested for HIV.

Data sources: HIV testing data; partner services records; evidence of linkage to care

Funding sources: CDC (i.e. ECHPP); Georgia DCH (Expanded HIV Testing Initiative)

Objective 12.1.4: By January 2012, 100% of those who test positive for HIV will be linked in primary care, PCRS, or other HIV-related medical services.

Data sources: Linkage to care tracking system

Funding sources: CDC (i.e. ECHPP)

Rationale

Optimized partner services activities will likely identify increased numbers of newly infected HIV positive clients and amount of dually diagnosed partners, thus allowing more opportunities for partners services to reach individuals who may have been exposed or infected by HIV or other STDs.

Intervention 13 (Required): Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV

Situational Analysis

Georgia DCH HIV Prevention Program recently established a Minimum Quality Standards document that details the minimum quality standards as well as policies and procedures grantees must meet in order to deliver quality, effective risk reduction interventions. Grantees are given the Quality Standards Document and the basic tenets of the document are reviewed with grantees during the orientation site visit. However, no formal training is conducted on the policy and procedures in this document, unless specifically requested in the form of technical assistance. One agency in the Atlanta MSA was funded to implement the VOICES/VOCES interventions targeting HIV positive persons. Prior to being enrolled in the intervention, clients participated in behavioral risk screening as prescribed by the Minimum Quality Standards. Georgia DCH acknowledges a definitive need to identify additional organizations to provide intervention services to HIV positive persons. In addition, there have been internal conversations regarding efforts to increase the capacity of other organizations to provide prevention with positives services. The Health Resources and Services Administration (HRSA) has identified the practice of behavioral risk screening followed by a risk reduction intervention as a quality standard performance measure. Among private providers, behavioral risk screening for clients is rarely adequately documented.

Goal Setting

Goal 13.1: Increase the capacity of service providers in the Atlanta MSA to make behavioral risk screening followed by risk reduction interventions for HIV positive persons who are at risk of transmitting HIV to people in the Atlanta MSA.

The National HIV/AIDS Strategies that this goal addresses are (#1) reduce new infections and (#3) increase access to care / improve health outcomes for people living with HIV disease. Otherwise, HIV positive individuals unaware of their risk for transmitting the virus will likely continue to engage in risky behaviors with partners.

Strategy 13.1.A: Assess the number of service providers that conduct behavioral risk screenings followed by risk reduction interventions.

Strategy 13.1.B: Schedule and provide technical assistance and capacity building trainings on prevention for positives interventions to service providers in the Atlanta MSA.

Strategy 13.1.C: Provide technical assistance to service providers that make behavioral risk screenings routine when enrolling individuals into risk reduction interventions.

Strategy 13.1.D: Develop mechanisms to determine the number of behavioral risk screenings that are conducted and the demographic of those individuals screened by service providers receiving funds from Georgia DCH.

Strategy 13.1.E: Assist service providers in Atlanta MSA that do not offer risk reduction interventions for HIV positive persons with establishing partnerships and collaborative efforts with other service providers in the Atlanta MSA that offer risk reduction interventions for HIV positive persons.

Strategy 13.1.F: Develop opportunities to increase the number of service providers or the capacity of current providers to provide additional prevention for positive interventions that target HIV positive persons.

Objective 13.1.1: By September 2011, Georgia DCH will conduct at least two technical assistance trainings regarding prevention for positive interventions reaching at least six service providers in the Atlanta MSA.

Data sources: Training calendar; participant attendance records; training evaluations and participant feedback

Funding sources: CDC (i.e. ECHPP)

Objective 13.1.2: By September 2011, Georgia DCH will have provided additional resources to two service providers to conduct prevention for positive interventions that target HIV positive person in the Atlanta MSA.

Data sources: Funding or resource allocation records or documents; monthly progress reported from grantees

Funding sources: CDC (i.e. ECHPP)

Rationale

Increased access to behavioral risk screening and risk reduction interventions will likely improve total health outcomes for PLWHA. Risk screenings will improve clients' capacity and understanding of risk behaviors and self assessment, which will also allow clients to develop and follow through with action steps fostered to reduce HIV transmission or infection.

Intervention 14 (Required): Implement linkage to other medical and social services for HIV-positive persons

Situational Analysis

In the Atlanta MSA, Part A providers utilize a screening tool to determine clients need for case management and/or mental health and substance abuse services. The assessment tool is a component of the Standard Operating Procedures for Part A providers. Training and technical assistance activities are conducted to ensure that the tool is properly administered by providers. Once assessments are conducted, resources are available to meet the needs of the client. More specifically, there are seven Part A agencies funded to provide mental health services and five Part A substance abuse providers. Within the Atlanta MSA, HOPWA services are administered by the City of Atlanta. There are currently 17 agencies funded to provide housing assistance for PLWHA in the Atlanta MSA.

Also within the Atlanta MSA, there are a number of medical and social service providers capable of meeting the needs of PLWHA. Unfortunately, the volume of individuals greatly limits the ability of providers to offer proper follow-up and monitoring of individuals receiving such services.

Limited resources and increased needs are resulting in a "push" from both prevention and care providers to coordinate service delivery and linkage systems. The addition of Georgia DCH's Linkage to Care Coordinator should formally open the dialogue and facilitate the development of structured linkage systems.

Goal Setting

Goal 14.1: Increase the number of HIV-positive individuals in the Atlanta MSA who access other medical and social services (e.g. mental health counseling, substance abuse counseling, and housing services).

The National HIV/AIDS Strategies that this goal addresses are (#2) reduce health disparities and (#3) increase access to care / improve health outcomes for people living with HIV disease. A variety of social factors increase risk behaviors among HIV-positive persons and those who are at high risk for acquiring HIV. Access to additional services (e.g. medical and social support services) can aid in mitigating these factors and, thus, reduce new infections.

> Strategy 14.1.A: Develop and host a forum for Georgia DCH and service providers in the Atlanta MSA to identify opportunities to strengthen linkage to medical and social service for HIV positive persons.
>
> Strategy 14.1.B: Provide technical assistance to service providers to strengthen their capacity to link HIV positive persons to medial and social services in the Atlanta MSA.

Objective 14.1.1: By September 2011, Georgia DCH will have conducted at least one training about linkage to care (e.g. medical and social services) reaching a least five service providers in the Atlanta MSA.

Data sources: Training calendar; participant attendance records; training evaluations and participant feedback

Funding sources: CDC (i.e. ECHPP)

Objective 14.1.2: By September 2011, Georgia DCH will have hosted at least one forum for medical treatment centers, health departments, community based organizations and other service providers to identify or strengthen linkage to care opportunities for HIV positive persons.

Data sources: Training calendar; participant attendance records; list of recommendations

Funding sources: CDC (i.e. ECHPP)

Rationale
Referrals to social services are a primary activity that is related to the HIV Care standard operating procedures and an integral part of the HIV prevention-care continuum.

III. RECOMMENDED INTERVENTIONS, INCLUDING SITUATIONAL ANALYSIS, GOAL SETTING, RATIONALES, AND OBJECTIVES

Intervention 16 (Recommended): HIV and sexual health communication or social marketing campaigns targeted to relevant audiences

Situational Analysis

In 2010, Georgia DCH partnered with the Kaiser Family Foundation to launch the Georgia Greater Than AIDS social marketing campaign in and across the Atlanta MSA. The Greater Than AIDS campaign is a social marketing campaign designed to raise awareness and increase testing in the African American community. The recent partnership resulted in Greater Than AIDS marketing materials being posted at MARTA (i.e. stations, bus stops, trains, and buses) as well as posters and billboards throughout the Atlanta MSA. Also, Georgia DCH will develop and implement other social marketing campaigns and efforts in relation to national HIV/AIDS awareness and observances. For example, for National Women and Girls HIV/AIDS Awareness Day (March 10), Georgia launched Sistas Organizing to Survive, a social marketing initiative that encourages African American women and girls who are at high risk for infection to get tested and access additional services based on their HIV status (e.g. prevention, care, and treatment options).

Goal Setting

Goal 16.1: Increase the distribution of HIV and sexual health social marketing campaigns (e.g. Greater than AIDS, Taking Control, and Sistas Organizing to Survive) in targeted areas in the Atlanta MSA.

Goal 16.2: Increase activities or events that are related to or that support national HIV/AIDS awareness days and observances that target HIV positive persons or those who are at highest risk for acquiring HIV disease in the Atlanta MSA.

The National HIV/AIDS Strategies that these goals address are (#1) reduce new infections and (#2) reduce health disparities. These efforts will raise awareness of risk and risk behaviors in communities disproportionately impacted by HIV/AIDS.

Strategy 16.1.A: Provide social marketing campaign materials about HIV and sexual health to service providers that target HIV positive persons and persons who are at high risk for acquiring HIV disease.

Strategy 16.1.B: Develop a tracking system that keeps records of social marketing campaign material distributions to service providers in the Atlanta MSA.

Strategy 16.1.C: Develop and implement activities or events that are related to HIV/AIDS awareness days and observances and will target specific populations.

Strategy 16.1.D: Partner with other service providers in the Atlanta MSA that provide services to the specific population that HIV/AIDS awareness days and observances target.

Objective 16.1.1: By September 2011, thirteen service providers in the Atlanta MSA will receive social marketing campaign materials that target HIV positive persons and persons who are at high risk for acquiring HIV disease (e.g. Greater than AIDS, Taking Control, and Sistas Organizing to Survive) from Georgia DCH.

Data source: Social marketing campaign materials and distribution lists

Funding source: CDC (i.e. ECHPP)

Objective 16.1.2: By September 2011, Georgia DCH will implement or sponsor a minimum of four activities or events that are related to or that support national HIV/AIDS awareness days and observances that target HIV positive persons or those who are at highest risk for acquiring HIV disease in the Atlanta MSA.

Data sources: Attendance records or event records/summaries; public service announcement; media coverage; and other social marketing assessment tools

Funding source: Centers for Disease Control and Prevention

Rationale
Given the disparate impact that HIV/AIDS is currently having on Georgia's African American community, including in the Atlanta MSA, there is a definitive need to promulgate prevention messages in high morbidity regions of the Atlanta MSA.

Intervention 19 (Recommended): Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-sero-discordant relationship

Situational Analysis
In 2011, agencies funded under the general prevention grant will focus more on a specific priority population at greatest risk. The monitoring tools created by the Contract Team should provide measurable data to determine the success of the program.

Goal Setting
Goal 19.1: Increase the capacity of service providers to use behavioral risk screening tools (e.g. using Behavioral Risk Assessment Tools) before enrolling or participating in individual or group-level evidence-based interventions in the Atlanta MSA.

The National HIV/AIDS Strategies that this goal addresses are (#1) reduce new infections and (#2) reduce health disparities. By reducing high risk behaviors among target populations, Georgia DCH expects reductions in new HIV infections as well as a closure in the gap of health disparities.

Strategy 19.1.A: Assess the number of service providers that conduct behavioral risk screenings followed by individual or group-level interventions for HIV-negative persons at high risk for acquiring HIV disease.

