FY 2020 EIIHA Plan
Early Identification of Individuals with HIV/AIDS

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

1) The planned EMA EIIHA activities for FY2020

In 2020, the EIIHA strategies will continue to identify individuals with HIV who do not know their status, make such individuals aware of their status and enable them to access core medical and support services, reduce barriers to routine testing, and reduce disparities in access and services among affected subpopulations and historically underserved populations.

a) Primary activities that will be undertaken:

Identify individuals who do not know their status:

- HIV Testing: Continue to provide HIV testing and partner services in Ryan White OAHS sites for partners, friends, or family members of Ryan White clients (funded via CDC Prevention funding). Work with local jails to ensure that HIV testing takes place and continue to expand routine testing in juvenile justice facilities.
- System level changes: Implement HIV opt-out testing policy at all County operated medical clinics; require all mental health and substance abuse service entity contractors to provide HIV testing and linkage to care; expand partner services by health department staff at community based organizations; and work on fully incorporating HIV testing into routine medical laboratory testing.
- Surveillance Data: Use surveillance data to identify HIV positive individuals who are not in care, link them to care, and support the HIV Care Continuum.

Make individuals aware of their status and enable them to use health and support services:

- Service expansion: Expand use of Rapid Entry Clinics to link PLWH to care (and access to ART) within 72 hours. All RWPA subrecipients will continue to have weekend and/or evening hours to facilitate access for individuals who are not able to make daytime appointments. A clinician will be assigned to mobile testing units so that individuals testing positive for HIV can immediately have their first medical appointment, including ART initiation, and high risk individuals with a non-reactive test result can initiate PrEP (medications paid for by non-Ryan White source).
- Linkage to care: Staff will be available to support clients from the time of their new diagnosis through linkage to care, and will continue to assist clients as needed to help them adjust to life with HIV. RWPA funded Patient Navigators serve clients in education, peer counseling, support, and assistance with navigating the healthcare system. As PLWH, Patient Navigators will share strategies to help those newly diagnosed remain engaged in HIV care, and navigate them through the challenges/barriers. Medical Case Managers will be used to assist with identifying the needs of those newly diagnosed or enrolled into care, to help link clients to the appropriate services, support client's continued engagement and retention in medical care, and help clients achieve the ultimate goal of viral suppression. Medical Case Managers will also provide medical adherence counseling, and facilitate linguistic services for those who need translation support at appointments, medical transportation assistance to case management and clinic appointments, and mental and oral health services. Medical Case Managers will work with clients to develop an individualized service plan that helps identify and address both immediate and long-term issues, and will be tasked with educating and advising clients

on how to identify potential barriers to care, and connect them to appropriate staff. Clients will be educated on the importance of retention in care, adherence to HIV care appointments, medication scheduling, accessing prescriptions, and how to communicate with case managers or health center staff to address concerns should they arise. Non-Medical Case Managers (Self-Management Coordinator) will help to facilitate linkage to and continued engagement in care by offering medically stable clients with low intensity social service needs, to serve as someone they can reach out to as needed. Referrals for Healthcare and Support staff (Client Benefits Specialists) are also included as a component of the EIIHA strategy as they help clients access resources that they may not have otherwise known they were eligible to receive by assisting them to complete and submit applications for client assistance programs and referring them to ACA counselors and navigators or other benefit programs. These efforts ensure additional safeguard for informing the newly diagnosed of their status.

- Continue to refine the State Electronic Notifiable Surveillance System (SENDSS) Linkage Module to connect the client's lab testing history including name of agency where they tested, with the client's partner services interview(s) inclusive of named partners, with the client's linkage referral and linkage outcomes.
- The Substance Abuse Prevention and Treatment Block Grant (SABG) program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity to prevent and treat substance abuse. The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the cornerstone of States' substance abuse prevention, treatment, and recovery systems. In Georgia, 38 SAPT HIV Early Intervention Service (EIS) programs are funded. In 2018, 12,728 individuals were tested for HIV through SAPT HIV EIS funds - 36 individuals had reactive test results – all of whom were unaware of their HIV infection in the prior 12 months.
- Since 1996, the Department of Behavioral Health and Developmental Disabilities (DBHDD) Early Intervention Services (EIS) program has tested over 200,000 individuals for HIV. On behalf of DBHDD, Imagine Hope, Inc. manages the EIS program. A network of EIS nurses and counselors are embedded in 39 DBHDD substance use treatment facilities, including medication assisted treatment (MAT) clinics, throughout the state. Through the HIV EIS program, HIV prevention services are offered on-site in the 39 participating substance use treatment facilities. HIV EIS workers offer free HIV prevention education, counseling, and testing to people entering treatment. HIV-positive clients, whether previously or newly diagnosed – are referred to medical care and social services. HIV EIS staff develops and enhances relationships with other healthcare providers, working together to assist in the development of a network of medical and social service providers that serve the substance-use population.
- System level interventions: Allowing for presumptive eligibility with the understanding that eligibility documentation MUST be provided at the next visit or the visit must be rescheduled until such time that documentation is provided. Presumptive eligibility allows individuals with proof of HIV status to be enrolled while collecting other required documents (e.g., proof of income, and proof of residency). This policy is designed to lessen barriers to care caused by the need to have all eligibility paperwork before being enrolled into Ryan White services; Continuing to improve the RWPA process for

