Ending the HIV Epidemic in the U.S.: A State-Based Approach to Serving Rural Populations

2022 National Ryan White Conference on HIV Care and Treatment

August 23, 2022

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Vision: Healthy Communities, Healthy People

Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Address gaps and barriers in service delivery to rural populations.

2. Explore opportunities for stakeholders to utilize data to end the HIV epidemic.

3. Identify methods to increase community engagement in rural jurisdictions.

Disclosures

Srujana Kunapareddy has no relevant financial interests to disclose.

Pamela Klein has no relevant financial interests to disclose.

Rebecca Bax has no relevant financial interests to disclose.

Leigh Oden has no relevant financial interests to disclose.

Tangee Summers has no relevant financial interests to disclose.

Gloria Dennis has no relevant financial interests to disclose.

Manny Singh has no relevant financial interest to disclose

Disclosure will be made when a product is discussed for an unapproved use.

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Health Resources and Services Administration (HRSA)
Overview

Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically challenged

HRSA does this through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

Every year, HRSA programs serve tens of millions of people, including people with HIV, pregnant individuals, mothers and their families, and those otherwise unable to access quality health care

HRSA's HIV/AIDS Bureau Vision and Mission

Vision

Optimal HIV care and treatment for all to end the HIV epidemic in the U.S.

Mission

Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.

HRSA's Ryan White HIV/AIDS Program (RWHAP) Overview

- **Provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV.**

- **Funds grants to states, cities, counties, and local community-based organizations to improve health outcome and reduce HIV transmission.**
  - Recipients determine service delivery and funding priorities based on local needs and planning process.

- **Provided services to nearly 562,000 people in 2020—more than half of all people with diagnosed HIV in the United States.**

- **89.4% of RWHAP clients receiving HIV medical care were virally suppressed in 2020, exceeding national average of 64.6%[i].**

AGENDA

- **Introduction**
  - HIV/AIDS Bureau (HAB) Rural Health & HIV Workgroup
  - HRSA RWHAP in Rural Areas
  - Ending the HIV Epidemic in the U.S. (EHE)
- **Recipient Presentations**
  - Missouri
  - South Carolina
  - Kentucky
- **Panel Discussion**
- **Live Q&A**

HAB Rural Health and HIV Workgroup

Workgroup Mission

To provide support and resources to RWHAP recipients and stakeholders to assist in the delivery of optimal care and treatment for people with HIV in rural communities.

Workgroup Goals

- Determine how the workgroup can support the Ending the HIV Epidemic in the U.S. (EHE) initiative
- Identify barriers/challenges faced by RWHAP recipients in rural communities and facilitate strategies to ameliorate them
- Provide a platform for rural RWHAP recipients to share successes and challenges and collaborate with other rural recipients
- Create partnerships with other HRSA Bureaus and Offices, federal, state and local stakeholders to develop activities and initiatives that address the needs of people with HIV in rural communities
- Expand the visibility of RWHAP in rural communities in national meetings, conferences, and other platforms
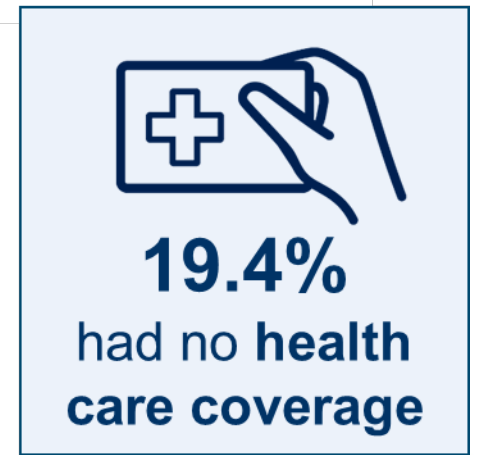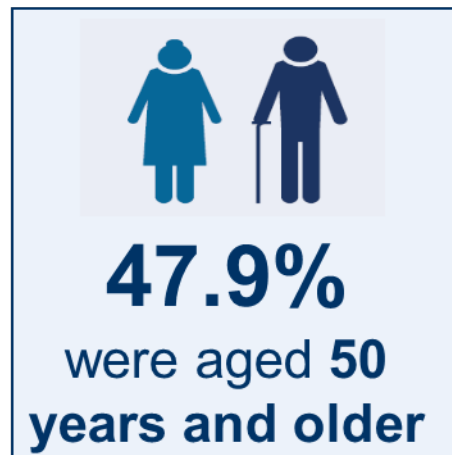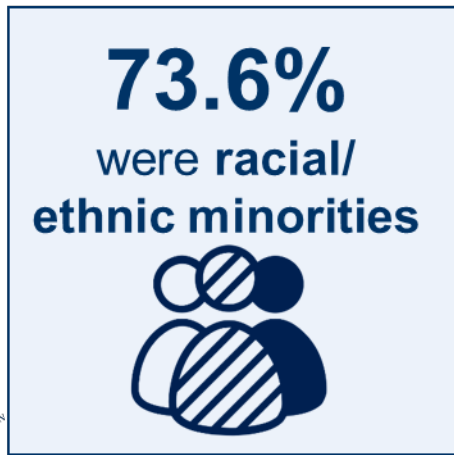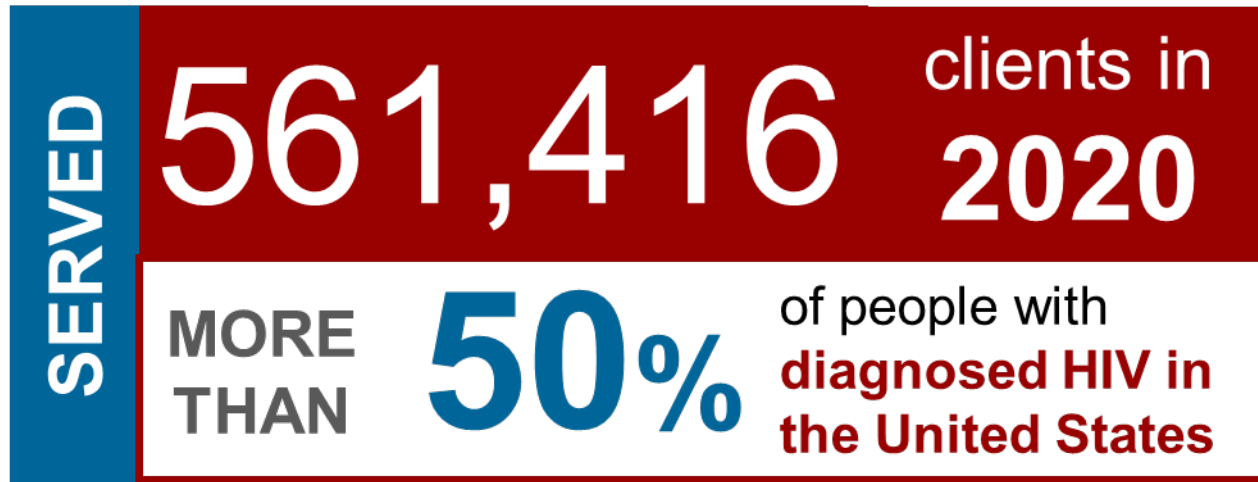
Rural Health and HIV Word Cloud

- Characteristics highlighted in black are positive attributes of medical care and support services delivery in rural communities.
- Characteristics highlighted in red are barriers to care in rural communities.
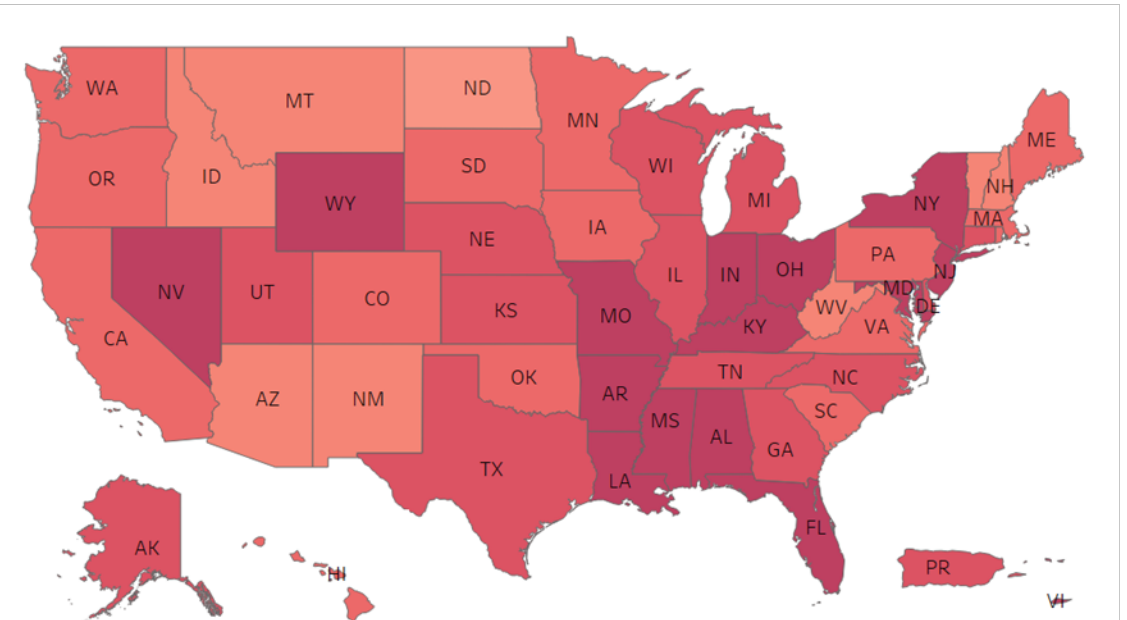- What other words come to mind?