Strategy 19.1.B: Schedule and provide technical assistance and capacity building trainings on individual and group-level interventions.

Strategy 19.1.C: Provide technical assistance to service providers that make behavioral screenings routine when enrolling individuals into an individual or group-level intervention.

Strategy 19.1.D: Develop mechanisms to determine the number of behavioral risk screenings that are conducted and the demographic of those individuals screened by service providers receiving funds from Georgia DCH.

Strategy 19.1.E: Assist service providers in Atlanta MSA that do not offer individual or group-level interventions with establishing partnerships or collaborative efforts with other service providers in the Atlanta MSA that do offer individual or group-level interventions.

Objective 19.1.1: By September 2011, Georgia DCH will have conducted at least two technical assistance trainings regarding individual or group-level interventions reaching at least six service providers in the Atlanta MSA.

Data sources: Training calendar; participant attendance records; training evaluations and participant feedback

Funding source: CDC (i.e. ECHPP)

Rationale

As a part of the recruitment plan for Health Education/Risk Reduction (HERR), the Behavioral Risk Assessment Tool (BRAT) is implemented as a part of the intake process to screen for high risk behavior. The BRAT can also be used as a three, six, or 12 month follow-up to determine any improvements or regression in high risk behaviors.

Intervention 24 (Recommended): Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV

awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors

Situational Analysis

In 2010, Georgia DCH launched a series of community mobilization efforts designed to engage and mobilize populations disparately impacted by the HIV/AIDS epidemic. Recent efforts included the "Taking Control" campaign designed to engage the MSM community in the Atlanta MSA and encourage action in the area of HIV prevention. Representatives from the Atlanta MSA MSM community were actively involved and provided recommendations regarding a campaign designed to mobilize the MSM community (with special emphasis on African American MSM) to "take control" of their lives and their health.

Georgia DCH also coordinated the first ever Georgia ACT Against AIDS Leadership Initiative (GAAALI). The GAAALI summit convened on December 1, 2010. The purpose of this initiative was to harness the collective strengths of longstanding African American organizations to increase HIV-related awareness knowledge and action within the African American community.

In March, Georgia DCH launched, Sistas Organizing to Survive (SOS), a statewide mobilization for African-American women. This initiative will focus on increasing testing among African-American women, reducing perinatal infection, and linking African-American women to care.

This summer Georgia Department of Community Health will launch the Atlanta, Business/Labor Responds to AIDS Project. This project will be a partnership between the health department, local businesses, and labor organizations to increase HIV/AIDS awareness, prevention, testing, and linkages to care among HIV positive persons and those living in areas of high HIV/AIDS prevalence.

Georgia DCH will partner with the Latino Commission on AIDS and other CBA providers to assist with community activities to promote HIV/AIDS awareness in Latino populations in the MSA.

Goal Setting

Goal 24.1: Increase the number of community mobilization efforts in the Atlanta MSA that include participation of community members at different levels (e.g. development, implementation, evaluation, support) and support HIV prevention (e.g. raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors)

The National HIV/AIDS Strategies that this goal addresses are (#1) reduce new infections and (#2) reduce health disparities. Mobilization efforts will raise awareness of risk behaviors with the target population and will work in conjunction with other interventions (e.g. Many Men, Many Voices, VOICES/VOCES) to reduce new HIV infections.

Strategy 24.1.A: Work with SOS advisory group to schedule a minimum of two regional mobilization meetings to include mobilization activities for African-American women of childbearing age, youth, and seniors.

Strategy 24.1.B: Schedule one year anniversary activities for Taking Control MSM initiative. The update will include MSM event, newsletter of twelve month activities and 2012 MSM prevention plan for the MSA.

Strategy 24.1.C: Launch BRTA/LRTA with business in the MSA that service priority populations identified by the Georgia Community Planning Group.

Strategy 24.1.D: Develop quarterly meetings with Act Against AIDS Leadership Initiative (AALI) to provide updates of HIV related activities for African-Americans in the MSA.

Strategy 24.1.E: Work with CBA providers to develop community mobilization activities for Latino populations.

Strategy 24.1.F: Develop a tracking system that keeps records of community mobilization events implemented in the Atlanta MSA by Georgia DCH or by service providers that receive support or resources from Georgia DCH.

Objective 24.1.1: By September 2011, Georgia DCH will implement at least three community mobilization activities from Taking Control, SOS, Latino mobilization, or BRTA/LRTA.

Data sources: Meeting records, community mobilization assessment tools, community feedback and surveys

Funding source: CDC (i.e. ECHPP)

Rationale
By harnessing the reach and relationships of longstanding African American, MSM, and Latino serving organizations and service providers, Georgia DCH ensures credibility and trust within the community in support of sustained prevention efforts.

IV. GEORGIA (ATLANTA MSA) ECHPP PLANNING PROCESS

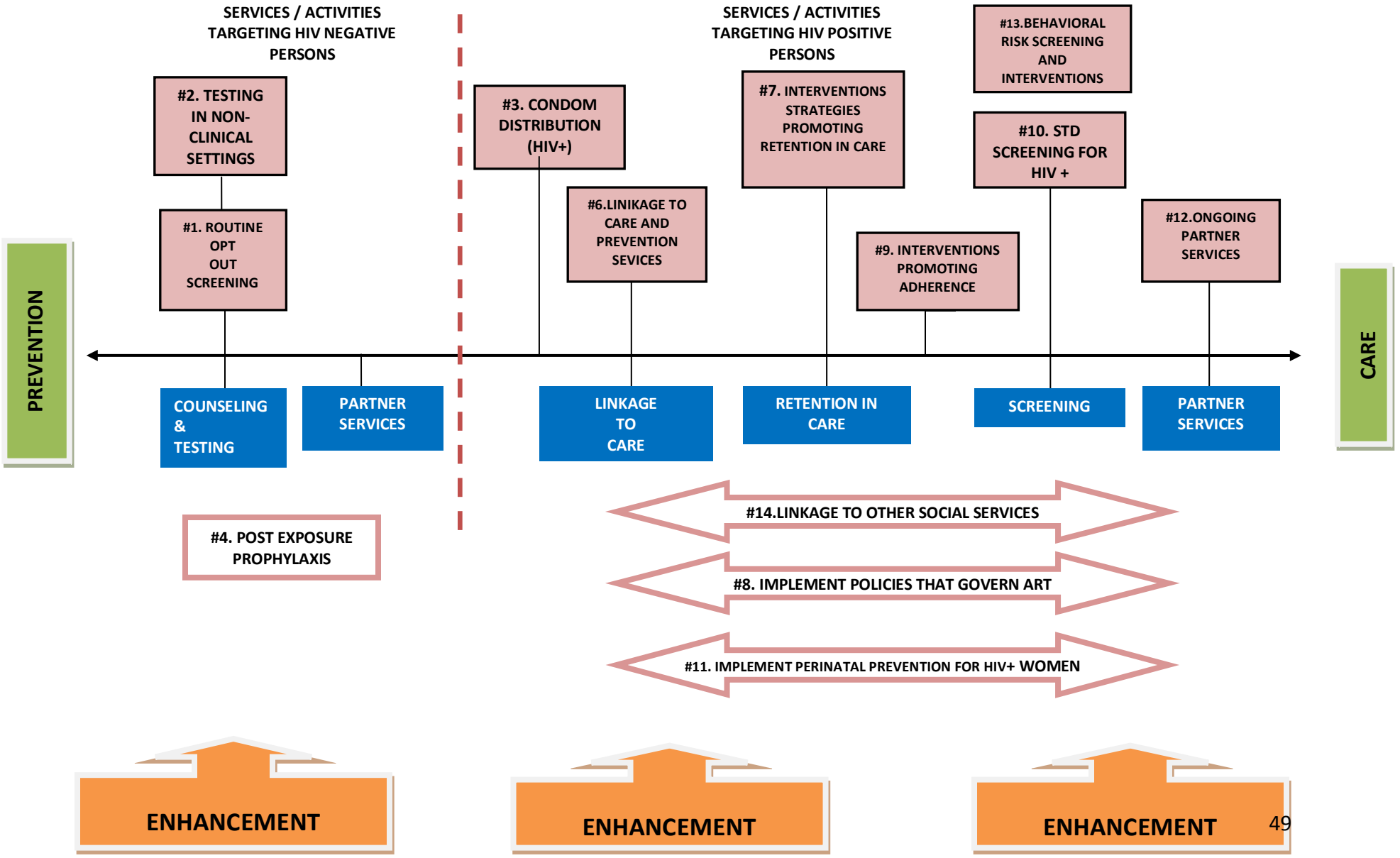
The ECHPP planning process for the Atlanta MSA brought together internal and external stakeholders from across the MSA. The first phase of "discovery" began with a series of internal stakeholder planning sessions that included leadership and key informants from the Georgia Department of Community Health HIV, STD, TB and Surveillance Units respectively. An outside consultant familiar with the organizational resources of all the programs moved participants through a facilitated discussion designed to inform the planning process. The conversation

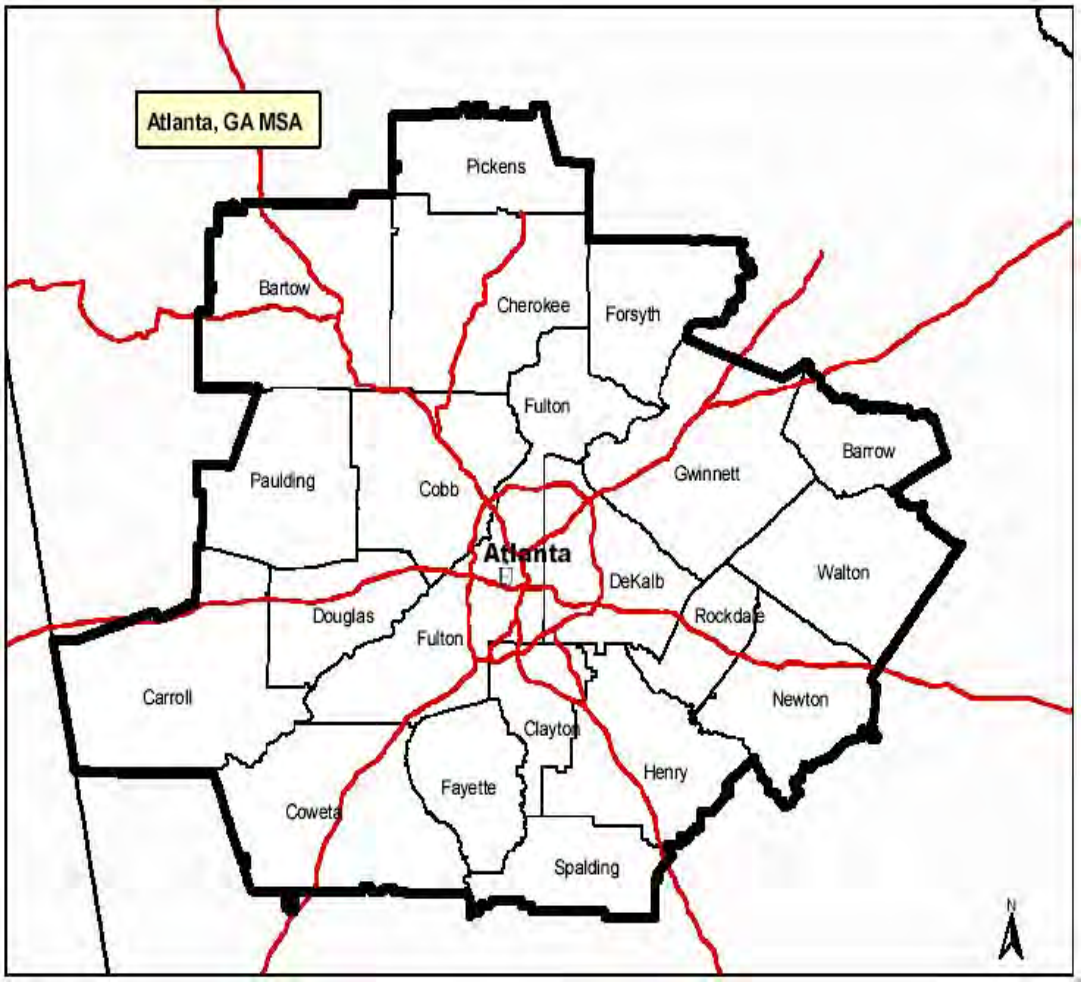
challenged state staff to think in terms of the localized (specific to the MSA) epidemic and localized resources. Participants were tasked with gathering and compiling data specific to their respective areas for the intervention. This information was supported by a substantive literature review on MSA specific articles an abstracts.

