III. Early Identification of Individuals with HIV/AIDS (EIIHA) Update

a. Describe the activities of the EMA/TGA's EIIHA Plan that were implemented during FY18. Indicate specific outcomes of each activity. Indicate any challenges or successes for each activity.

Identification of individuals who do not know their status

HIV testing was strengthened through a number of ways: 1) Implementation of opt-out HIV testing for all patients ages 13-64 was completed in one Ryan White Part A agency; 2) HIV rapid testing (INSTI) for Ryan White clients which uses simple flow-through technology to detect HIV-1 and HIV-2 antibodies using a drop of human finger stick blood was also provided; The test is intended for use by untrained lay users as a self-test to aid in the diagnosis of HIV-1 and HIV-2 infection using a small drop (50µL) of blood obtained through finger stick collection procedures. This INSTI HIV self-test detects HIV infection quick and accurate with convenience and privacy protection; 3) HIV testing was also conducted through local jails, contracted community-based organizations; and 4) continued to expand routine testing in juvenile justice facilities.

Successes: Rapid/INSTI testing was utilized which allowed for preliminary test results to be obtained without the need to return for results. It also reduced the time involved in linkage to care and potentially removed the transportation barriers of routine HIV testing. Expanded testing hours and locations provided more venues to identify individuals who do not know their status. Additional efforts were made to establish partnerships in the private medical community with linkage staff. Prevention staff and RW staff working together to successfully link and retain patients and eliminate barriers. One agency successfully performed an average of 1,000 HIV tests a month, had over 90% linkage to care for HIV patients, and has offered at least one training a month. Direct referrals of newly diagnosed increased from 0 to approximately 50 in FY2018.

Universal testing was used within the healthcare setting to reduce stigma associated with HIV and to normalize HIV testing by offering it as part of the regular medical visit. Mobile testing units provided testing service at a number of organizations: treatment centers, community centers, pharmacies, apartments, churches, parks, concerts, and special events. Expanded testing was provided during non-traditional hours (evenings, weekends) at Same Gender Loving (MSM) night clubs and other venues. Targeted testing was primarily provided through a mobile testing unit utilizing surveillance mapping.

Making such individuals aware of their status and linking them to HIV care, and enable them to use health and support services.

All Ryan White Part A sub-recipients had weekend and/or evening hours to facilitate access for individuals who are not able to make traditional-hour appointment. Rapid entry to care was set up at several sites with designated providers to enable patients to see the medical

provider during the 1st visit and were given ART. Implemented medical case manager to make sure newly diagnosed patients are linked into care. Ensured eligible patients enrolled in ADAP and case management. Re-enrolled patients out of care or lost to care into HIV medical care. Substance abuse day program, psycho social support groups and individual counseling were offered in Ryan White Part A sub-recipients. Utilizing a full cadre of staff to facilitate linkage to care through Patient navigator program, peer support presence in staff meetings and program planning.

Successes: Linking newly diagnosed HIV positive patients into medical care in less than 30 days (one agency reported in average of 6 days). Moving prevention to be in the same place as treatment helped newly diagnosed from the prevention side linked to care the same day. MAI was added to service category and the number of minority who returned to care was increased. Increased overall client enrollment in services. Integrated prevention and treatment into a multiple-site FQHC while linkage and treatment performance measures remain high. Increased number of newly enrolled clients and reenrollment of those out of care. Established formal direct referrals of PLWH from RW providers to sub-recipients. Peers now participate consistently in program development and help increase clients retention via Trans Support Group.
Rapid entry was expanded via mobile unit by providing targeted HIV testing to at risk population.

Reducing barriers to routine testing-affected and underserved
Developed ongoing QM initiative through admission tracking, client participation and linkage to care via monthly census log. All TB tested individuals also tested for HIV. Offered cultural humility training for staff to reduce stigma and bias in the clinics. Monthly chart audits and census tracking tool gives data in real time and measure the performance for overall program goals.

Partnership building: Continued to engage current partners to send positive clients for care and treatment. Meeting with partners to go over details of eligibility and answer questions. Collaborated with Department of Correction for rapid entry into care of those inmates with HIV. Fear of stigma and discrimination is a factor discouraging testing, including fear of exclusion from housing or shelter. Partner with HOPWA and housing providers presented important opportunities for HIV testing.

Successes:
Increased testing numbers, more patients co-managed with TB/HIV, broader testing span, increased viral suppression rates. Increased enrollment by 40 % via improved inter-agency referrals, Improved f/u tracking to ID actual medical F/U appointment within our own clinic and outside clinic. Collectively met or exceeded all identified goals serving MSM/Trans living with HIV and drug use.