In 2020, the RWHAP served more than half a million people in the United States and 3 territories[a]
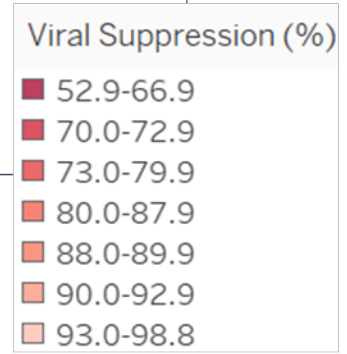
SERVED

561,416 clients in **2020**

MORE THAN **50%** of people with **diagnosed HIV in the United States**

73.6% were **racial/ethnic minorities**

47.9% were aged **50 years and older**

4.8% had **unstable housing**

60.9% were living at or below **100% of the Federal Poverty Level**

19.4% had no **health care coverage**

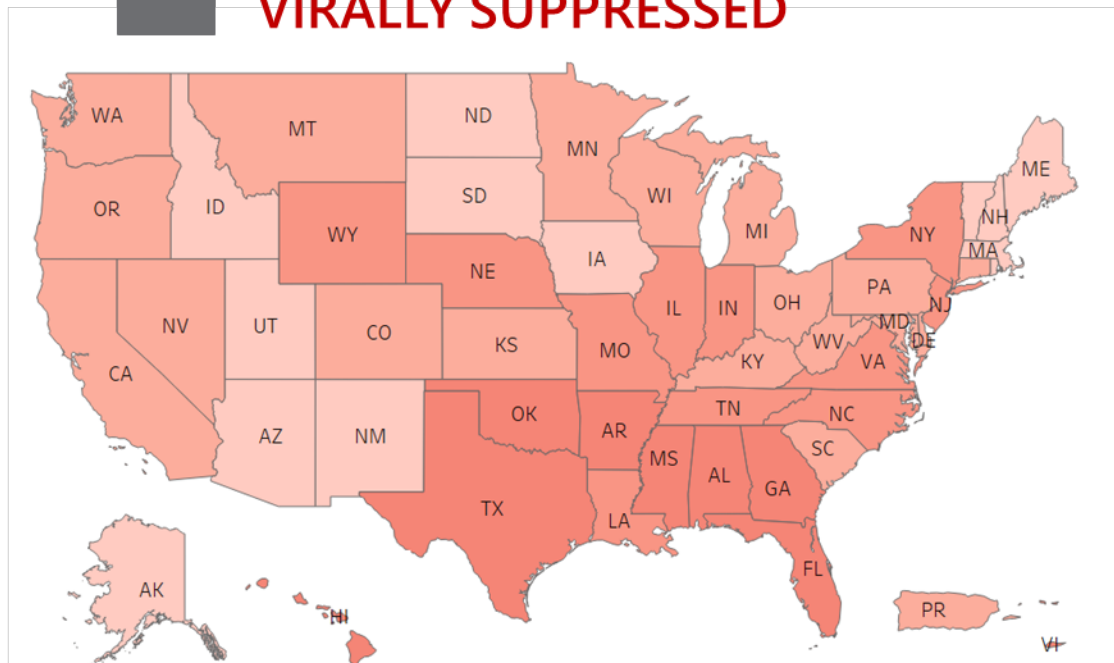[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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Viral Suppression among RWHAP Clients, by State, 2010 and 2020—United States and 2 Territories[a]

IN 2020 **89.4%** VIRALLY SUPPRESSED

IN 2010 **69.5%** VIRALLY SUPPRESSED

Viral Suppression (%)
- 52.9–66.9
- 70.0–72.9
- 73.0–79.9
- 80.0–87.9
- 88.0–89.9
- 90.0–92.9
- 93.0–98.8

Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
[a] Puerto Rico and the U.S. Virgin Islands.

HRSA RWHAP Providers in Rural Areas, 2020

- Nationally, 8.2% of RWHAP providers were located in rural areas

- Nearly 90% (85.6%) of rural providers received Public Health Service Act 330 funding (HRSA-funded Health Centers)

- Nearly half (46.8%) served more than 100 RWHAP clients
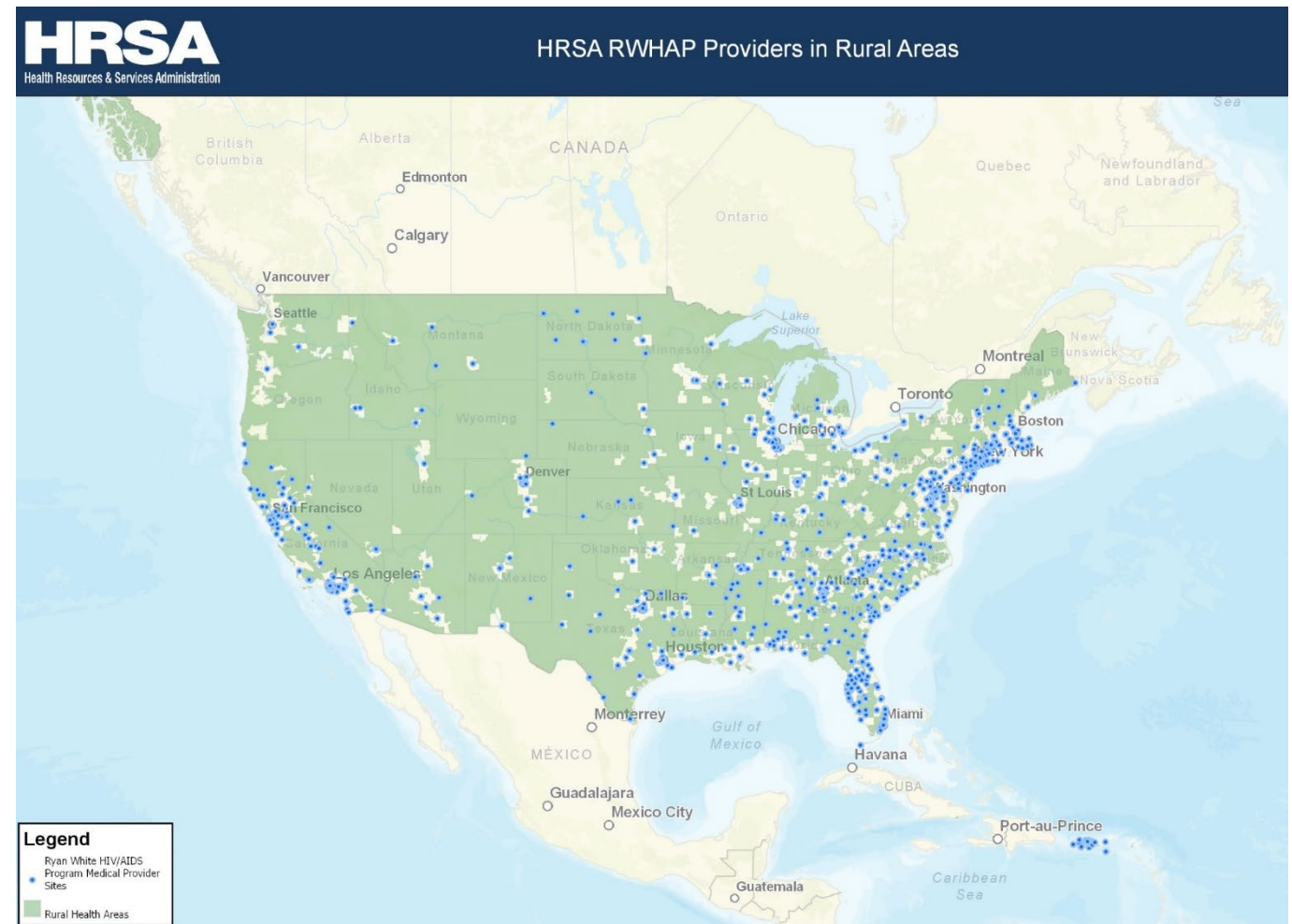
Data in this slide was updated from the following article: Klein PW, Geiger T, Chavis NS, Cohen SM, Ofori AB, et al. (2020) The Health Resources and Services Administration's Ryan White HIV/AIDS Program in rural areas of the United States: Geographic distribution, provider characteristics, and clinical outcomes. PLOS ONE 15(3): e0230121. https://doi.org/10.1371/journal.pone.0230121
Map: HRSA Map Tool. https://data.hrsa.gov/maps/map-tool/. HRSA RWHAP Providers in Rural Areas Created 5/19/2022.

Top 10 Services Delivered by Rural RWHAP Providers, 2020

2020 Rank	Service Category	% Rural Providers Delivering Service
1	Outpatient Ambulatory Health Services	52.4%
2	Medical Case Management	50.6%
3	Medical Transportation	44.7%
4	Oral Health Care	40.6%
5	Emergency Financial Assistance	40.6%
6	Non-Medical Case Management	37.7%
7	Mental Health Services	31.8%
8	Early Intervention Services (EIS)	22.4%
9	Health Insurance Premium and Cost Sharing Assistance	21.3%
10	Housing	19.4%

In 2020, nearly 20,000 clients visited rural RWHAP providers the United States and 3 territories[a]

3.5%
of all RWHAP clients (n=19,814) visited **rural providers** in 2020

57.6%
were **racial/ethnic minorities**

50.4%
were aged **50 years and older**

5.0%
had **unstable housing**

57.6%
were living at or below **100% of the Federal Poverty Level**

18.9%
had no **health care coverage**

Viral Suppression among RWHAP Clients who Visited Rural RWHAP Providers, 2020

90%
of clients who visited rural providers reached viral suppression in 2020

- **Consistent with the national RWHAP average of 89.4% clients virally suppressed in 2020**
- **Increased 5 percentage points over the last 5 years (85.1% viral suppressed in 2016)**

Viral suppression was based on data for people with HIV who had at least 1 outpatient ambulatory health services visit during the measurement year and whose most recent viral load test result was <200 copies/mL.

HRSA
Ryan White HIV/AIDS Program

RWHAP Rural HIV Care Fact Sheet

HRSA's Ryan White HIV/AIDS Program: HIV Care and Treatment in Rural Communities

https://ryanwhite.hrsa.gov/resources/factsheets

HRSA's Ryan White HIV/AIDS Program: HIV Care and Treatment in Rural Communities — Population Fact Sheet | September 2021

Now is the time to end the HIV epidemic in the U.S.

We have access to the most powerful HIV treatment and prevention tools in history and and we know where infections are rapidly spreading.

By equipping all communities at risk with these tools, we can end HIV in America.

Four Pillars of Ending the HIV Epidemic in the U.S. (EHE)

75%
reduction in new HIV diagnoses in 5 years and a 90% reduction in 10 years.

Diagnose

All people with HIV as early as possible.

Treat

People with HIV rapidly and effectively to reach sustained viral suppression.

Prevent

New HIV transmissions by using using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).

**Respond**

Quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Focused Jurisdictions for the Ending the HIV Epidemic in the U.S. Initiative

Efforts focused in 48 counties, Washington, DC, and San Juan, PR, where more than 50% of HIV diagnoses occurred in 2016 and 2017, and the seven states with substantial rural HIV burden.
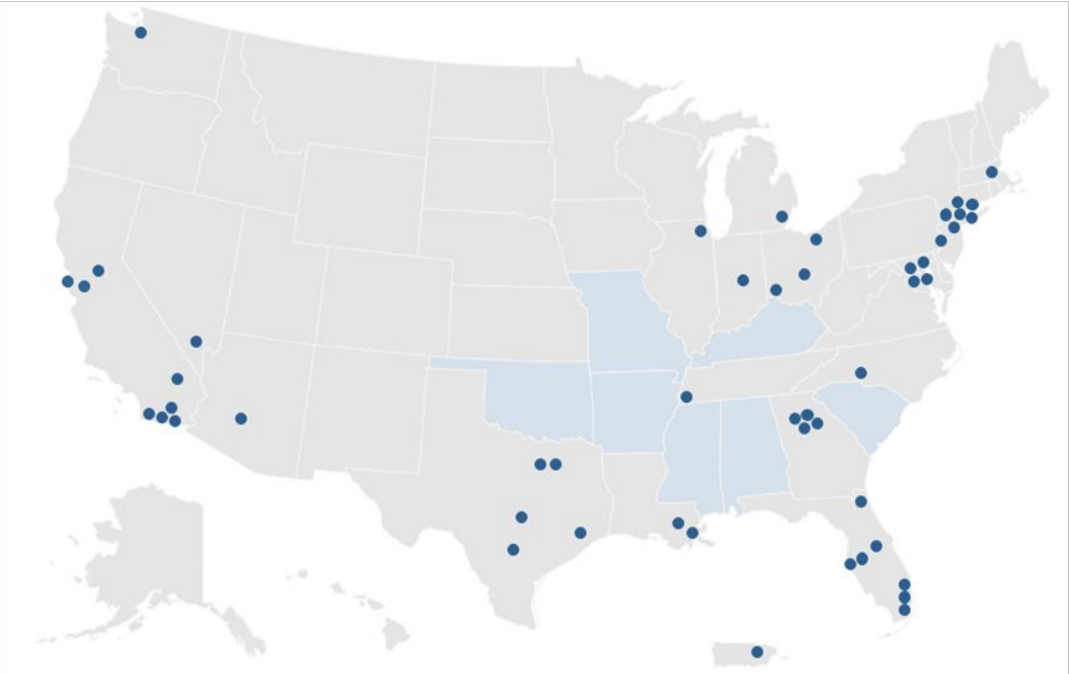
Achieving the Ending the HIV Epidemic in the U.S. Goals