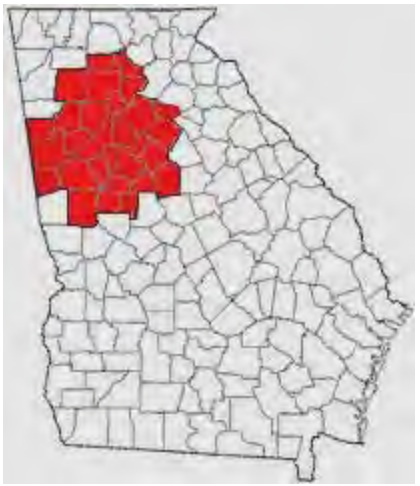
The Planning phase would then move to external key stakeholder group sessions. A multidisciplinary team of individuals with extensive background in HIV prevention, care, support services and related medical services was assembled for two four hour workgroups. The goal: to move participants through the HIV prevention and Care continuum while each informed the situational analysis and ultimately the goals and objectives for the ECHPP. Facilitators used visuals to prompt dialogue and frame the conversation. The final planning session concluded with participants defining the goals and objectives for the Atlanta MSA ECHPP. Key stakeholders reported a sincere appreciation for the opportunity to collectively discuss their work and the interrelatedness of their collective efforts.

V. TABLES, GRAPHS, AND CHARTS

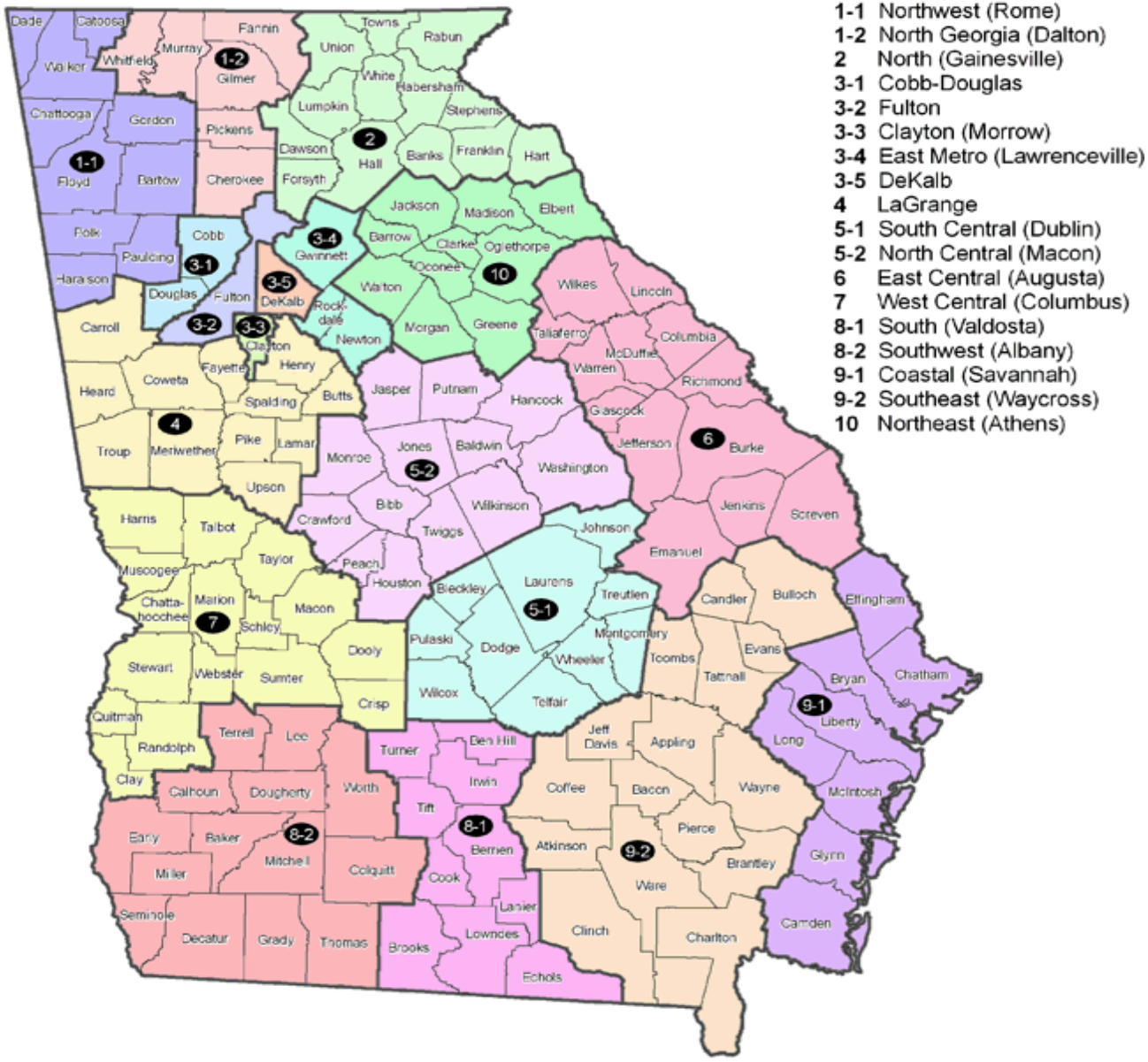
ECHPP HIV PREVENTION-CARE CONTINUUM
Required Interventions







THE ATLANTA MSA (28 Counties)



Georgia's 18 Health Districts

TABLES

Cumulative Cases of HIV Infection (not AIDS) and AIDS by Public Health District of Residence at Diagnosis, Georgia, 2007.

Table 1. Newly diagnosed HIV Infection (not AIDS) By Gender, Georgia, 2007

Table 2. Newly diagnosed HIV Infection (not AIDS) By Race/Ethnicity, Georgia, 2007

Table 3-a,b,c. Newly Diagnosed HIV Infection (not AIDS) by Gender (Male) and Transmission, Georgia 2007

Table 4. Newly Diagnosed HIV Infection (not AIDS) Cases by Public Health District of Residence at Diagnosis, Georgia 2007

Table 5. Persons Living with HIV Infection (not AIDS) by current Public Health District of Residence, Georgia, 2007

Table 6. Newly Diagnosed HIV Infection (not AIDS) by Public Health District of Residence at Diagnosis, Georgia 2007

Table 7. Cumulative Cases of HIV Infection (not AIDS) by Public Health District of Residence at Diagnosis, Georgia, 2007.

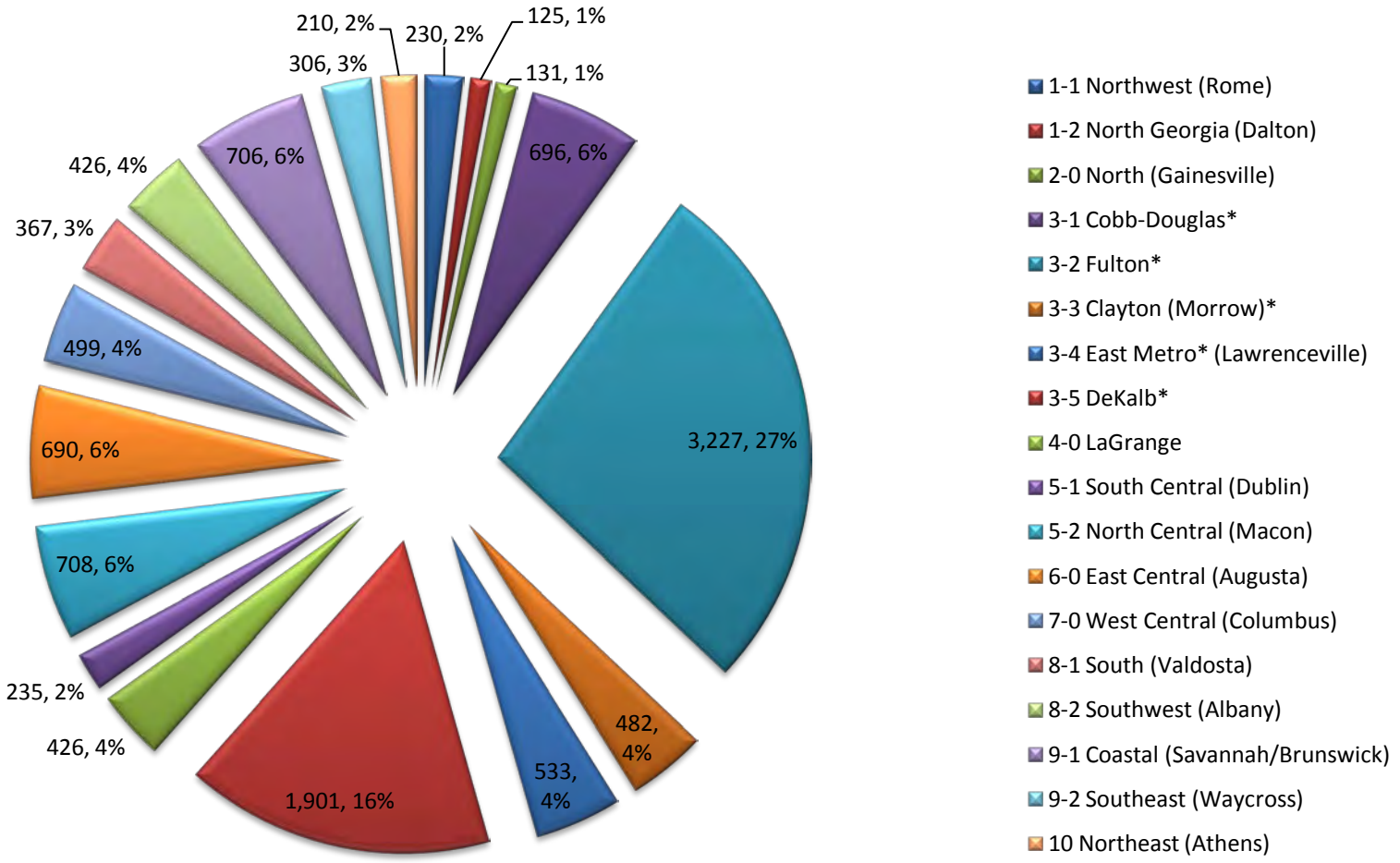
Table 8-a,b,c. Demographics of the Atlanta MSA for Persons in HARS vs. HET 1 Cycle
Cumulative HIV (not AIDS) Atlanta MSA for Persons in HARS in Georgia Through 2008:

Table 9.People living With HIV-NA(PLWH-NA) cases according to the Transmission Categories and Black Females for 5 counties as of year 2007.