Challenges:

- Biggest challenges is related to inadequate funding to support the increasing needs and consumer participants from target communities.
- Staff shortage and turnover kept us struggling with submitting State Electronic Notifiable Disease Surveillance System (SENDSS) data in a timely effort.
- Barriers of increasing awareness of HIV status and education regarding the benefits of early HIV treatment.
- Keeping clients in care and constant reminders about them staying on medications and coming back to see their providers every 3-4 months.
- Streamlining the process in prevention, linkage to care and retention in care.
- Tracking client services in Care Ware needs improvement.
- Target population: Testing site selection for MSM population; Engaging people in the middle 20's to late 30's as well as having reliable contact information.

b. Describe how the overall FY18 EIIHA Plan contributed to the National Goals to End the HIV Epidemic.

The FY18 EIIHA plan was created in line with the National Goals to End the HIV Epidemic. The strategy's three primary goals--*reduce new HIV infections, increase access to care and optimize health outcomes for people living with HIV(PLWH)*, and *reduce HIV- related health disparities and health inequities*—was reflected by the three planned activities in 2018 EIIHA plan. They are: 1) Identifying individuals who do not know their status, 2) Making such individuals aware of their status and linking them to HIV care, and enable them to use health and support services, and 3) Reducing barriers to routine testing-affected and underserved. Both EIIHA plan, the integrated plan, and the Futon county strategy to end the HIV epidemic utilized the same goals and objectives. Interagency partnerships were developed between HIV stakeholders and the National Goals to End the HIV Epidemic was used as a baseline for all HIV prevention and care activities.

c. Describe how the FY18 EIIHA Plan incorporated and addressed activities surrounding the target populations identified in the application.

The target populations identified in the application are: Young Black MSM (13-24), Black MSM (25-44), and Black Female. These demographics are heavily impacted by HIV with worse health outcomes than other age/racial groups in the 20 counties within Metro Atlanta. To address their unique needs and barriers to care, a number of activities have been taken place and will continue to make efforts in reducing health disparities.

To increase numbers of HIV testing, walk-in testing was allowed in several clinics, and encouraged couples to get tested together. HIV testing was also integrated in testing events with community events in parks, college health fairs, and other community venues to reach young people at rick. There was also continued efforts in working with Ryan White Part D to address vertical transmission of HIV which is related to Black women.

Cultural competency training was provided to make targeted populations comfortable when receiving HIV test. Additionally, clinicians were also trained that on how to use appropriate

language to inform clients of their HIV status without stigma or hurt. New collaboration were built with Morehouse School of Medicine's project to reach hard-to reach populations. Partnerships were forged with Atlanta Board of Education to implement HIV testing in high school clinics and continue to push opt-out education to internal providers.

d. ***Since your last grant application submission, describe any efforts undertaken to remove legal barriers to routine HIV Testing, including barriers at the State/Local laws and regulations. State "None" if no efforts have been undertaken.***

Georgia has several laws which criminalizes HIV and some argue that Georgia's criminalization statute is a barrier to HIV testing because it deters people from getting tested for HIV; "*people don't get tested because they're afraid they'll be charged with a crime.*" There are efforts to repeal Georgia's HIV criminalization statute for this and other reasons. A bill was introduced in the 2019 session: http://www.legis.ga.gov/legislation/en-US/Display/20192020/HB/719. Atlanta Legal Aid (Ryan White Part A) is not involved in these repeal efforts because federal regulations prohibits grassroots lobbying and advocating for statutory reform. Georgia's repeal efforts are being coordinated by the Positive Justice Project (PJP, https://www.hivlawandpolicy.org/initiatives/positive-justice-project) and the Sero Project (www.seroproject.com).

Testing Data - January 1, 2018 – December 31, 2018:

State of Georgia

i.	Total number of publicly funded Test Events	111,193
ii.	Total number of New HIV positive tests	813
iii.	Total number of previously diagnosed HIV positive individuals	873
iv.	Total number of new HIV positive individuals with results received	484
v.	Total number of new HIV positive individuals linked to medical care	719
vi.	Total number of previously diagnosed HIV positive individuals linked to medical care	598
vii.	Total number of new HIV positive individuals who received partner services	437
viii.	Total number of new HIV positive individuals linked and referred to prevention services	N/A
ix.	Total number of new HIV positive individuals who received CD4 cell count and viral load testing	N/A
x.	Total number of previously diagnosed HIV positive individuals linked to and accessed CD4 cell count and viral load testing	N/A
Source: C&T – HIV Counseling and Testing Database, as of 07 May 2019. Georgia Department of Public Health, Division of Health Protection, HIV Prevention Unit, LM		