People with HIV in care

- Improve viral suppression rates
- Decrease disparities

People newly diagnosed with HIV

- Enhance linkage to care
- Enhance engagement in care

People with HIV out of care

- Expand re-engagement in care
- Improve retention in care

Seven Ending the HIV Epidemic in the U.S. (EHE) States

In FY 2021,

HRSA awarded nearly $10 million to the RWHAP Part B recipients in the 7 EHE states with a substantial number of HIV diagnoses in rural areas

Alabama

Arkansas

Kentucky

Mississippi

Missouri

Oklahoma

South Carolina

Ryan White HIV/AIDS Program

Seven Ending the HIV Epidemic in the U.S. (EHE) States, 2020

52,416
clients served within the 7 EHE states in 2020
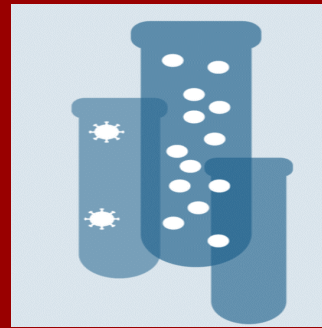
89.2%
of RWHAP clients served within these 7 EHE states reached viral suppression

Viral suppression: ≥1 outpatient ambulatory health service (OAHS) visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

HRSA
Ryan White HIV/AIDS Program

Viral Suppression among select Priority Populations Served by the Ryan White HIV/AIDS Program, 2010 and 2020—7 EHE States
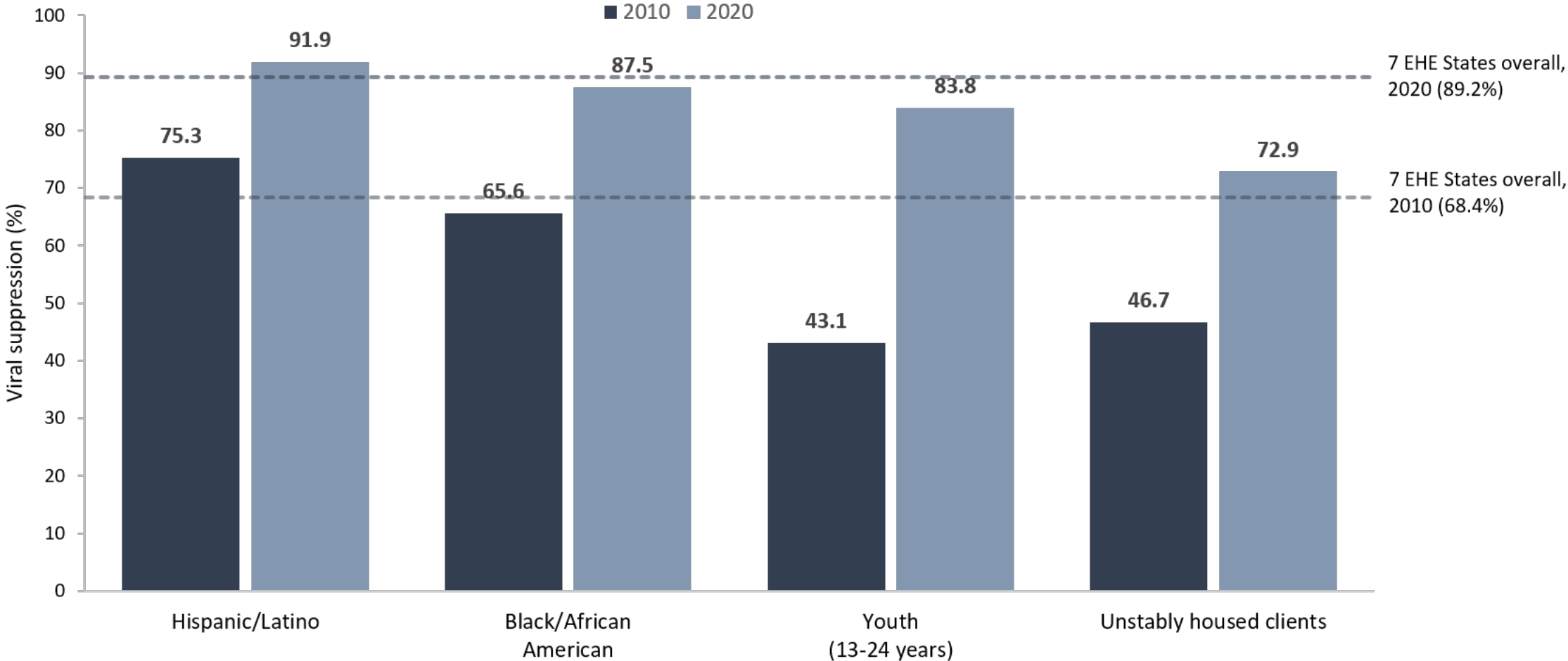
Hispanics/Latinos can be of any race.
Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

RWHAP Providers in Rural Communities

RWHAP encourages innovative practices to best meet the needs of people with HIV in rural communities. Although barriers remain, RWHAP service programs in rural areas have demonstrated success in such areas as:

- Telemedicine
- Rapid antiretroviral therapy
- Transportation service
- Use of community health workers

Rural Health and HIV Resources

- RWHAP Part F AIDS Education and Training Centers (AETC) Program
- HIV Prevention and Treatment Challenges in Rural America: A Policy Brief and Recommendations to the Secretary
- National Rural Health Association (NRHA): Rural Health Resources and Best Practices
- National Rural Health Resource Center (NRHRC): Rural Response to Coronavirus Disease 2019 (COVID-19)
- Prevention and Treatment of HIV Among People Living With Substance Use and/or Mental Disorders
- Rural HIV/AIDS Prevention and Treatment Toolkit
- Telehealth Resource Centers (TRCs)
- HRSA's RWHAP HIV Care and Treatment in Rural Communities Fact Sheet
- Rural HIV/AIDS Planning Program Grantee Sourcebook 2020-2021

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Evaluation, Analysis, and Dissemination Branch

Division of Policy and Data

HIV/AIDS Bureau (HAB)

Health Resources and Services Administration (HRSA)

Web: ryanwhite.hrsa.gov

Connect with the Ryan White HIV/AIDS Program

Learn more about our program at our new website:
https://ryanwhite.hrsa.gov

Sign up for the Ryan White HIV/AIDS Program Listserv:
https://public.govdelivery.com/accounts/USHHSHRSA/signup/29907

Connect with HRSA

Learn more about our agency at:

www.HRSA.gov

✉ [Sign up for the HRSA eNews](#)

FOLLOW US:

Missouri Ending the HIV Epidemic Community Engagement

Rebecca Bax, M.A.

Ending the HIV Epidemic Grant Project Manager

Missouri Department of Health and Senior Services

Division of Community Public Health

Bureau of HIV, STD, and Hepatitis

2022

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Increase knowledge of how social and digital media and virtual engagement can drive development and continuous improvement.

2. Increase knowledge of how virtual community forums can be used to inform and collect information.

Ending the HIV Epidemic In Missouri

Missouri's Ending the HIV Epidemic Plan

We offer several options for engagement and want to hear from you! Use the comment option if you wish to provide a broad comment on the plan. The feedback option can be used to provide more structured feedback and the email address can be used for questions. We look forward to hearing from you!

- Quick Overview of Missouri's EHE Plan
- Provide a Comment
- Send Us Your Feedback
- Missouri's Ending the HIV Epidemic Plan

speakuphiv.com/ehe

Overview of Community Engagement Efforts

Gaps and Barriers

You're Invited!

VIRTUAL Community Forum

Topic: Older Adults Living with HIV

SATURDAY, JUNE 11, 2022
10 - 11 A.M.
OR
TUESDAY, JUNE 14, 2022
5:30 - 6:30 P.M.

Ending the HIV Epidemic In Missouri

Innovation

Partnerships:

- People living with HIV

- AIDS service organizations

- Local public health agencies (LPHAs)

- Substance abuse centers

- Organizations that serve minority populations

- Community-based organizations

- Public and private universities

- Federally qualified health centers (FQHCs)

Data Utilization
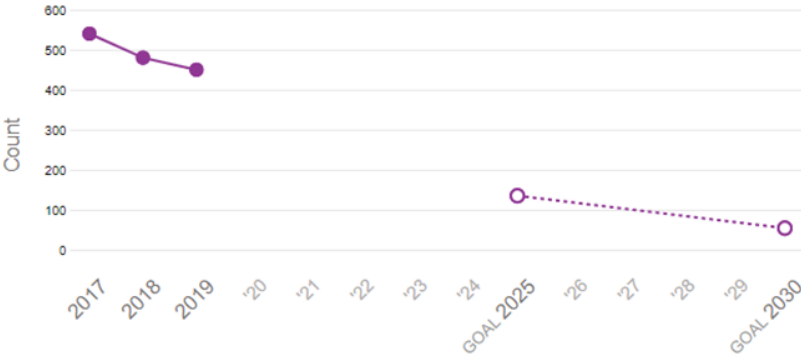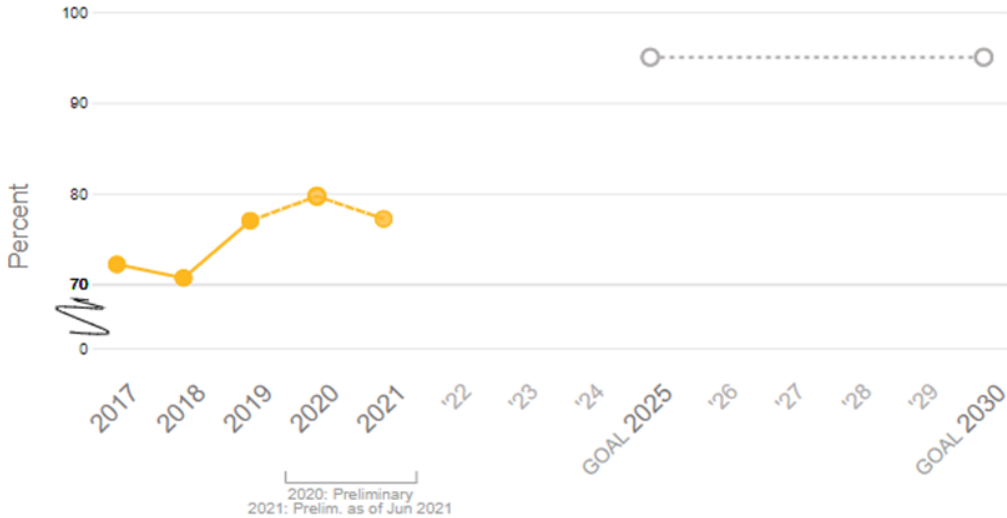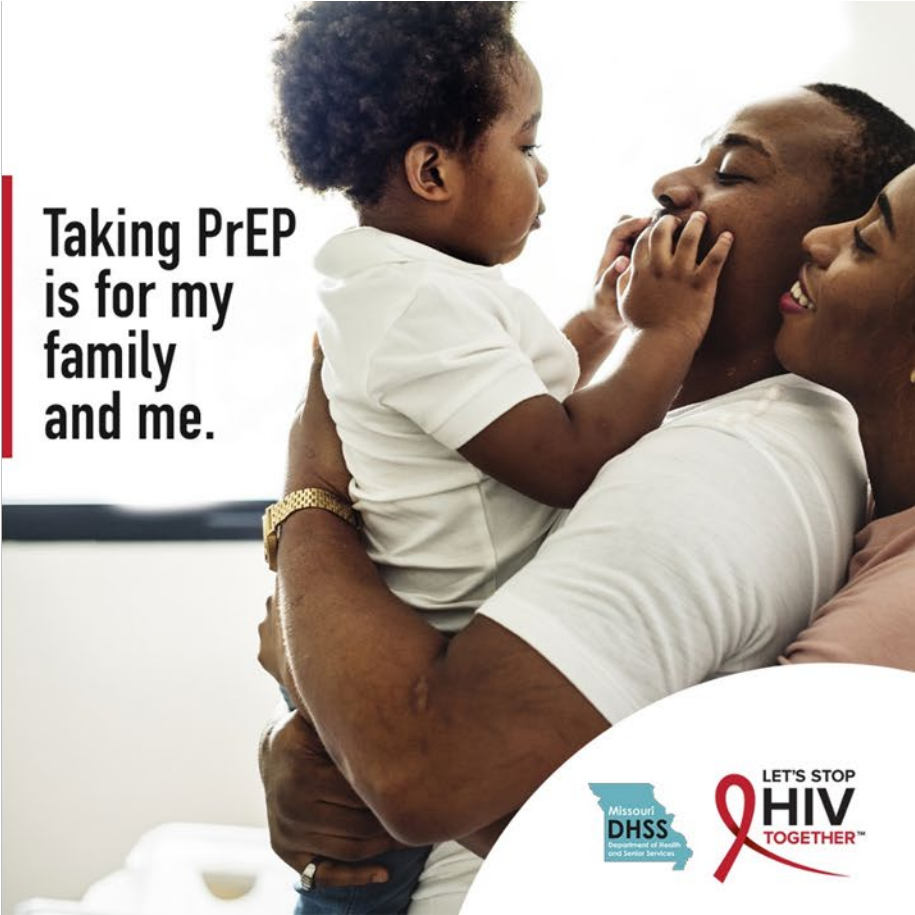
Lessons learned and best practice