Table10.Newly diagnosed HIV-NA cases according to the Transmission Categories and Black Females for 5 counties for the year 2009.

Table11.Cumulative HIV-NA cases according to the Transmission Categories and Black Females for 5 counties as of year 2007.

Cumulative Cases of HIV Infection (not AIDS) in Georgia 2007



Cumulative Cases of HIV Infection (not AIDS) and AIDS by Public Health District of Residence at Diagnosis, Georgia, 2007.

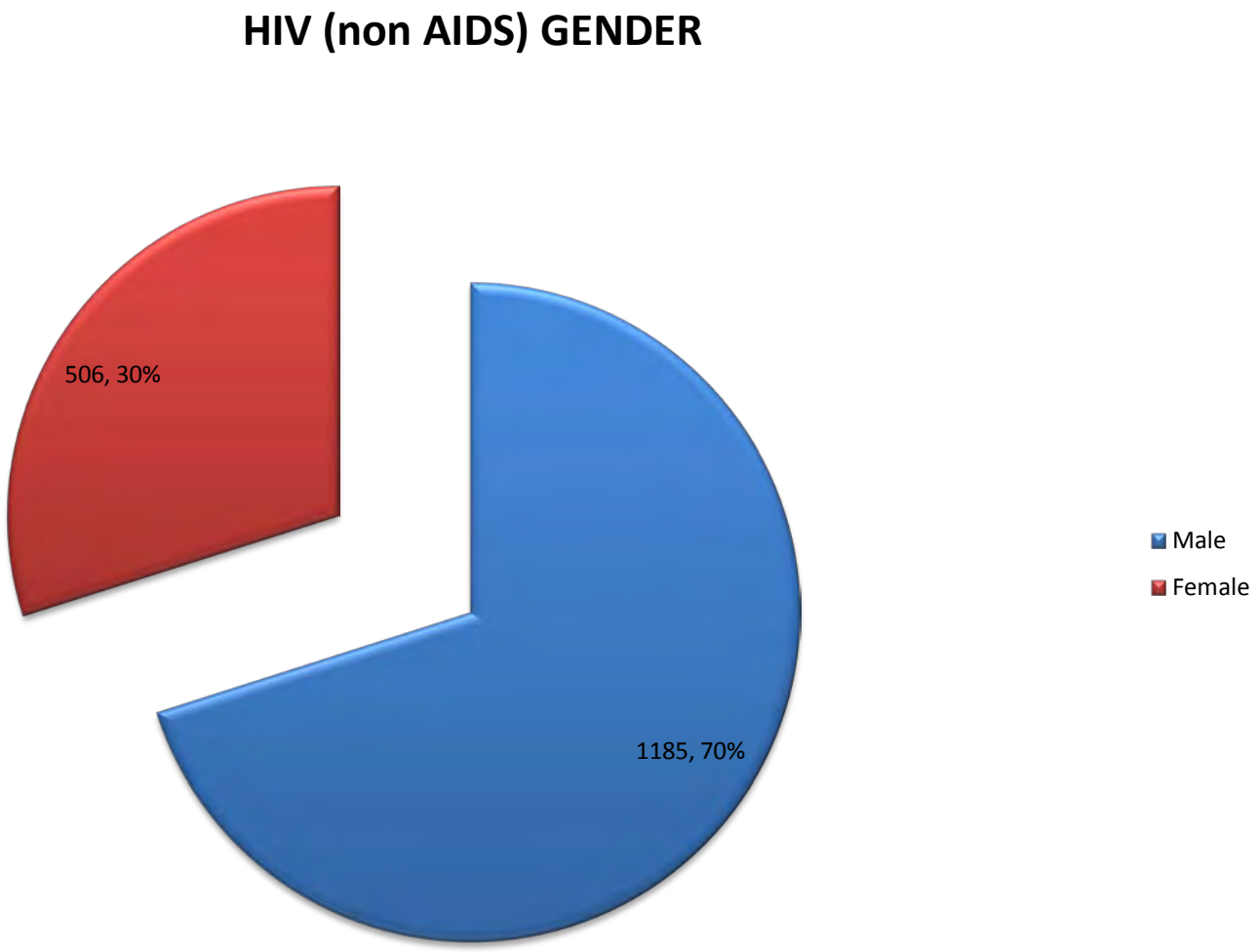


Table 1. Newly diagnosed HIV Infection (not AIDS) By Gender, Georgia, 2007

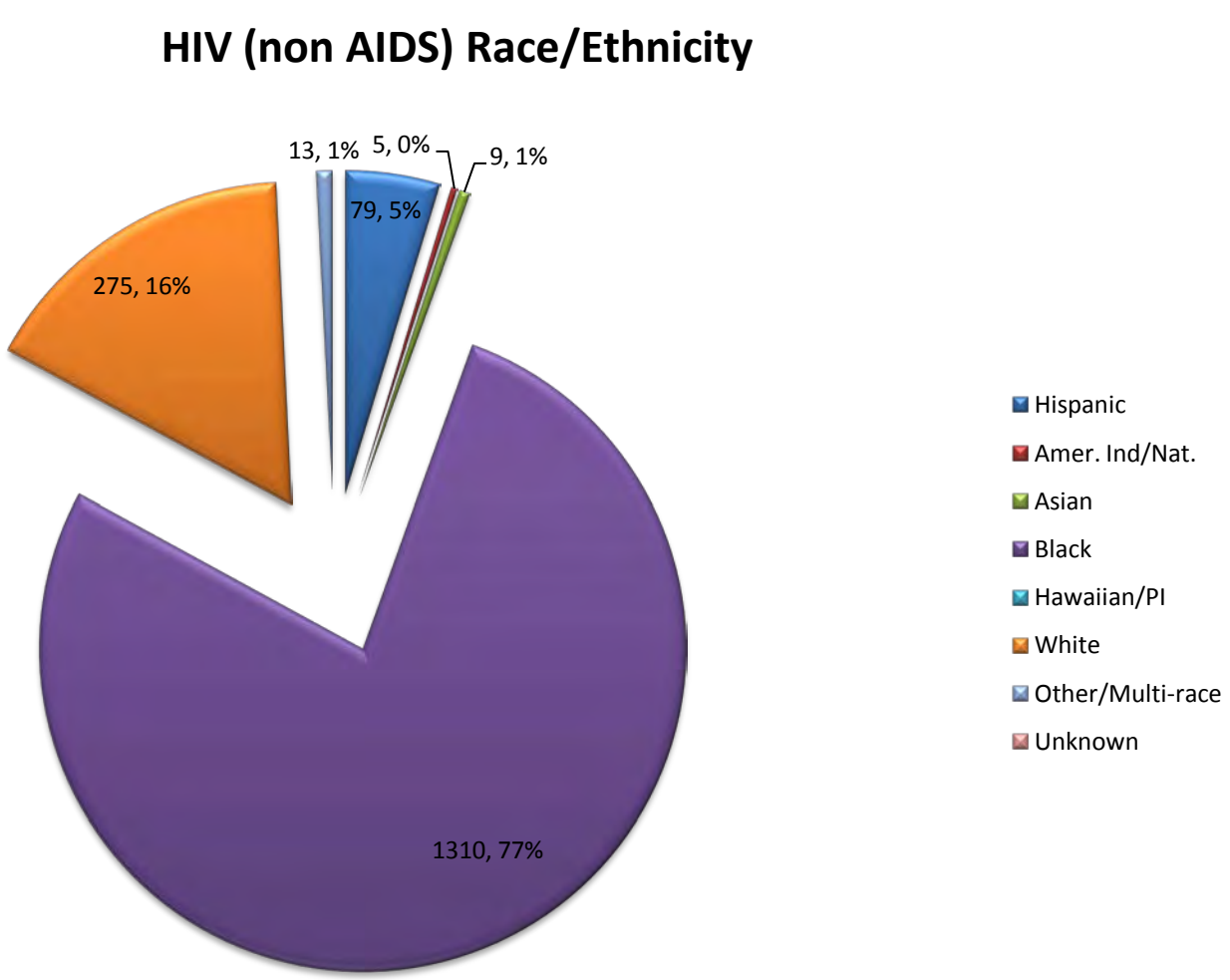


Table 2. Newly diagnosed HIV Infection (not AIDS) By Race/Ethnicity, Georgia, 2007