Fulton County

i.	Total number of publicly funded Test Events	30,071
ii.	Total number of New HIV positive tests	395

iii.	Total number of previously diagnosed HIV positive individuals	242
iv.	Total number of new HIV positive individuals with results received	393
v.	Total number of new HIV positive individuals linked to medical care	300
vi.	Total number of previously diagnosed HIV positive individuals linked to medical care	122
vii.	Total number of new HIV positive individuals who received partner services	83
viii.	Total number of new HIV positive individuals linked and referred to prevention services	335
ix.	Total number of new HIV positive individuals who received CD4 cell count and viral load testing	*
x.	Total number of previously diagnosed HIV positive individuals linked to and accessed CD4 cell count and viral load testing	*
*these variables are not tracked within GA and Atlanta instances of EvalWeb Source: Fulton County Department of Health and Wellness		

e. Based on the three target populations identified from the FY18 application, describe EIIHA Plan activities that were successful or unsuccessful. Include the following:

a. For the EIIHA Plan activities that were successfully implemented:

i. Describe **what was done** to achieve the successful outcomes;

- Adding staff through new or additional funding. For example, hiring a medical case manager through Ryan White Part A funds aided in ensuring linkage to care.
- Developed and presented a training module for RW clinics to start the direct referrals, and established new offsite intake at clinics upon request.
- Outreach activities have been done to implement HIV testing and HIV prevention education.
- Maintained great partnerships with outside agencies through constant communication, and collaboration with other providers on the inter-agency referral process.
- Built linkage networks with private providers, OBs substance abuse and mental health providers, FQHC, community care providers. Designed linkage form and steps to assist providers in delivered by HIV results; build capacity of area partner agencies to provide testing and serve as Rapid Testing sites. Streamlined and incorporated PS 18-1802 High Impact HIV with the Ryan White Program providers. Continue to emphasize rapid testing and rapid entry services and maintain active referrals from website advertising and community knowledge.

ii. Describe **the resources and partnerships** used (both internal and external to the program);

- Ryan White Part B and GA Department of Public Health: Data to Care activities and piloted an Out of Care EHARS re-engagement program
- Linkage to care: Continue to work on establishing collaborations with other medical clinics in Cobb/Fulton/DeKalb. Contacted with DFCS UDS program to gain access to their referral system. Working with a testing organization called "A Vision For Hope" allowed us to link newly diagnosed and patients seeking PrEP within 2 business days
- Community partnership: partner with PRIDE, Drag Races, Manifest, Flex, Hideaway, Sanctuary and MSM club owners for HIV testing, HIV/STI Prevention Education, PrEP enrollment and education.
- Housing: Internal emergency lodging and partnership with Living Room

iii. Describe **any barriers and/or challenges** faced in achieving the specific successful outcomes.

- **Funding**: Need more funding to cover HIV testing events, PrEP, and employment cost.
- **Agency**: Some RW providers were non-responsive to collaboration requests or trainings could not be scheduled.
- **Care**: the need to respond immediately to the sense of urgency presented with a walk-in client for testing; needs immediate care in conflict with the ongoing care of our chronic patients. Client enrollment and retention can be challenging as they must be motivated to engage in OPBH f/u services on a consistent basis.
- **Client**: A great deal of what happens is reliant on the client's readiness and/or their contact information being accurate.
- **Other**: too many "to do's" for management of all grants and not enough time; shortage of available housing.

b. For the EIIHA Plan activities that were unsuccessfully implemented:

*i. Describe any **barriers and/or challenge**s faced;*

- Shortage of staff members and funding
- Paper charts limited the information sharing with patients
- Challenges in identifying contact person when doing collaboration with communities
- Limited number of rural providers
- Testing burnout
- Organizational infrastructure

*ii. Describe **what could have been done differently** to achieve more favorable outcomes;*

- Additional persons could have been hired whose job duties specifically involved SENDSS reporting to Georgia Department of Public Health.
- There could have been more venues for MSM testing, multiple funding streams, and more collaborations with prospective community partners.
- Electronic Medical records would help to better to share information.
- A tracking list to capture anyone who could needed to be contacted for follow-up.
- In some of the rural area there is resistance to adapting some HIV testing policies; there are still area where there is no access to free HIV testing.

iii. Describe the resources and partnerships that could have been used (both internal and external to the program) to achieve a more favorable outcome.

- Department of Health DIS officers
- Collaboration with providers and case management agents; navigation to mental health and substance abuse services within the community.
- Funding Resources
- Grady IDP, Positive Impact and local CSB to market Ryan White services, Trans services, MSM club owners, Living Room HOPWA, and OPBH counseling services
- Ongoing activities to engage rural providers

f. Describe how you have shared EIIHA plan outcomes with the HIV stakeholder community (e.g., presentations at conferences, journal articles, presentations to planning bodies, etc.).

EIIHA plan outcomes were shared both internally and externally. Presentations were made at Georgia Prevention and Care Council meetings, Consumer Advisory Board meetings, Quality Management trainings and Assessment Committee/Planning Council meetings. Information was shared at County Board of Health meetings, provider meetings and RW Consortium meetings. Additionally, there was collaboration with other Districts to train on the protocol of *Linkage to Care and Data to Care*.