Missouri's EHE Community Engagement Impact

Get Connected

- speakuphiv.com/ehe
- speakuphiv.com/mo
- speakuphiv.com/providers
- Email ehe@health.mo.gov to sign up to receive Community Forum invitations.

Rebecca Bax, EHE Grants Project Manager

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(573)526-2117

South Carolina
Ending the HIV Epidemic
and Use of Provide Enterprise

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Understand how data is analyzed and used to provide recommendations for action in program planning and management, advocacy, policy/decision making, and delivering EHE-related services.

2. Understand how data is utilized to monitor and evaluate EHE subrecipients to identify the most valuable and efficient use of resources

South Carolina Ryan White Part B Program

RWB Program Overview

- South Carolina AIDS Drug Assistance Program (ADAP)
  - Administered by SC Department of Health and Environmental Control (DHEC)
- Ryan White Part B Core and Support Services
  - Provided through a network of DHEC contracted subrecipients

South Carolina ADAP Service Tiers

1. Direct Dispensing Program (DDP)
2. Insurance Assistance Program (IAP)
3. Medicare Assistance Program (MAP)

   *Qualifying FPL: ≤ 550% for all service tiers

South Carolina
Ryan White Part B Program

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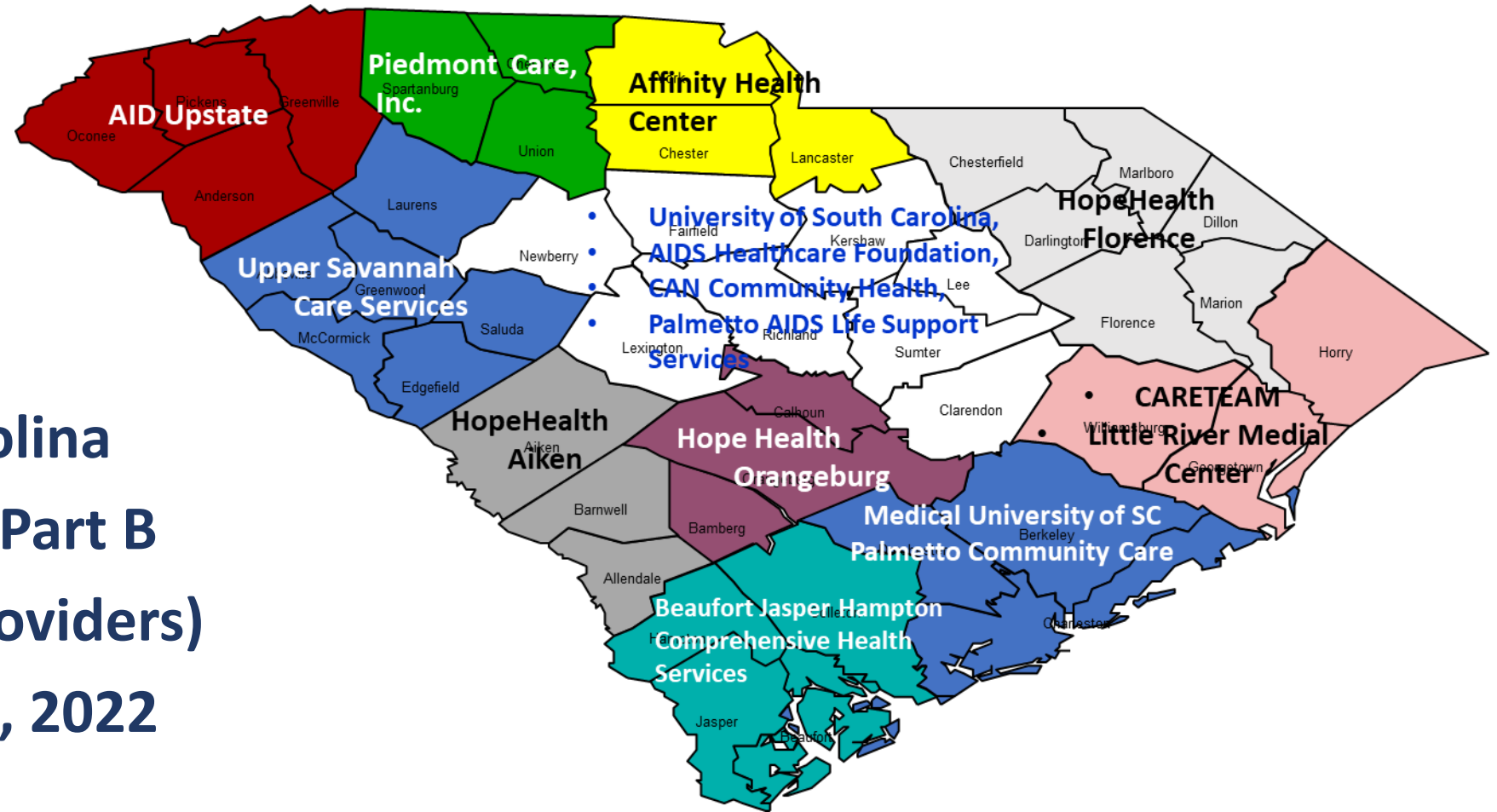
South Carolina

Ryan White Part B

(16 Service Providers)

As of April 1, 2022

Provide Enterprise (PE) in South Carolina

- South Carolina began using *PE* in the mid-1990s

- ADAP and all Ryan White Part B Subrecipients in SC plus some Ryan White Part C providers use *PE*

- RSR reporting

- Customizable
  - Medical Case Management Action Plan;
  - Enhanced Care Plan;
  - Clinical Report Card;
  - ADAP Billing Module

- Currently developing EHE enrollment and evaluation *PE*

SC RWB EHE Program Planning

- SC Ending the Epidemics Plan
  - Community involved planning process in 2020*

- Data
  - *Provide Enterprise*
  - Division of Surveillance, Assessment, and Evaluation

  *This process was initiated in our state in 2017

South Carolina

Population	2012	2013	2014	2015	2016	2017	2018	2019	2020
People Living with HIV or AIDS (PLWHA)	15,305	15,695	16,222	18,340	18,998	19,749	20,166	20,334	**19,437**
Served by Ryan White Part B (RWB - Care)	8,112	8,475	8,760	8,816	9,089	9,393	10,347	11,583	**11,428**
Percent of Prevalence Served by RWB - Care	53%	54%	54%	48%	48%	48%	51%	57%	**59%**
PLWHA Out of Care [1]	36%	37%	34%	32%	37%	32%	31%	29%	**24%**
Uninsured in ADAP	76%	75%	74%	65%	55%	53%	54%	56%	**53%**

Data Source: SC Epi Profiles
1. PLWHA Out of Care is based on absence of HIV tests at intervals within the calendar year.

SC Care Continuum Yearly Comparison (statewide)
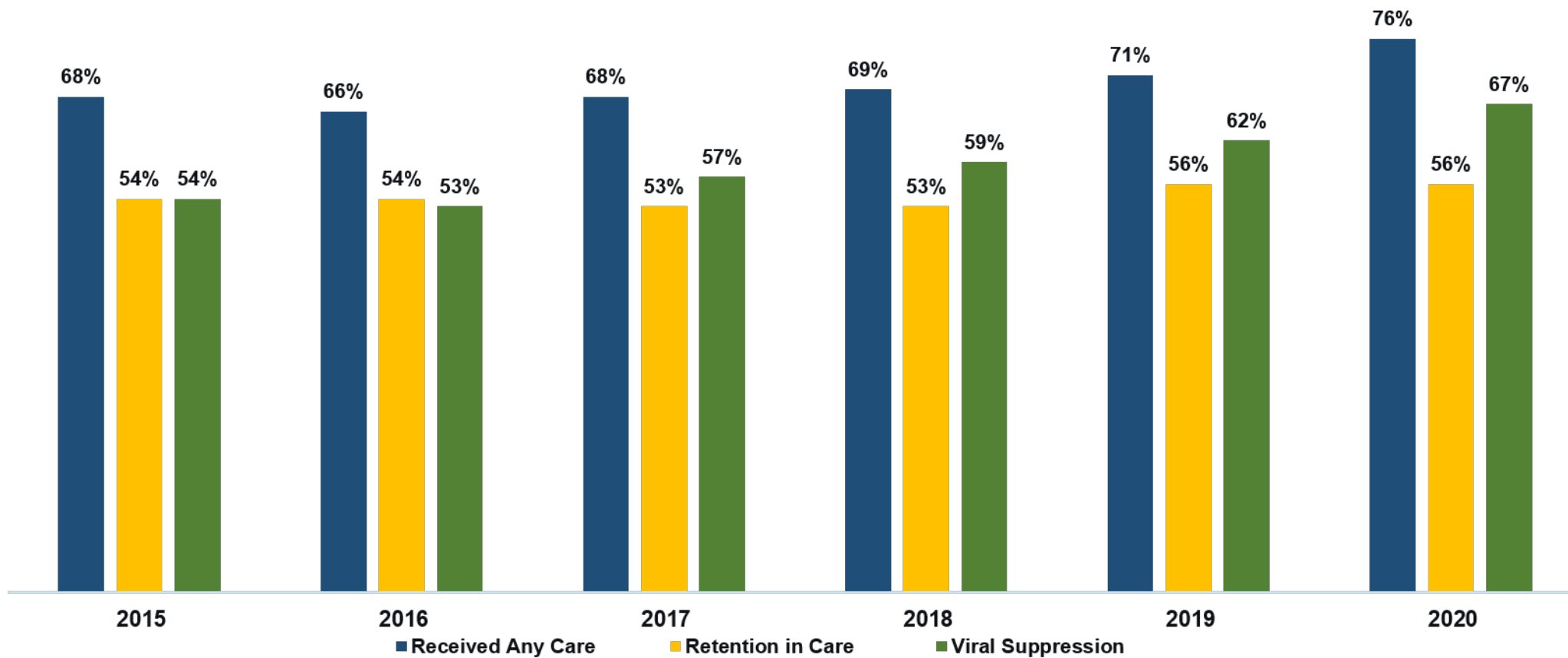
Data Source: 2020 SC Epi Profiles