HIV (non AIDS) Cases MALES

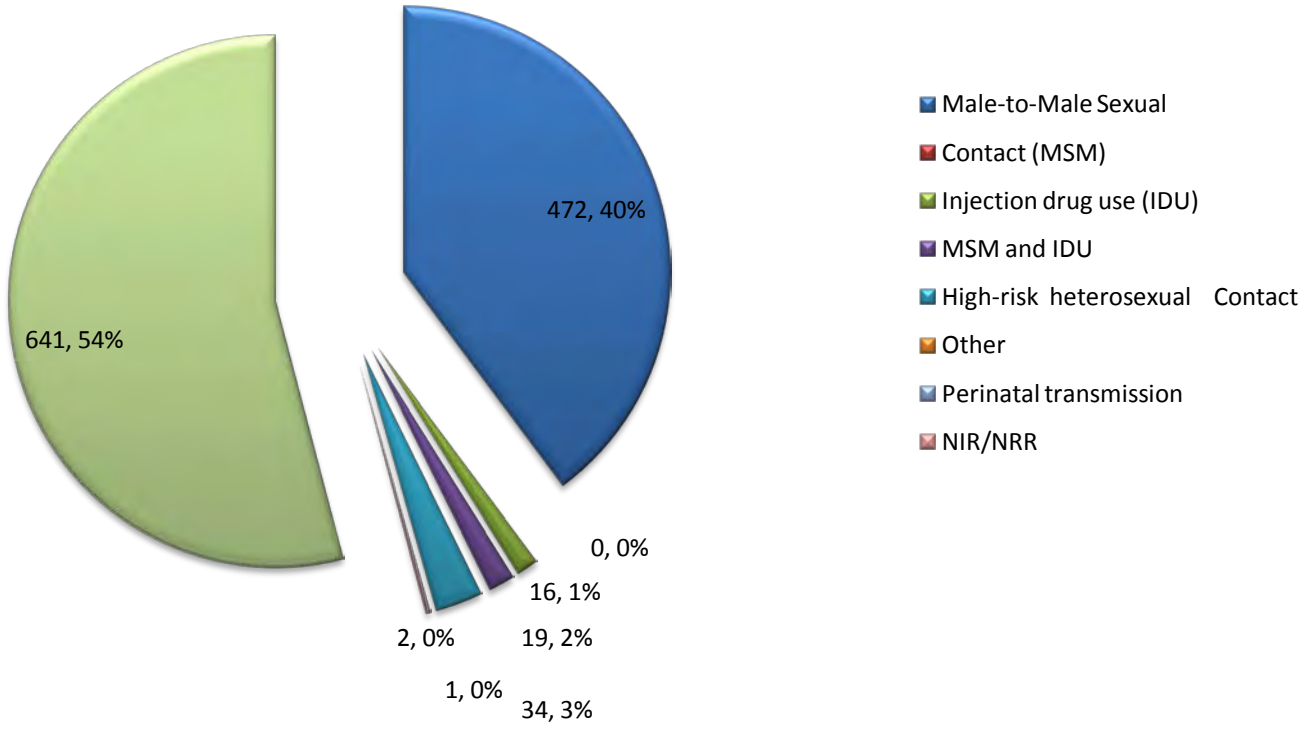


Table 3a. Newly Diagnosed HIV Infection (not AIDS) by Gender (Male) and Transmission, Georgia 2007

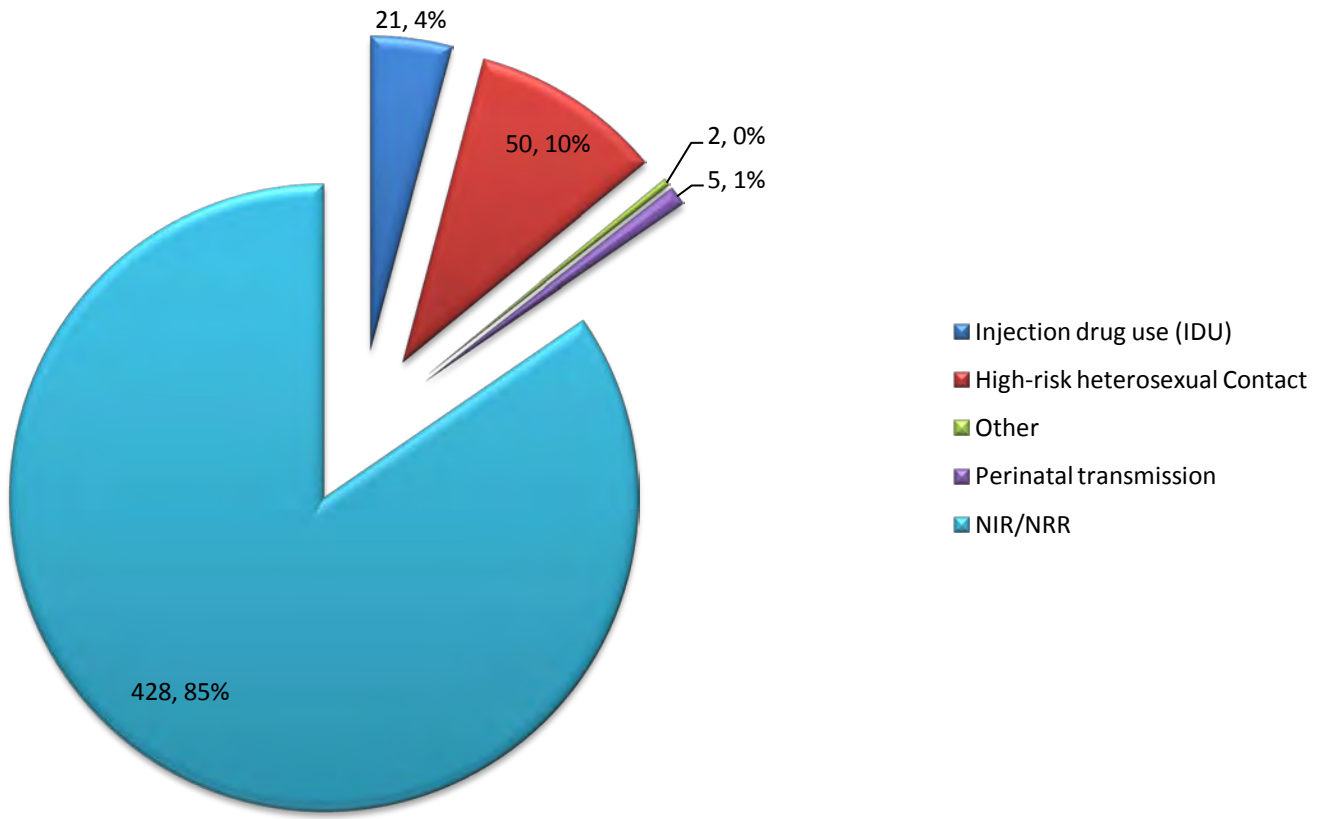


Table 3b. Newly Diagnosed HIV Infection (not AIDS) by Gender (Female) and Transmission, Georgia 2007

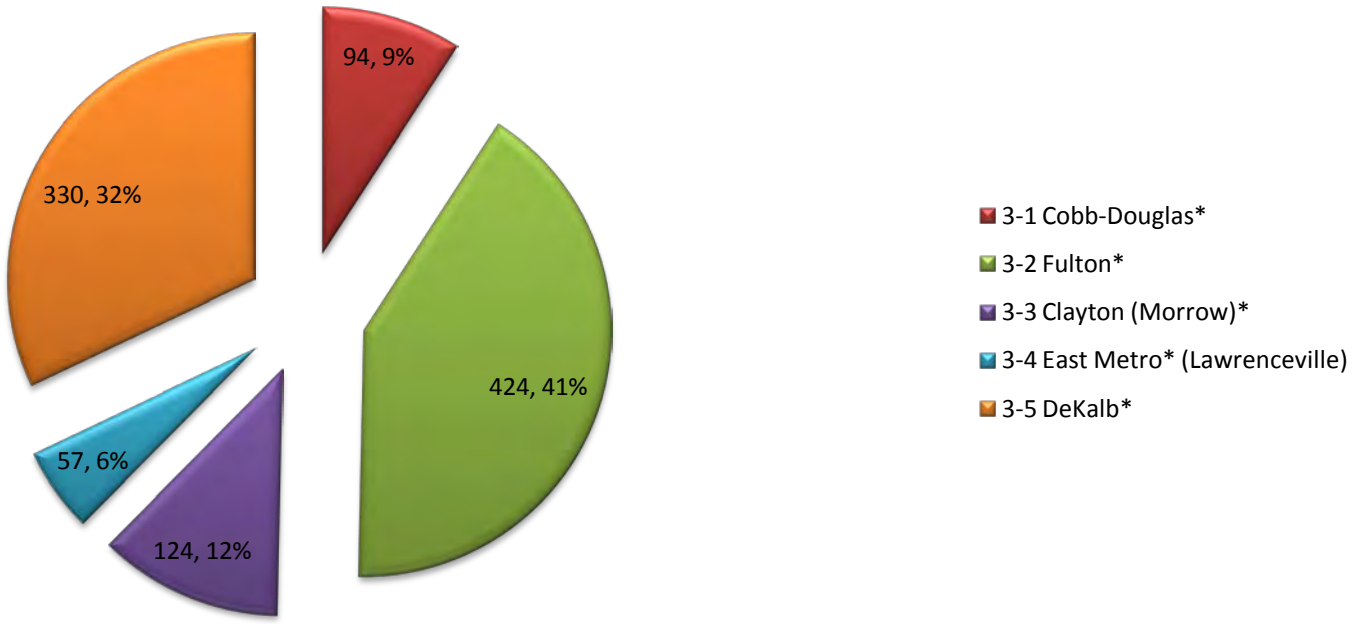


Table 4. Newly Diagnosed HIV Infection (not AIDS) Cases by Public Health District of Residence at Diagnosis, Georgia 2007

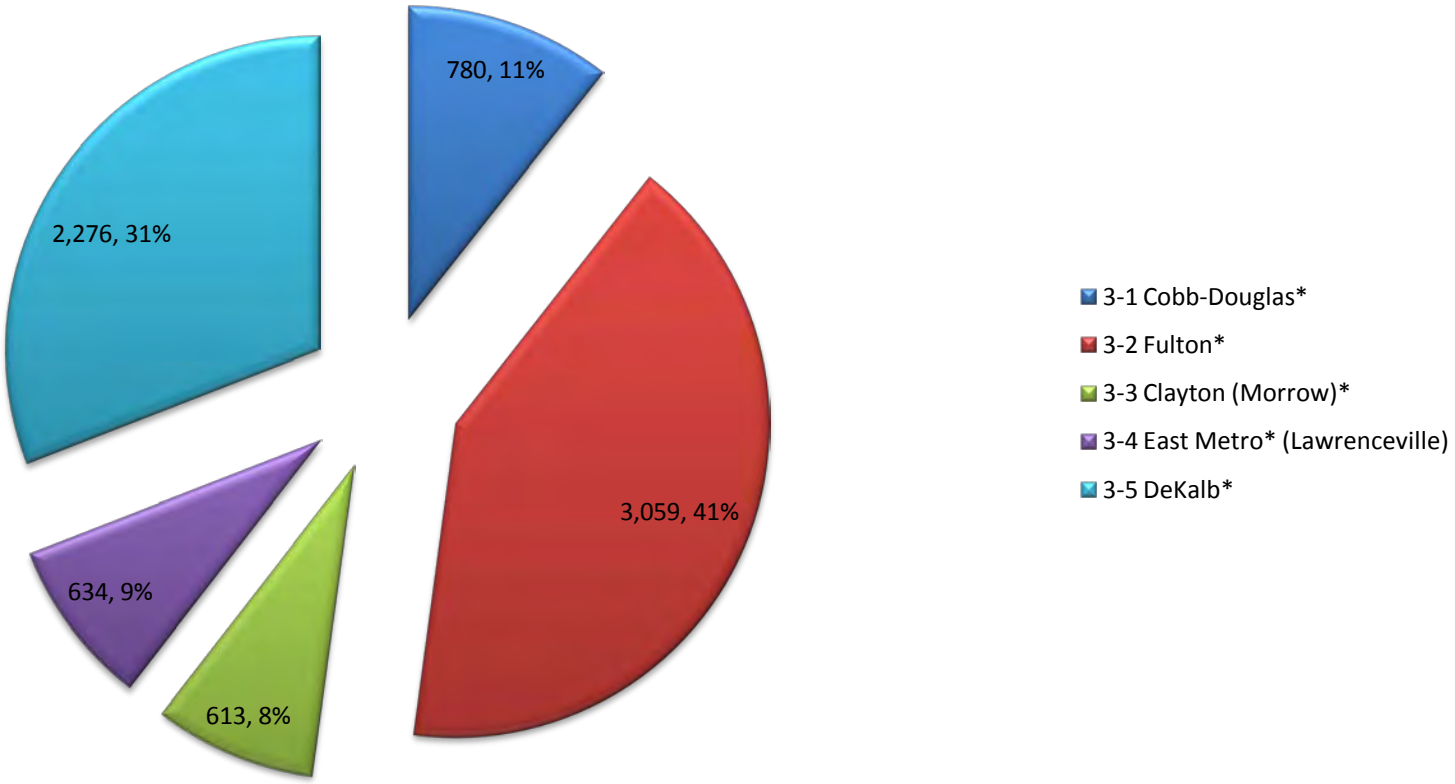


Table 5. Persons Living with HIV Infection (not AIDS) by current Public Health District of Residence, Georgia, 2007