RSR: SC RW All Parts Retention in Care

Year	Rate	Total Clients	Total Clients Retained
2020	84.2%	10,518	8,859

Data Source: RW HIV/AIDS Program Annual Client-Level Data Report 2020, as derived from Ryan White Services Report (RSR) data
https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2020.pdf

Date Notes:
1) Retention in care was based on data for PLWH who had at least 1 outpatient ambulatory health services visit by September 1 of the measurement year, with a second visit at least 90 days after.
2) The national average for Retention in Care (CY2020) is 79.0%%

Data Source: RW HIV/AIDS Program Annual Client-Level Data Report 2020, as derived from Ryan White Services Report (RSR) data -
https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2020.pdf

RSR: SC RW All Parts Viral Suppression Year-to-Year Comparison

RSR: SC Viral Suppression Year-to-Year Comparison

Year	Value
2012	76.90%
2013	79.50%
2014	81.70%
2015	83.90%
2016	84.70%
2017	85.70%
2018	87.70%
2019	89.30%
2020	90.30%
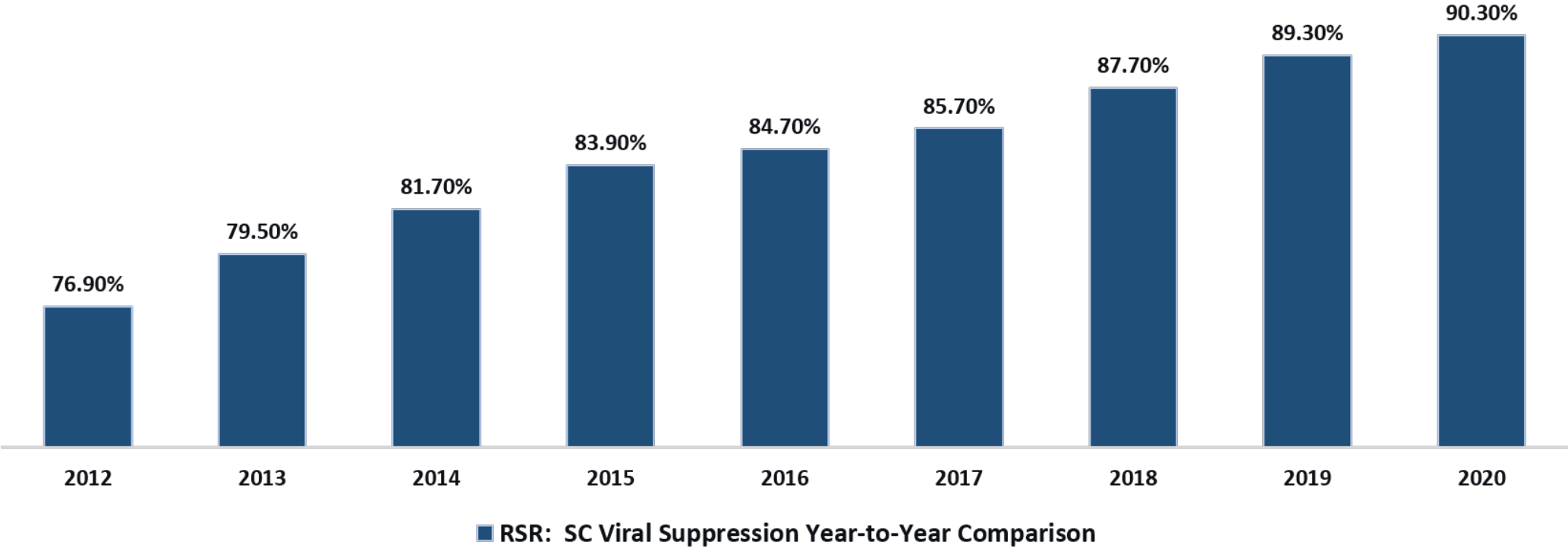
Data Source: RW HIV/AIDS Program Annual Client-Level Data Report, as derived from Ryan White Services Report (RSR) data

South Carolina Ryan White Part B Program

RW Part B Clients Served: 11,428

South Carolina RWB Most Utilized Services, 2020

Type of Service	No. of clients receiving service	No. of visits per category	Average no. of visits per client
Medical Care	8,053	27,976	3
Medical Case Management	9,724	113,481	12

Data Source: 2020 SC Epi Profile

SC Ryan White Part B
EHE Funded Services

- A Request for Grant Applications for Ryan White Part B Ending the HIV Epidemic funds was released in Spring 2021.
  - To be eligible to receive funds, subrecipients were required to develop and implement or expand Rapid Access to Care and ART Initiation.
  - Goals of the program include (1) linkage to care no more than 2-3 days after diagnosis or returning to care, with a strong preference for day of linkage to care, and (2) initiation of ART at the first medical visit.
- DHEC awarded RWB EHE funding to 7 subrecipients to implement/enhance the rapid care and treatment initiative.
  - Additionally, 4 of the 7 requested and were funded for staffing to support behavioral heath needs, including mental health and substance abuse.

Subrecipient RWB EHE Funded Services – Recorded in _Provide Enterprise_ for Tri-Annual Data Reporting

Subrecipient RWB EHE Funded Services
1.   Outpatient Ambulatory Medical Care / Outpatient Ambulatory Health Services
2.   Early Intervention Services (EIS)
3.   Mental Health Services
4.   Substance Abuse Outpatient Care
5.   Medical Case Management (Inc. Treatment Adherence Services)
6.   Non-Medical Case Management Services
7.   Health Education / Risk Reduction (Inc. Peer Adherence and Patient Navigation)
8.   Medical Transportation Services
9.   Outreach Services
10. Substance Abuse Services (Residential)
11. EHE Initiative Services

SC Ryan White Part B EHE Funded Services

EHE Initiative Services – EHE Initiative Services are unique, non-traditional Ryan White Services employed to achieve EHE goals.

EHE Initiative Services funded in South Carolina include -
- specialized linkage to care services for newly diagnosed and returning to care clients
- medication starter packs to facilitate immediate prescription of antiretroviral therapies
- testing, linkage, and immediate medical care via mobile unit
- employment of technology to increase client retention and medication adherence
- programs, trainings, and outreach to increase equitable, culturally appropriate access to HIV treatment and services

EHE Infrastructure – Investments in technological improvements to facilitate more efficient, high-quality care for people living with HIV.

SC EHE Goals and Metrics – Rapid Engagement

-	Current Standard	EHE Goal	EHE Goal Timeline
Confirmatory HIV Positive Test	1. First rapid test - positive result 2. Blood test – confirmatory positive result 3. Linked to Social Worker/Linkage Coordinator **within 7 days** of confirmatory test	Referred to Social Worker/Linkage Coordinator the **same day** as confirmatory test	For organizations not currently referring newly diagnosed patients the same day, reduced the average number of days to referral by 3 days every six months.
Confirmatory HIV Positive Test	1. First rapid test – positive result 2. Second rapid test – confirmatory positive result 3. Linked to Social Worker/Linkage Coordinator **within 7 days** of confirmatory test	Referred to Social Worker/Linkage Coordinator the **same day** as confirmatory test	For organizations not currently referring newly diagnosed patients the same day, reduced the average number of days to referral by 3 days every six months.
Confirmatory HIV Positive Test	1. Blood test - confirmatory positive result 2. Linked to Social Worker/Linkage Coordinator **within 7 day**s of confirmatory test	Referred to Social Worker/Linkage Coordinator the **same day** as confirmatory test	For organizations not currently referring newly diagnosed patients the same day, reduced the average number of days to referral by 3 days every six months.
Days from confirmatory positive test, or re-engagement in care, to first medical visit	**14-30** days (avg. 14)	**Day of** confirmatory positive test (preferred) **2-3 days** (acceptable)	For organizations not currently offering same day appointments, reduce the number of days to first medical visit by 2 days every 6 months.

SC EHE Goals and Metrics – Rapid ART

-	Current Standard	EHE Goal	EHE Goal Timeline
Days from confirmatory positive test, or re-engagement in care, to ART prescription	Not currently defined (typically, follows results of initial lab work)	Day of first visit	Following completion of trainings provided, offer ART initiation at first medical visit
Initial supply of ART	Not available	Supplied during first visit (ex. 5-day starter pack)	Immediate
Initial 30-day supply	Not available	Manufacturer vouchers provided for 30-day supply	Immediate
Access to ADAP	14 days for eligibility checking	3-5 days for eligibility checking – if manufacturer voucher is not available	Immediate
PantheRx	3-4 days shipping	Expedite/Overnight 2-day shipping - if manufacturer voucher is not available	Immediate

SC EHE Goals and Metrics –
Viral Suppression & Engagement in Care

-	Current Standard	EHE Goal	EHE Goal Timeline
Days from confirmatory positive test or re-engagement in care to viral suppression	6 months	4 months or less	If not currently meeting EHE goal, reduce by 10% every 6 months
Percentage of PLWH achieving viral suppression in the measurement year	92% (per Ryan White Statewide Clinical Report Card)	Greater than 92%	If not currently meeting EHE goal, increase by 2.5% every 6 months
Medical visit two or more times, at least three months apart, in the measurement year	84.75% (per Ryan White Statewide Clinical Report Card)	Greater than 84.75%	If not currently meeting EHE goal, increase by 2.5% every 6 months

SC Provide Enterprise – EHE Enrollment Data Points

Element	Response Options
Status	Pending Open Closed
Date Opened	-
Date Closed (if status is closed)	-
Agency Creating	Users Agency Only
Provider Creating	-
Reason for Enrollment	Rapid Access to Care Service Expansion
Rapid Access Type	Newly Diagnosed New to Care Network In Care - Not Virally Suppressed Prison Release Other Reason
Gender at Birth	-
Current Gender	-
Date of Birth	-
Races	(all self-identified)
Ethnicity	Hispanic Not Hispanic

Element	Sub-Element	Response Options
HIV Data	Stage of Disease	HIV AIDS
-	Date of HIV+	Date of HIV+
-	Date of AIDS	Date of AIDS (if applicable)
-	Risk Factors	MSM IDU MSM IDU Heterosexual Other
Address	-	Street Address City County State Zip
Embedded View of Proof of HIV - Scanned Document	-	-
Embedded View of Referrals	-	-
Embedded View of Viral Load Tests	-	-
Embedded View of Scheduled/Kept Medical Visit	-	-
Embedded View of ARV Medication Dispense Records (ADAP Dispenses)	-	-

- Date of Confirmatory HIV Test
- Date of Referral to Linkage to Care Staff
- First ARV Dispense Data
  - Date of First Dispense after EHE Enrollment Opened
  - Drug Brand Name
  - Drug Generic Name
  - Funding Source
  - Days Supply
- Virally Suppressed when Enrollment Opened
- Date Virally Suppressed (first virally suppressed result after Enrollment)
- Date First Medical Appointment Kept after Enrollment Opened
- Date First Medical Appointment Kept at least 90 days after First Medical Appointment Kept
- Date First ARV Dispense record started after Enrollment Opened

- Days between Proof of HIV and Referral to Linkage Social Worker
- Days between Proof of HIV and Viral Suppression
- Days between Proof of HIV and First Kept Medical Appointment
- Days between Enrollment Opened and Viral Suppression
- Days between Enrollment and First Kept Medical Appointment
- Days between Enrollment Opened and First ARV Dispense
- Date between Date of Diagnosis and Date Virally Suppressed
- Two or Medical Visits since Enrollment Opened

Thank You!

www.scdhec.gov

(803) 898-DHEC (3432)

Kentucky RW Part B Program Incarceration Policy

Gloria Dennis

Ryan White Federal Program Specialist,
Kentucky HIV/AIDS Section

Meeting with Jailers' Association

- Once our policy was approved by legal and HRSA, Douglas Thoroughman had a meeting with the Jailers Association to inform all local jails of this new policy.

- **Introduction of PCN-18-02 - The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved.**
  - o Removes barriers to HIV testing and care for those incarcerated in non-federally funded facilities.

- **In the past, all Kentucky Ryan White Programs were prohibited from providing care to all persons living in federal, state, and local prison, jails, or living in half-way houses during the former inmates discharge program.**

Overview of Kentucky Data, as of 06/30/2020

- **11,180** cumulative HIV infections diagnosed and reported.
  - Approximately 2/3 (62%) have progressed to AIDS.
  - **9,242**, reported among males (83% of total cases).
  - Most cases diagnosed 30-39 years of age **(33.1%).**
  - Men who have sex with men (MSM) remains the highest transmission risk category **(~55% of total cases, 67% of male cases).**
- In the last 10 years (January 1, 2010 to December 31, 2019) a total of 3,368 new HIV cases were diagnosed in Kentucky.

HIV and Kentucky Corrections

- Since the beginning of the HIV epidemic, **302** Kentuckians have been diagnosed in Kentucky correctional facilities (local, state, federal), representing **3.9%** of the **11,180** cases for whom Kentucky HIV surveillance has information on facility of diagnosis.
  - For every 100 Kentuckians diagnosed with HIV for whom the data for facility of diagnosis is available, almost three were diagnosed in correctional facilities.

Ryan White (RW) HIV Services Program

- Established in 1990.

- Comprehensive system of HIV primary medical care, essential support services, and medications for low-income people living with HIV who are uninsured or under-insured.

- More than half of people diagnosed with HIV in the United States receive Ryan White services annually.

- In 2020, 89.4% of RW HIV/AIDS Program clients were virally suppressed.
  - National average: 65.5%

HRSA Policy Clarification Notice 18-02

- **Prior to 2018**
  - RW Programs prohibited from providing care to persons in federal and state prison, local jails, or otherwise justice involved (half-way house, etc.).
- **November 30, 2018**
  - Introduction of Policy Clarification Notice 18-02 - The Use of RW HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved
  - Removes barriers to HIV testing and care for those incarcerated in non-federally funded facilities.

HRSA Policy Clarification Notice 18-02

- Two classifications of RW care for persons living in jails and prisons.
  - **Short Term – Applies to Local/County Jails**
    - Refers to "time-limited provision of core medical and support services not prohibited by the statutory payor of last resort requirements."
    - HRSA HAB* lets jurisdictions determine the time limitation.
    - HRSA HAB* recognizes that, in some instances, the time limitation will equal the duration of incarceration.
  - **Transitional - Applies to Prisons and Jails receiving Federal and State Funding**
    - Time-limited HIV medical and support services to ensure linkage to and continuity of care for those who will be eligible for Ryan White services after release.
    - Effective when release is imminent.
    - HRSA HAB* defers to recipients/sub-recipients for a determination of the time limitation.
      - Generally 180 days or fewer

* Health Resources and Services Administration, HIV/AIDS Bureau

In Summary: Funds for HIV+ Persons who are Locally Incarcerated

- RW HIV/AIDS Program Funds now available for people living with HIV who are incarcerated in local and county jails.

- Help people living with HIV stay virally suppressed while incarcerated and reduce the risk of spreading HIV.

- Allows for core medical and support services to be covered.

- Transitional care only for state and federal prisoners.

KY RW Part B Program Components

- **Kentucky HIV/AIDs Care Coordinator Program (KHCCP)**
  - Oversees management of RW Part B core medical and support services
  - Core medical services include: ambulatory medical care, laboratory testing, mental health services, oral health services, etc.
  - Support services include: transportation, nutrition services, etc.

- **The Kentucky AIDS Drug Assistance Program (KADAP)**
  - Designed to ensure that every HIV+ person residing in Kentucky receives life-saving HIV medications.
  - Available KADAP medications are listed on a KADAP drug formulary managed by a team of medical professionals.
  - Available by mail order pharmacy- Kentucky Clinic Pharmacy.

- **Sub-recipients**
  - Subcontractors of the KHCCP or KADAP programs.
  - Selected either as regional providers or by their proximity to areas with above-normal incidence of HIV.
  - Direct providers/coordinators of Ryan White Part B Services.

KHCCP & KADAP Services for HIV+ Incarcerated Persons

- **KHCCP and KADAP**
  - AIDS Drug Assistance Program Treatments
  - Early Intervention Services (EIS)
  - Medical Case Management
  - Linguistic Services
  - Medical Transportation

Kentucky RW Part B Program
Policy and Procedure for Implementation

- Facilities who wish to have their HIV+ inmates receive RW Part B Services should reach out to the Ryan White Services Care Provider/Coordinator in their region to complete the required questionnaire.

- The questionnaire will be submitted to the KADAP Administrator for review and approval.

- Facility staff and RW Services Care Provider/Coordinator staff should collaborate on a plan to identify HIV+ individuals and link them to necessary core medical and support services.

Kentucky HIV Care Coordinator Regions

Kentucky map showing HIV Care Coordinator Regions (Regions updated 03/21/2019)

Matthew 25
Allen, Barren, Breckinridge, Butler, Daviess, Edmonson, Grayson, Hancock, Hardin, Hart, Henderson, Larue, Logan, McLean, Marion, Meade, Metcalfe, Monroe, Nelson, Ohio, Simpson, Union, Warren, Washington, & Webster

NKY District HD
Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, & Pendleton

UK Bluegrass Care Clinic
Anderson, Bath, Bourbon, Boyd, Boyle, Bracken, Carter, Clark, Elliott, Estill, Fayette, Fleming, Franklin, Garrard, Greenup, Harrison, Jessamine, Lawrence, Lewis, Lincoln, Madison, Mason, Menifee, Mercer, Montgomery, Morgan, Nicholas, Powell, Robertson, Rowan, Scott, & Woodford

U of L KCCP
Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, & Trimble

LivWell Community Health Services
Ballard, Caldwell, Calloway, Carlisle, Christian, Crittenden, Fulton, Graves*, Hickman, Hopkins, Livingston, Lyon, McCracken, Marshall, Muhlenberg, Todd**, & Trigg
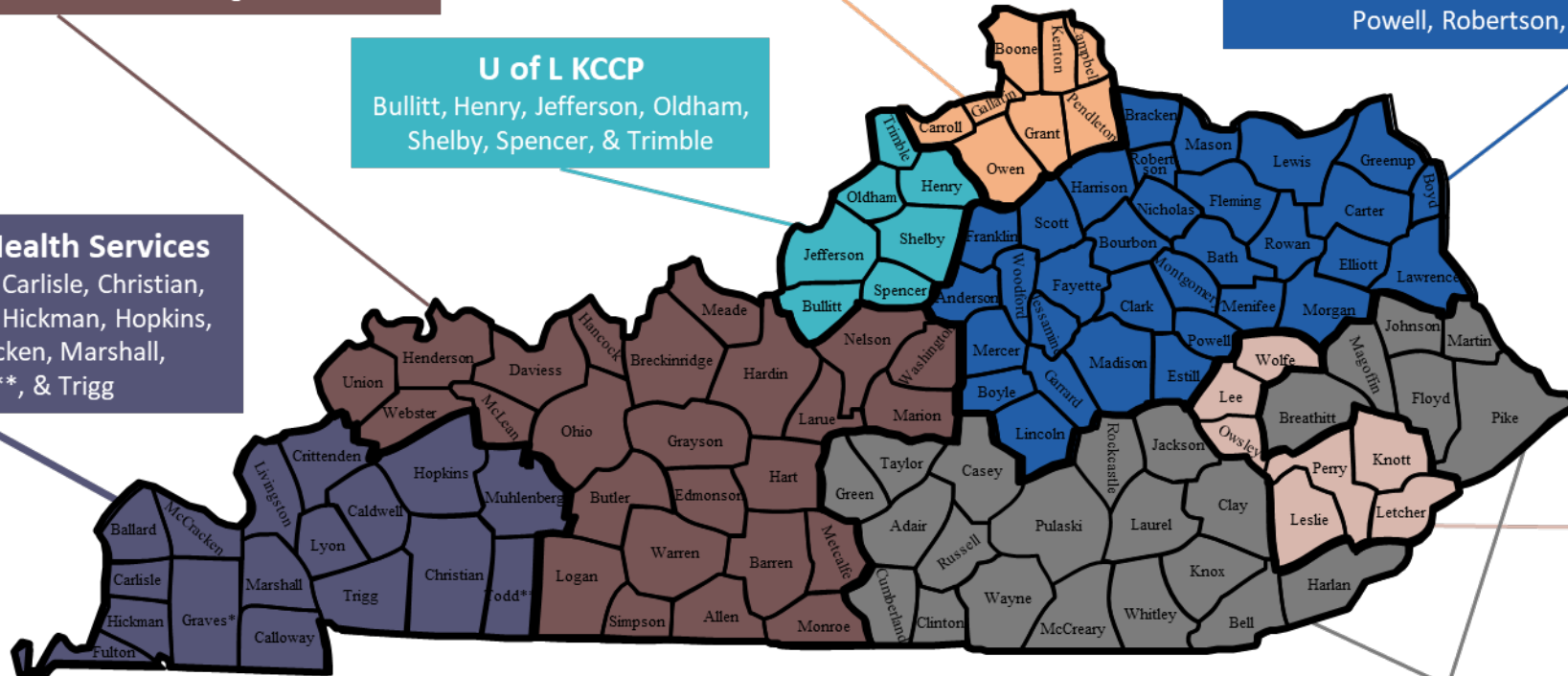
KY River District HD
Knott, Lee, Leslie, Letcher, Owsley, Perry, & Wolfe

Lake Cumberland District HD
Adair, Bell, Breathitt, Casey, Clay, Clinton, Cumberland, Floyd, Green, Harlan, Jackson, Johnson, Knox, Laurel, Magoffin, Martin, McCreary, Pike, Pulaski, Rockcastle, Russell, Taylor, Wayne, & Whitley

*Graves County is currently being served by both Heartland CARES, Inc. and the Graves County HD.
**Todd County is currently being served by both Heartland CARES, Inc. and the Todd County HD.