Newly Diagnosed HIV Infections (Not AIDS)

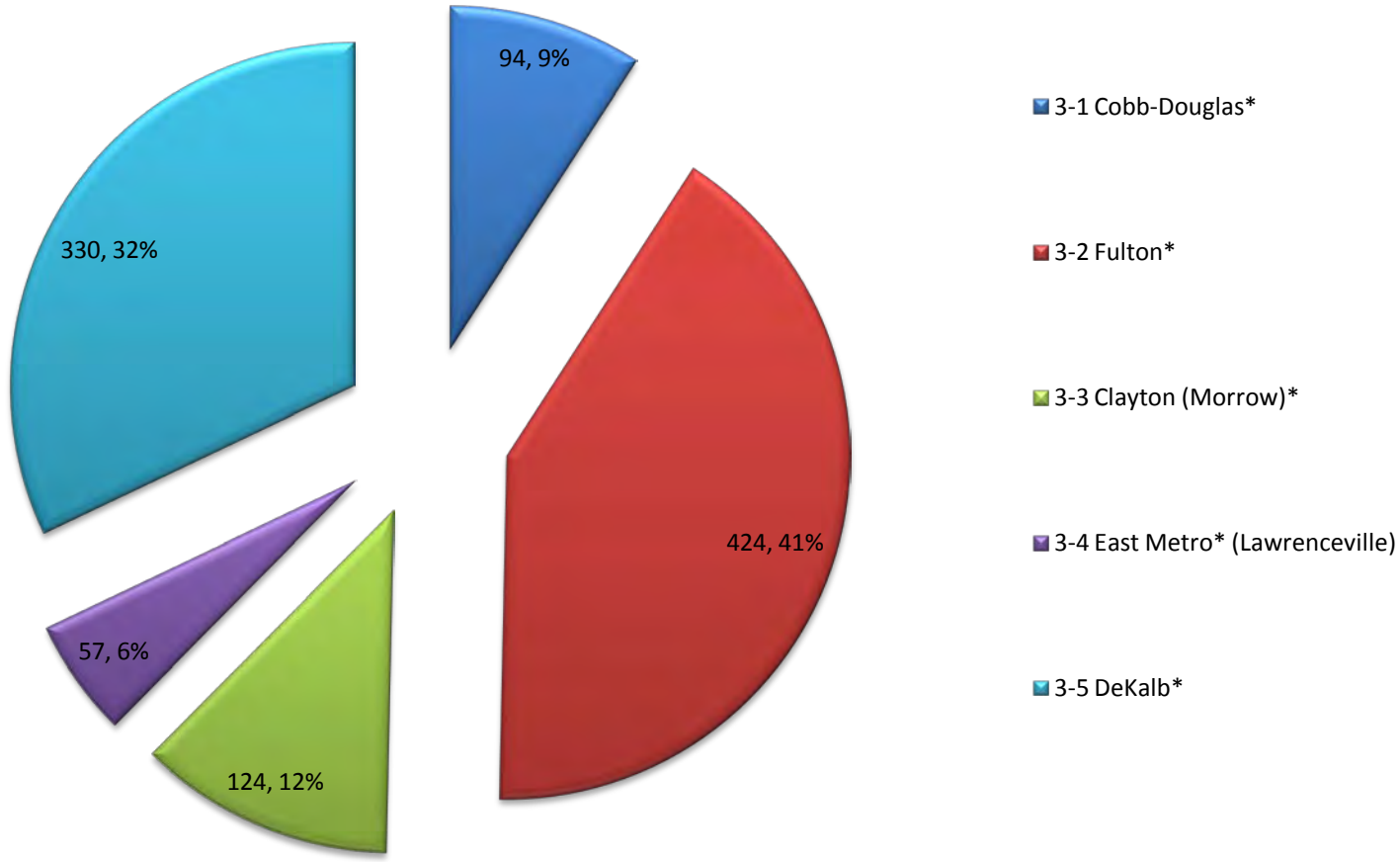


Table 6. Newly Diagnosed HIV Infection (not AIDS) by Public Health District of Residence at Diagnosis, Georgia 2007

Cumulative Cases of HIV Infection (not AIDS)

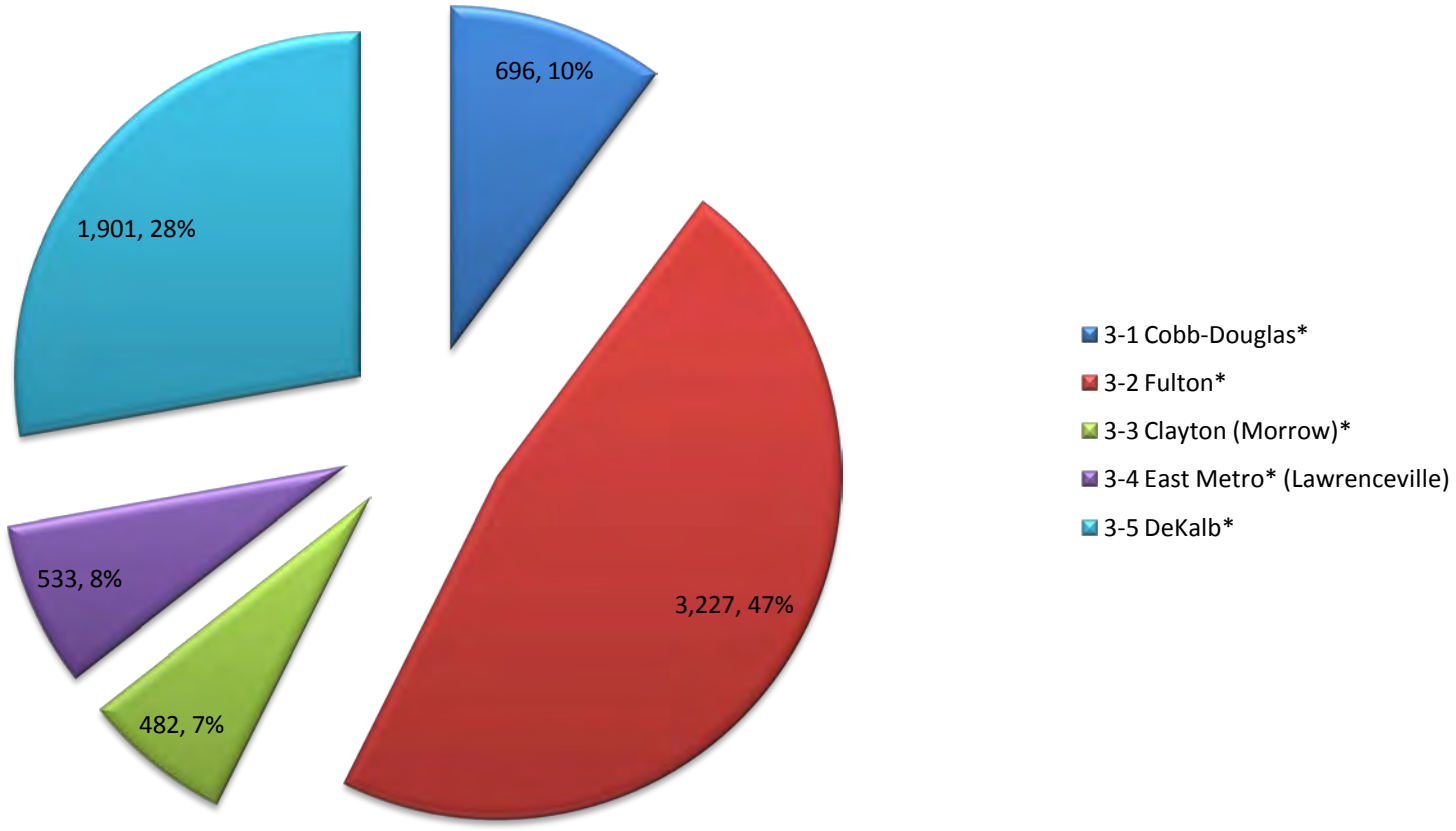


Table 7. Cumulative Cases of HIV Infection (not AIDS) by Public Health District of Residence at Diagnosis, Georgia, 2007.