Q & A

Contact:

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5025646539 ext. 4279

Questions?

Transmission Cluster

- Transmission cluster is a group of HIV–infected persons (diagnosed or undiagnosed) connected by HIV transmission.

- Transmission clusters can represent recent and ongoing HIV transmission in a population where prevention efforts could prevent new infections.
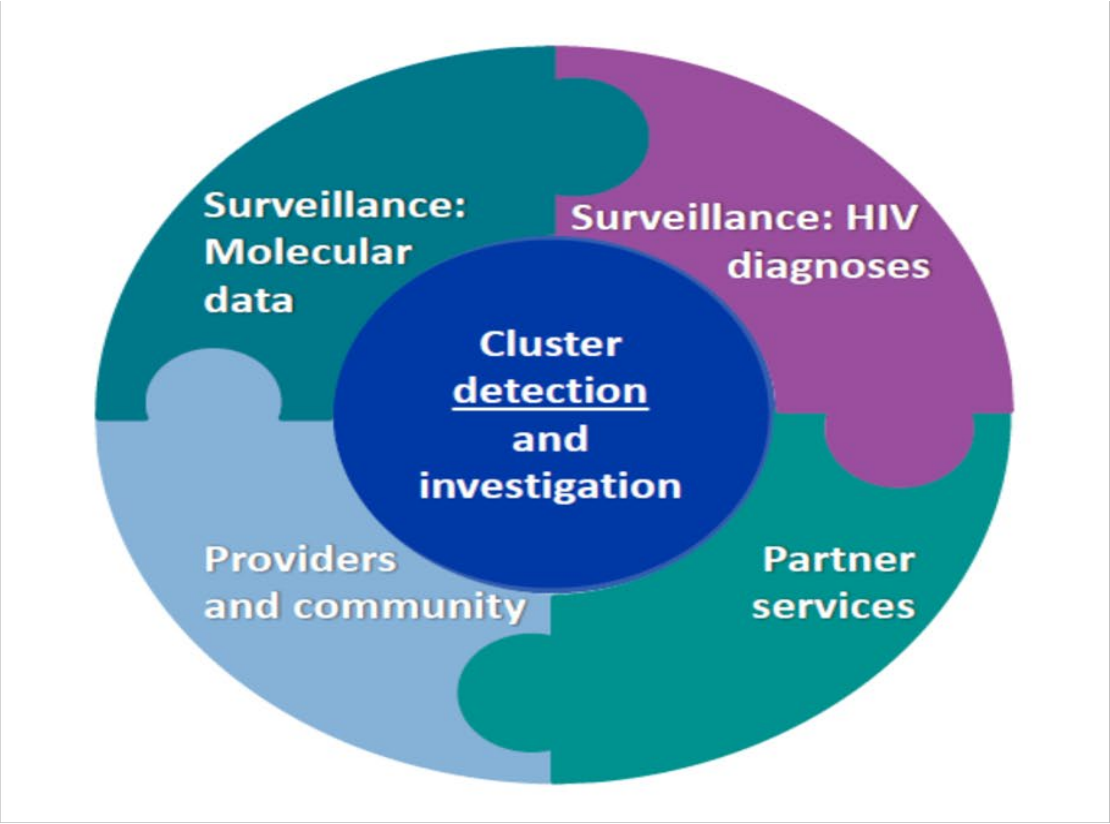
https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS-18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

Why detect an HIV Cluster?

- More than 1 million people with HIV infection in the United States.
- Overall, only 4 transmissions per 100 persons living with HIV each year.
- For Clusters, 44 transmissions per 100 persons living with HIV each year.

Oster AM, France AM, Panneer N, Bañez Ocfemia MC, Campbell E, Dasgupta S, Switzer WM, Wertheim JO, Hernandez AL. Identifying Clusters of Recent and Rapid HIV Transmission Through Analysis of Molecular Surveillance Data. J Acquir Immune Defic Syndr. 2018 Dec 15;79(5):543-550. doi: 10.1097/QAI.0000000000001856. PMID: 30222659; PMCID: PMC6231979.

Identification of HIV Cluster

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

Identification of Transmission Clusters

- Transmission clusters can be identified through multiple mechanisms:
  - Astute health department staff, care providers, or community members
  - HIV partner services and contact investigations
  - HIV case surveillance data
  - **Molecular HIV surveillance data**

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS-18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

MHS Data Flow: Collection of HIV Nucleotide Sequences
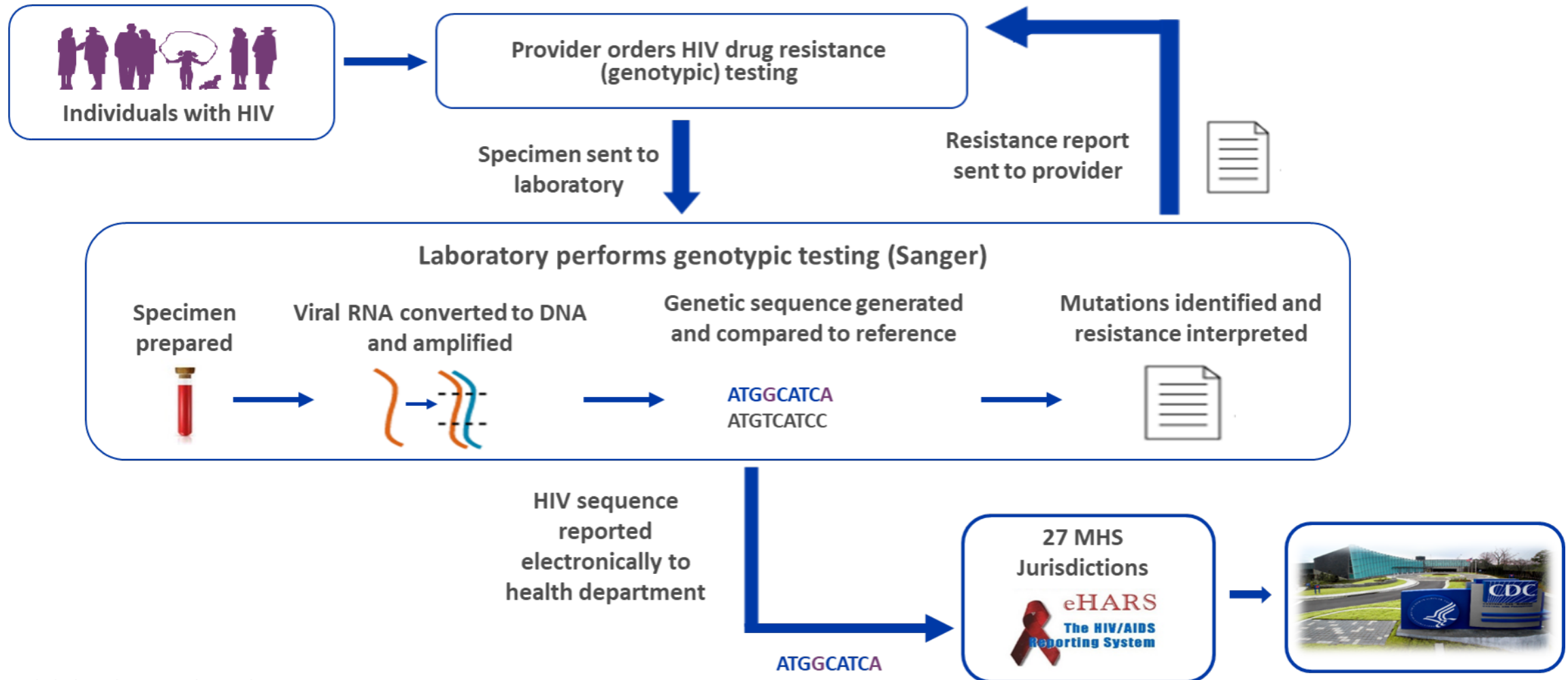
Molecular Cluster

- A molecular cluster is a group of persons with diagnosed HIV infection who have genetically similar HIV strains.

  o The genetic sequence of HIV accumulates changes over time, sometimes rapidly.

  o Immediately following transmission of HIV between two people, the genetic sequence of the HIV strain in the recipient will be nearly identical to strains found in the transmitting person.

  o As time passes, however, the strains infecting each person will change independently of one another and will look more and more different.

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS-18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

Molecular Data and Clusters

- Why do we use molecular data for cluster identification?
  - A transmission cluster can not always be detected as an increase in diagnoses.
  - A transmission cluster may not be local to a certain area or jurisdiction.
  - If a cluster is occurring in an area with a lot of diagnoses, it is hard to detect the increase.

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS-18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

What do Molecular Clusters tell us?

- Molecular clusters may represent recent and ongoing HIV transmission, which is critical for focusing HIV prevention efforts where they are needed most.

- Because HIV is constantly evolving, people whose viral strains are genetically similar may be closely linked – directly or indirectly – by transmission.

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS-18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

What do Molecular Clusters NOT tell us?

- Two individuals may be linked because they have a similar HIV genetic sequence, but this does not mean that one person transmitted HIV to the other.

- The genetic information only tells us that there is a link between two people, but cannot tell who gave the virus to whom.

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS-18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

What does it mean when two nucleotide sequences are closely related?
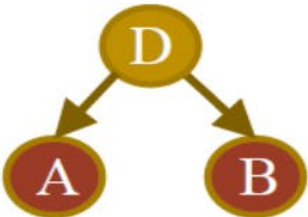

A → B
Person A infected person B

OR

A ← B
Person B infected person A

OR

A → C → B
Person A infected person C, who infected person B

OR

D → A, D → B
Persons D infected persons A and B

We can infer that there is either a direct OR indirect epidemiologic link
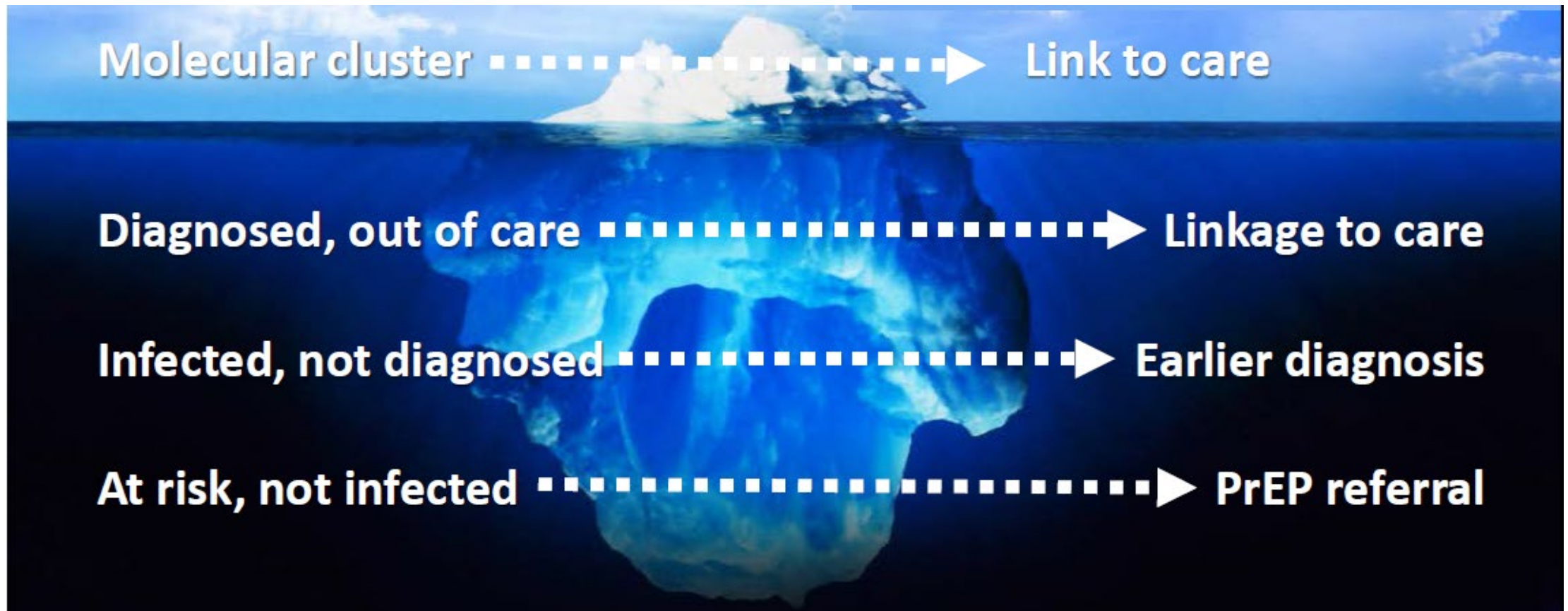**We cannot infer directionality**

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf

Facts to Remember

- Molecular analysis identifies groups of HIV strains that are very similar.

- Because HIV evolves quickly, similar viral strains signal that HIV transmission is occurring rapidly within a common network.

- Molecular analysis uses laboratory data that are already generated through routine medical care after a person is diagnosed with HIV.

https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttachmentE-Detecting-Investigating-and-Responding-to-HIV-Transmission-Clusters.pdf
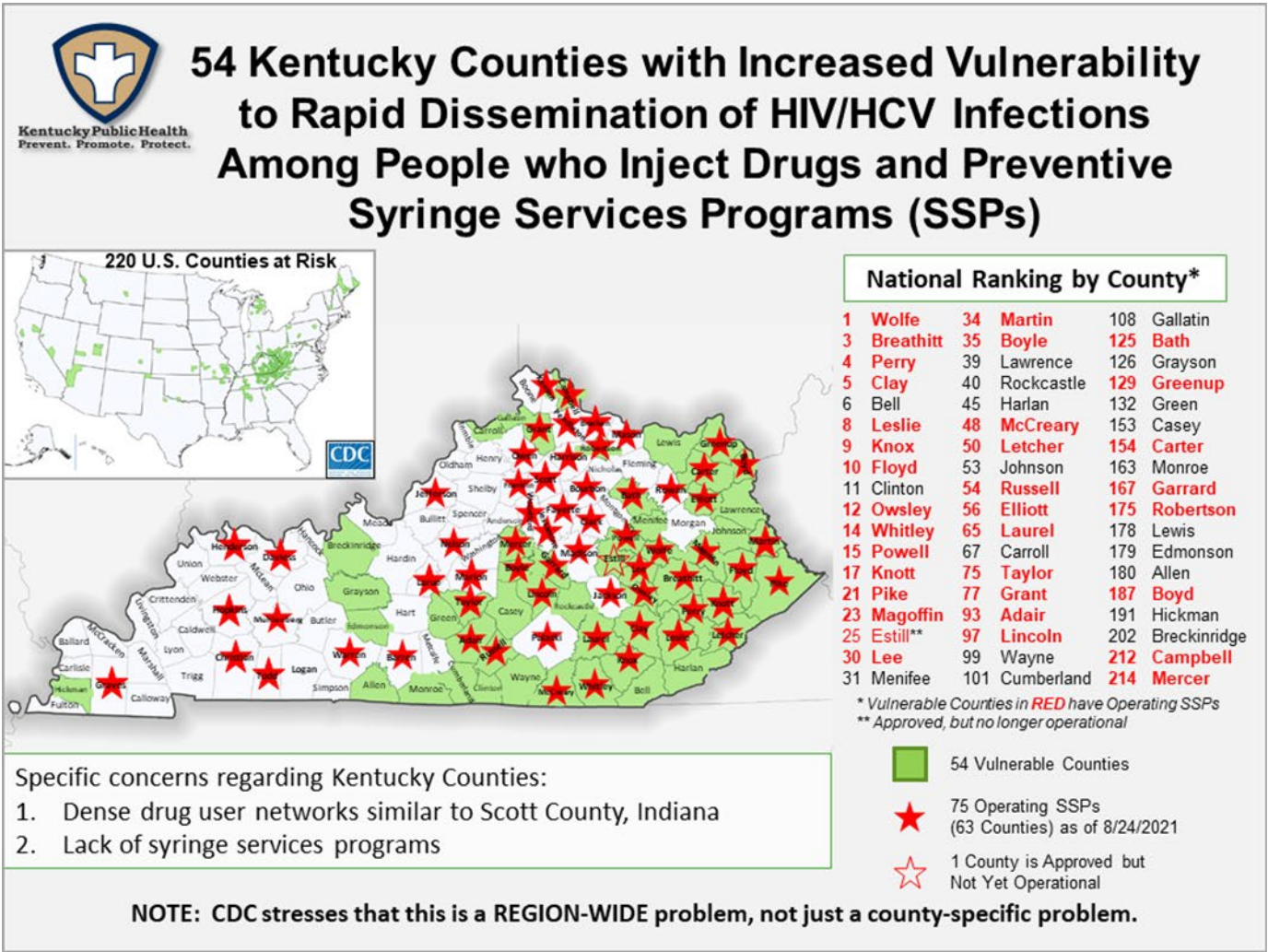
Needs

Molecular cluster ·····▶ Link to care
Diagnosed, out of care ·····▶ Linkage to care
Infected, not diagnosed ·····▶ Earlier diagnosis
At risk, not infected ·····▶ PrEP referral

Oster_Muckleroy_HIV in 3D_Cluster Outbreaks; HIV/AIDS CDC Grantees Meeting, 2019.

Increased Vulnerability

Cluster Outbreak Investigations

2017-2020: Cincinnati Metro and NKY among PWID

2014: Austin, IN among PWID

2018-2019: Jefferson County among MSM
2021: PWID, MSM

2018: Hardin County among MSM

2019: Cabell County, WV among PWID
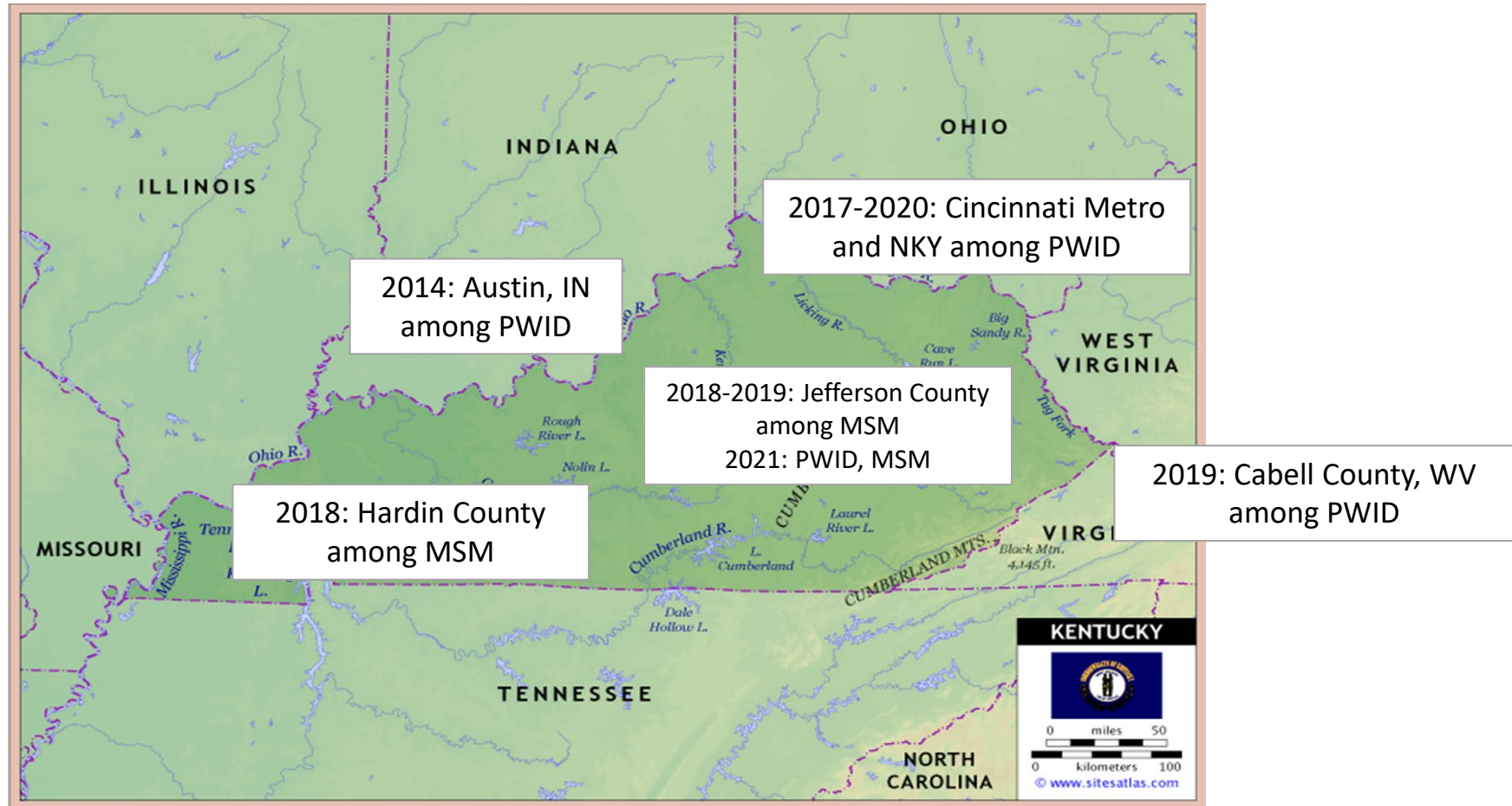
Kentucky HIV/AIDS Surveillance Data 2021; http://libertaddeeleccion.org/geographic-map-of-kentucky/

- Encounters
  - Mean # encounters before HIV diagnosis: 4.1
  - Percent with prior HIV(-) 12 months before diagnosis: 19.3%
  - Cases receiving PrEP or PEP: 0
- Overdoses
  - Percent with ≥1 overdose prior to HIV diagnosis: 45%
  - Mean overdose encounters prior to HIV diagnosis: 1.0 (range 0-6)
  - Percent with ≥1 HIV test at time of overdose
    - KY cases: 14.3%
    - OH cases: 25.0%

CDC Epi-Aid Team findings for Northern Kentucky-Cincinnati HIV Cluster

Q & A

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Questions?

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