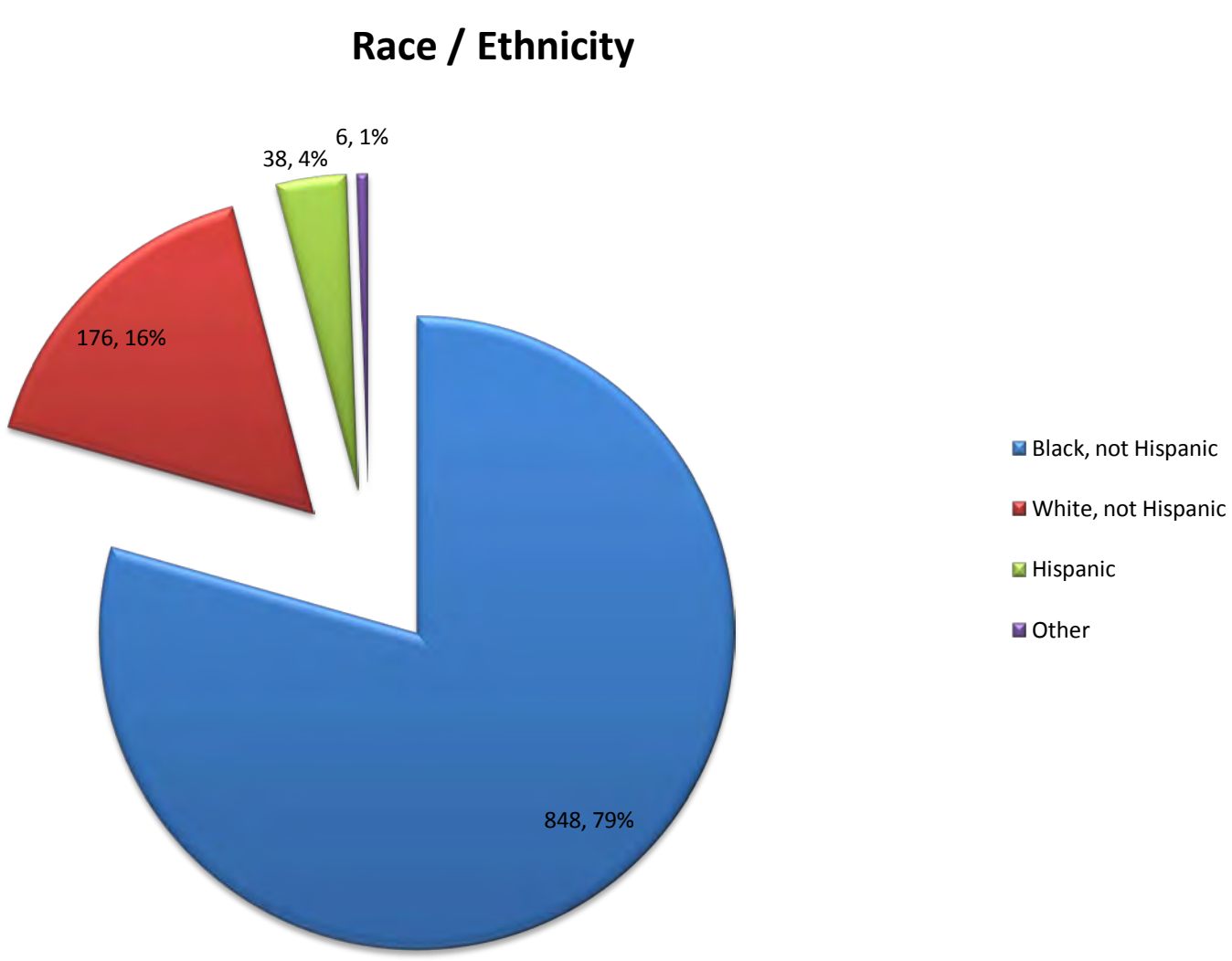


Table 8a. Demographics of the Atlanta MSA for Persons in HARS vs. HET 1 Cycle

Cumulative HIV (not AIDS) Atlanta MSA for Persons in HARS in Georgia Through 2008:

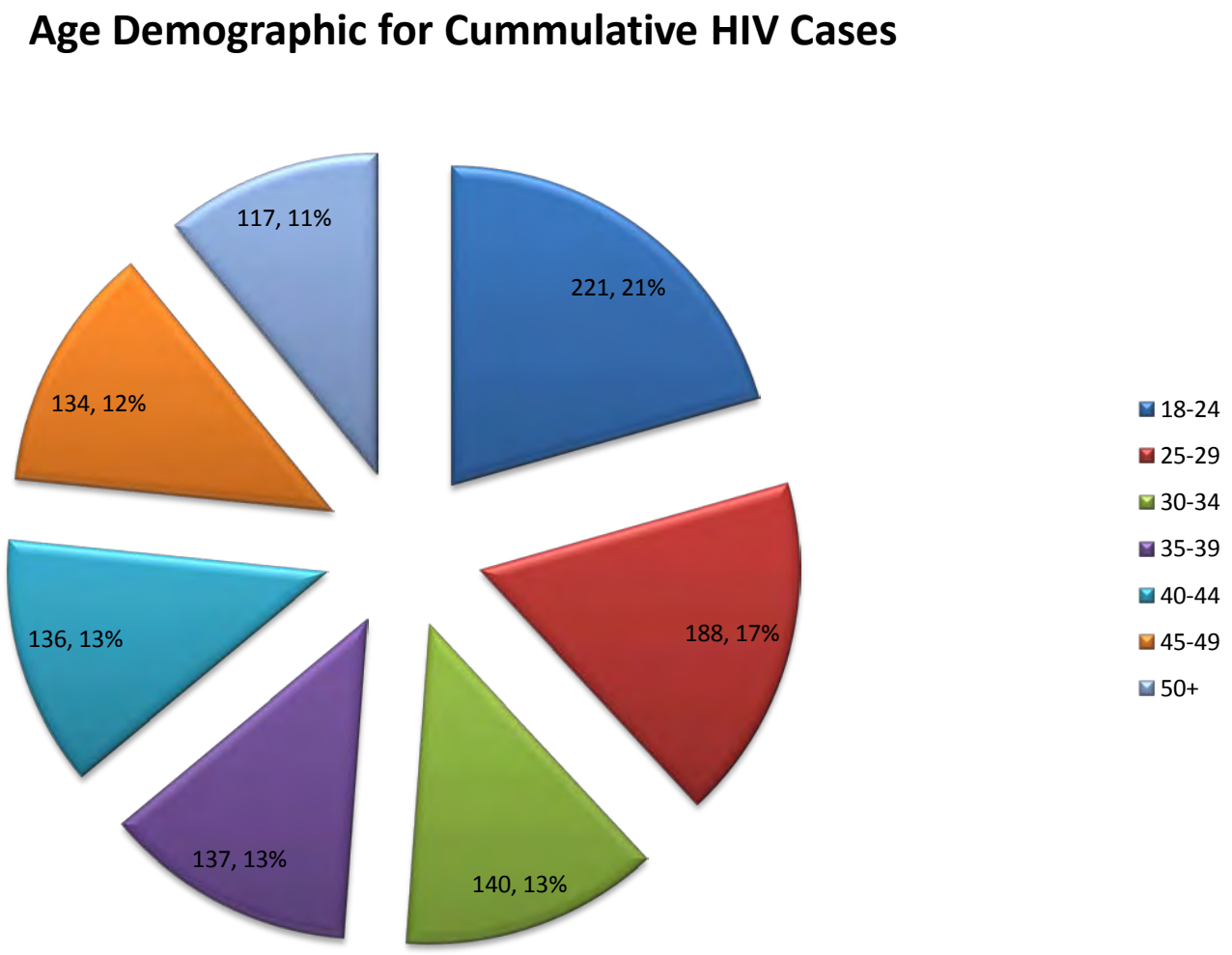


Table 8b. Demographics of the Atlanta MSA for Persons in HARS vs. HET 1 Cycle

Cumulative HIV (not AIDS) Atlanta MSA for Persons in HARS in Georgia Through 2008:

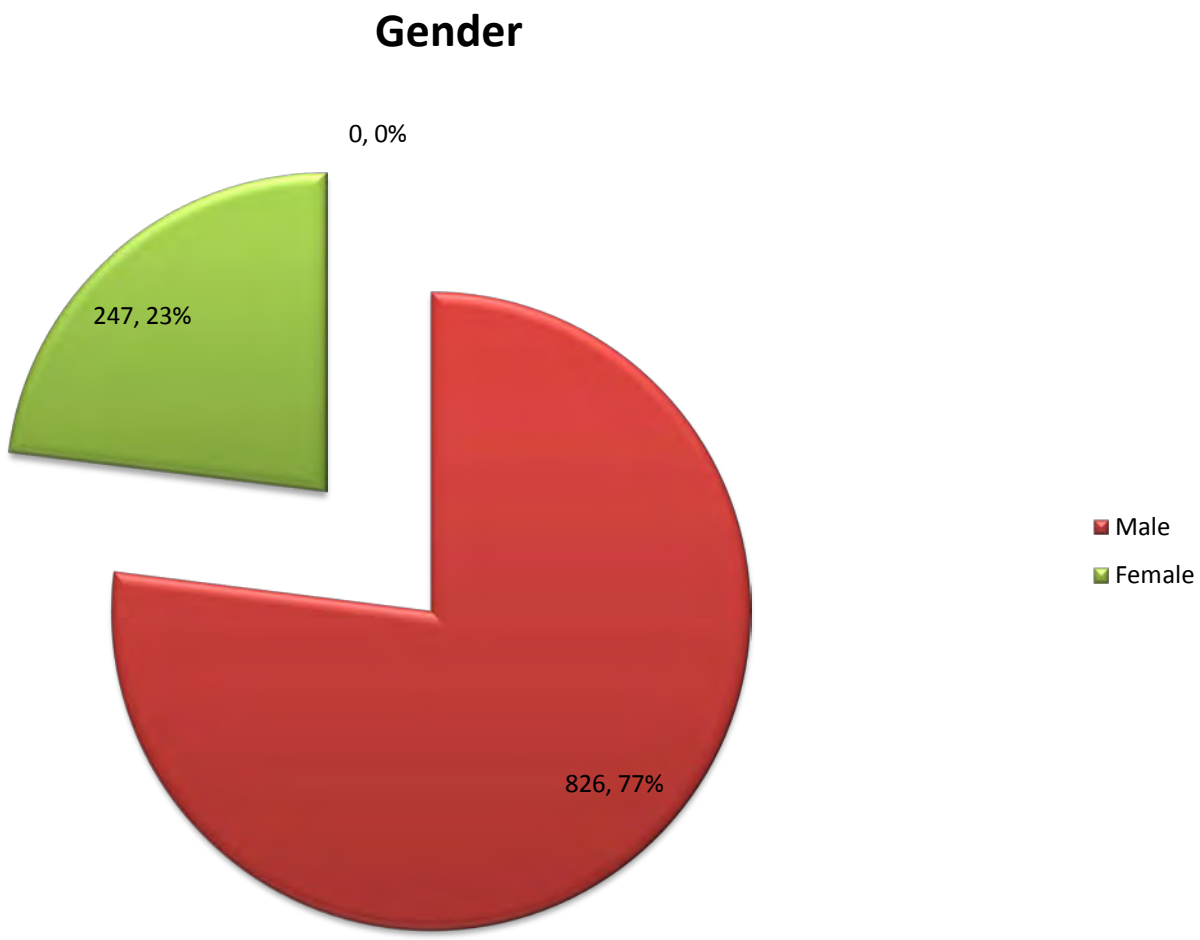


Table 8c. Demographics of the Atlanta MSA for Persons in HARS vs. HET 1 Cycle
Cumulative HIV (not AIDS) Atlanta MSA for Persons in HARS in Georgia Through 2008:

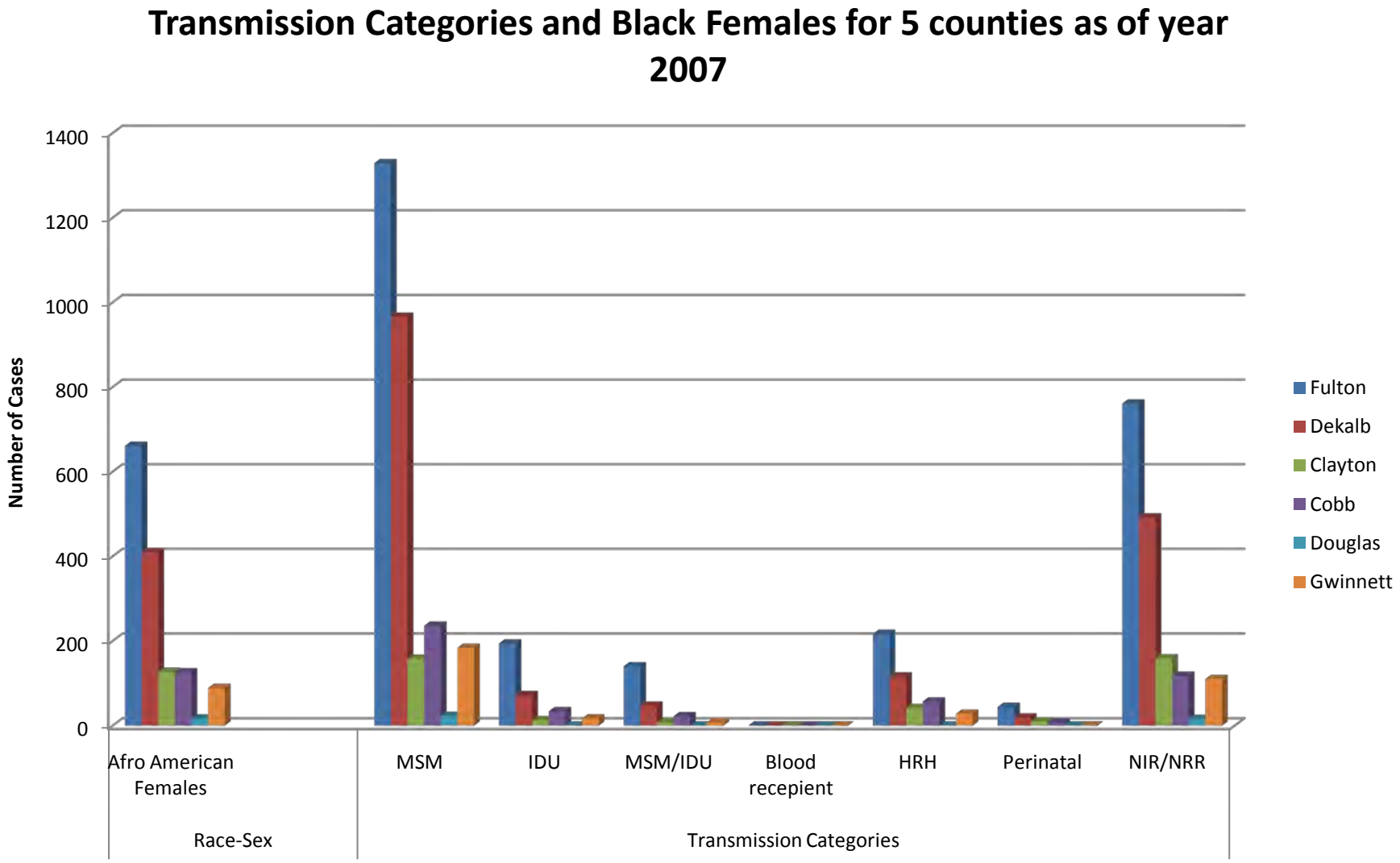


Table 9.People Living With HIV-NA(PLWH-NA) cases according to the Transmission Categories and Black Females for 5 counties as of year 2007.

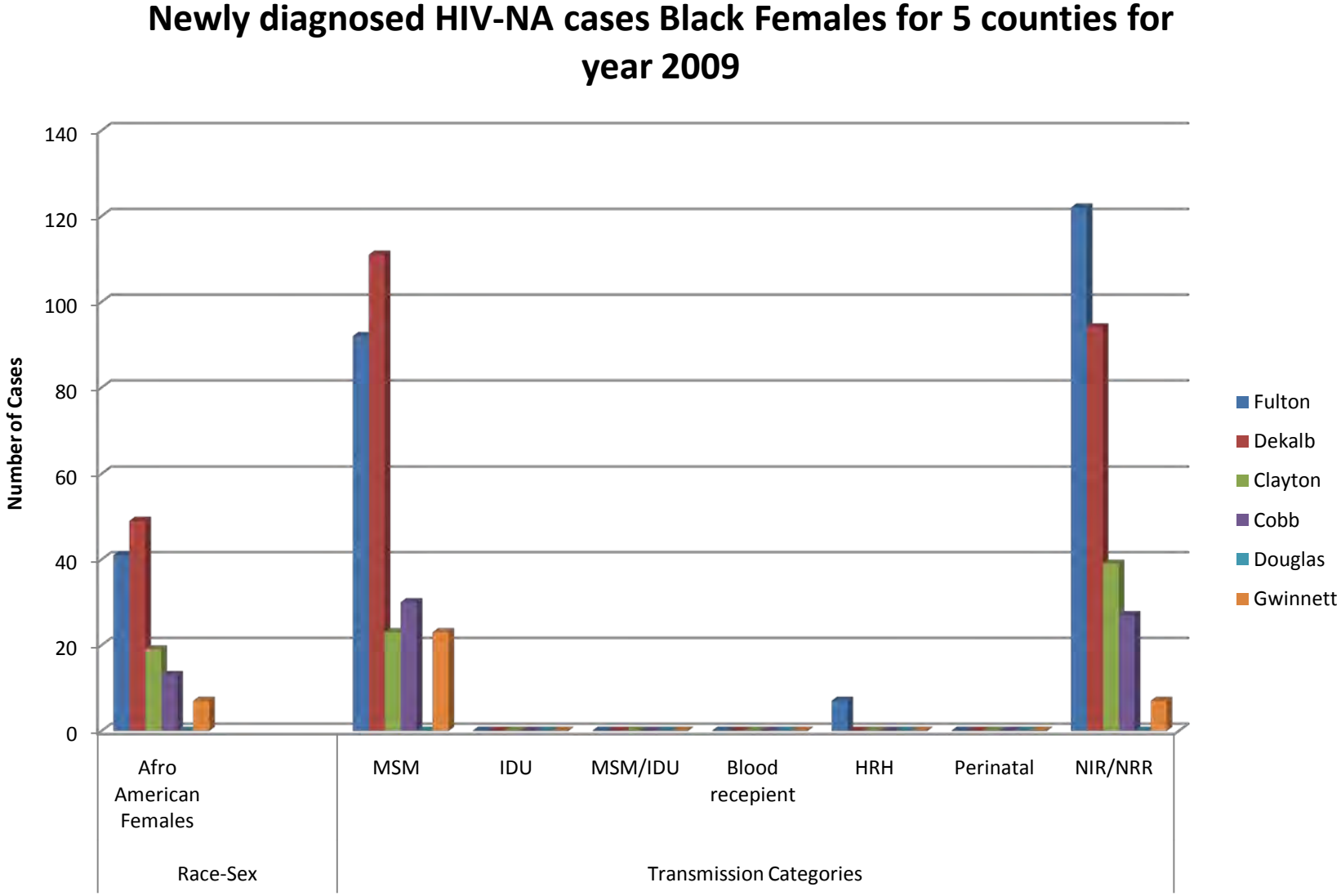


Table10.Newly diagnosed HIV-NA cases according to the Transmission Categories and Black Females for 5 counties for the year 2009.

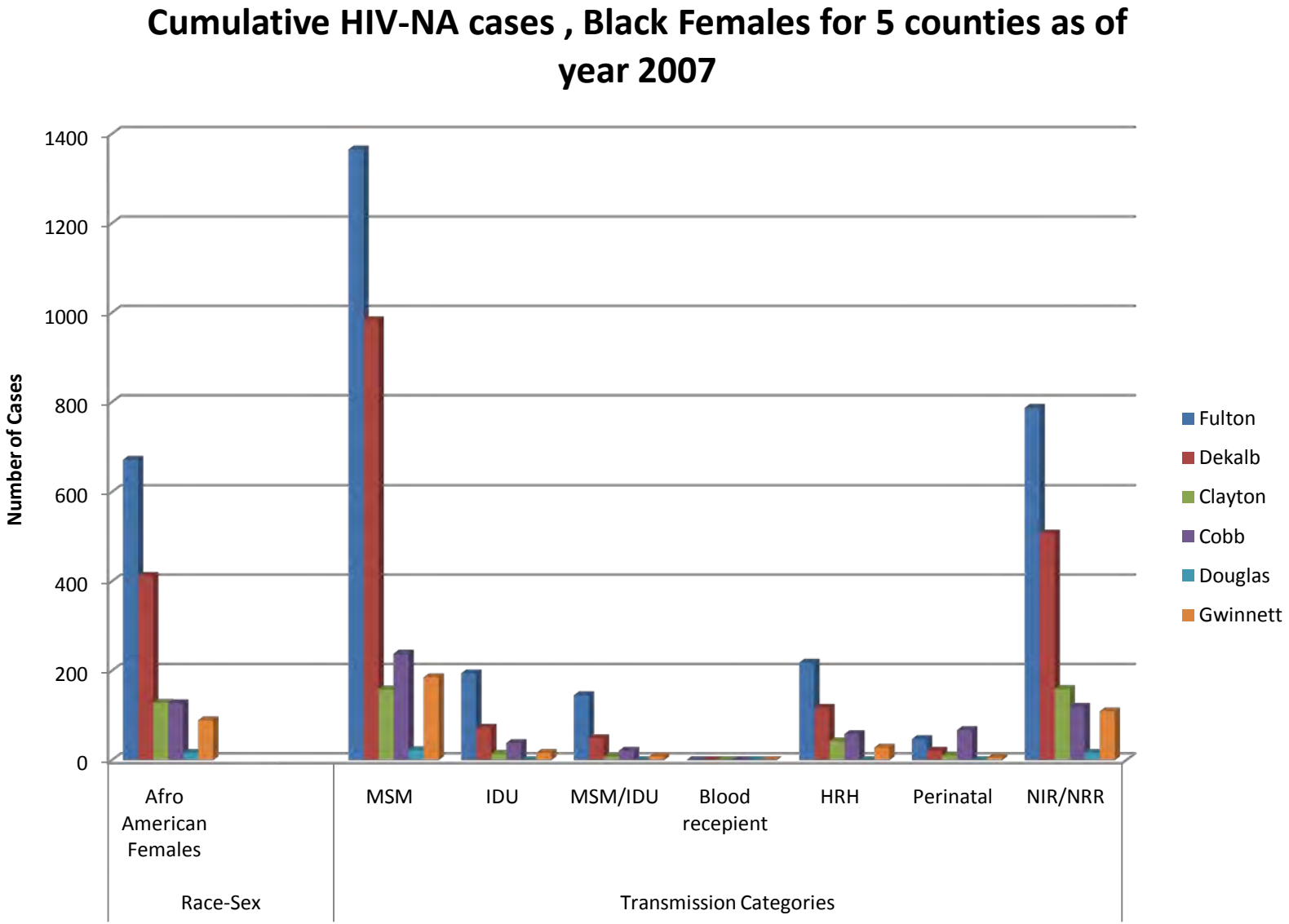


Table11.Cumulative HIV-NA cases according to the Transmission Categories and Black Females for 5 counties as of year 2007.