allowing eligibility documentation to be scanned into CAREWare and accessed by other providers so clients do not have to provide the paperwork to each provider from whom they seek services. Ensuring all Ryan White subrecipients are aware of EMA policies and procedures which allow individuals with only a preliminary positive test result to enter care and RWPA funds may be used for confirmatory HIV testing; ensuring clinicians are following current protocols of ART initiation regardless of CD4 count or viral load.

Reducing barriers to routine testing – affected and underserved

- **Stigma:** The U.S. Preventive Services Task Force recommends HIV screening for all persons aged 15 to 65, but only about half of all Americans have ever been tested, including many at the highest risk. Fear of stigma and discrimination is still a factor discouraging testing. RWPA continues to utilize social marketing, social media, education, awareness-raising, and routine HIV testing to reduce stigma surrounding HIV. The EMA will support initiatives to normalize HIV testing and detect HIV more quickly. Other efforts include the use of social network testing which reduces stigma by enlisting peers to promote access to testing services, and targeting testing messages among high-risk communities.
- **Housing:** Housing status is a stronger predictor of HIV health outcomes than individual characteristics such as gender, race, age, drug and alcohol use, mental health issues and receipt of social services.[30,31] Persons experiencing homelessness are at heightened risk of acquiring HIV, with rates of new infections as high as sixteen times the rate in the general population. Even after accounting for other factors such as substance use, mental health and access to services, the condition of homelessness is independently associated with increased rates of behaviors that can transmit HIV. Fear of exclusion from housing or shelter plays a negative role in getting people in HIV testing. Partnerships between the U.S. Department of Housing and Urban Development (HUD) housing programs and other service organizations present important opportunities for HIV education and testing to support HIV prevention, timely HIV diagnosis, and linkage to ongoing medical care for both HIV positive and HIV negative persons.[32]
- **Increasing HIV testing:** Work will continue on increasing HIV testing in geographical areas with high burden of disease among priority populations BMSM, MSM, transgender, Black Females, and Hispanics. Efforts will be taken to employ members of target populations to provide testing and partner services. They will be responsible for contact tracing and contact testing of newly diagnosed HIV infected individuals while giving priority to those with acute infections. Other potential strategies for increasing HIV testing include: HIV testing and counseling for couples, partnering with CBOs, faith-based agencies, group homes, beauty salons, barber shops, gas stations, bars, night clubs, extended stay motels, and higher education institutions in disproportionately affected zip code areas to provide testing, counseling, and education.
- **Culturally sensitive outreach:** HIV prevention funded-CBOs will continue to focus their HIV messaging, outreach, and HIV testing and counseling activities to target groups in ways that are culturally and linguistically appropriate and that address culturally-established patterns for avoidance of HIV status awareness. Activities include Effective Behavioral Interventions (EBIs) and other health education strategies (e.g., health fairs, awareness days, social marketing).

- **System level interventions:** Interventions will address barriers that keep people from testing and access to care. CDC recommends HIV testing for all patients over the age of thirteen, with the option to opt-out. Following this policy, efforts will continue to fully embed HIV testing into routine medical laboratory testing to reduce stigma and increase the number of individuals that consent to testing. This policy will be adopted in Federally Qualified Health Centers (FQHC), emergency departments, and medical clinics such as college student health clinics, adult health clinics, STD/TB clinics, refugee clinics, family planning clinics, perinatal/maternal clinics, pediatric clinics, and high school clinics.

b) Major Collaborations: EIIHA is a multiagency collaboration and a number of partnerships will be involved to further EIIHA objectives. Examples of collaboration include but not limited to:

- **THRIVE SS, Inc.:** Is RWPA's new partner for Building Capacity for HIV Elimination in RWPA Jurisdictions. THRIVE SS, Inc. is a 501c3 nonprofit organization whose mission is to improve health equity for black gay men living with HIV through direct support, advocacy, and building collective power. THRIVE SS, Inc. will communicate needed information via messaging; encouraging clients to get in care and stay in care. Intervention with BMSM can help build retention and adherence to medication, eventually leading to viral suppression.
- **University of California San Francisco (UCSF):** UCSF's Center for AIDS Prevention Studies was funded by HRSA for a SPNS project: Capacity building in the RWHAP to Support Innovative Program Model Replication. The EMA will partner with UCSF in a learning collaborative to implement multifaceted approaches to reducing HIV-related disparities in health outcomes.
- **Georgia Integrated HIV Prevention & Care Plan, 2017-2021:** The integrated plan enables the EMA and the State of Georgia to collaborate on issues which will improve testing, awareness of status, linkage and retention in care, and lead to improved health outcomes by improved viral suppression rates.
- **CDC-funded Agencies:** Partner with CDC-funded agencies for HIV testing to ensure linkage protocols are in place.
- **Atlanta Area Outreach Initiative (AAOI):** The AAOI in conjunction with the High Impact Prevention Program (HIPP) and the RWPA Program will continue to develop and disperse the annual resource directory which includes care, prevention, and testing sites.
- **HOPWA and other housing providers:** Host the annual Housing Forum and provide housing resources with HOPWA and other housing providers.
- **RWHAP Part D:** Interventions will continue to address vertical transmission of HIV with the Part D program.
- **RWHAP Part C:** EIS awarded agencies continue to provide testing services.
- **Correction facilities:** Collaboration between groups that are testing in jails and prisons (prevention funding) and pre-release planning (Part A and Part B funding).
- **Fulton/DeKalb Jurisdictional Planning Group:** Explore integration into the PC to fully integrate prevention and planning in the HIV Care Continuum.

c) Anticipated outcomes: Overall, the EMA expects to achieve outcomes including increased awareness of HIV status and improved linkage to care among the target

populations, both HIV-positive and HIV-negative. In alignment with the "Georgia Integrated HIV Prevention & Care Plan, 2017-2021", the following outcomes will be achieved:

- By December 2021, increase the percentage of PLWH who know their serostatus to 90%.
- By December 2021, reduce the number of new diagnosis by at least 25%.
- By December 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of HIV diagnosis to at least 90% and engage individuals identified as out of care (no medical appointment in last 6 months) with no differences by race/ethnicity or risk.
- Expand linkage processes in correctional facilities to ensure newly released persons are linked to a medical appointment within 30 days of release.
- By 2021, increase the percentage of PLWH from 85% to at least 90% who are virally suppressed.
- Prescribe antiretroviral medications for at least 90% of clients enrolled in medical care.
- Reengage individuals identified as out of HIV care within seven days of identification implementing Data to Care models.
- By December 2021, increase the percentage of persons diagnosed with HIV infection that are virally suppressed to at least 80%.
- By 2021, 90% of clients among minority populations engaging in HIV care will achieve a viral load of less than 200 copies/mL.

Long-term outcomes:

- The percentage of individuals in the EMA who have ever tested for HIV should continue to increase with all individuals age 13-64 receiving at least one HIV test and individuals with ongoing risk are tested between one and four times per year.
- The portion of late diagnoses falls to 30% for all racial/ethnic and risk groups.
- Virtually no perinatal HIV transmission.
- Targeted populations will be tested and identification of individuals who test positive for HIV will continue to improve.
- Ongoing reduction in health disparities and access to care through geographically located primary care sites, provision of antiretroviral medications, and allocation of all MAI funding to the medical treatment of minority populations.

2) Target Populations:

a) The target populations, YBMSM (13-24), BMSM (25-44), and Black Females were selected for the EIIHA Plan based on the following:

YBMSM (13-24): 17% of all new diagnoses in 2018 in the EMA were among YBMSM (15% in 2016), with unmet needs of retention of 43% and viral load suppression rate of 51%. "Youth with HIV are the least likely of any group to be linked to care in a timely manner and have a suppressed viral load."[33] In Fulton and DeKalb Counties, in routinized testing in healthcare settings, all priority populations had a positivity rate above 0.1% with YBMSM being the highest at 5.3%. In non-healthcare settings, close to 3,000 testing

events were captured under HIPP Category A at over 41 different sites. Again, the highest positivity rate was among YBMSM at 2.1%.

BMSM (25-44): Gay and bisexual men continue to be most affected by the HIV epidemic in the U.S.[34] Among BMSM who received an HIV diagnosis, 41% (4,088) were aged 25 to 34 in 2017. In the EMA, BMSM 25-44 accounted for 27.8% of new diagnoses in 2018 (a little decrease compared to 30.2% in 2016), unmet retention need of 49% and viral suppression at 53%. The CDC notes that the presence of STIs greatly increases the likelihood of acquiring or transmitting HIV. The EMA has an extremely high syphilis rate among Black Men. Rates of gonorrhea and syphilis are also higher among Black Men than among White or Hispanic Men. Furthermore, among Black Males, the lowest percentage of linkage to care was among those who lived in counties with the lowest education (66.4%) and lowest health insurance or health care coverage (65.1%) in 2016.[35]

Black Females: Blacks are by far the most affected racial or ethnic group with a lifetime HIV risk of 1 in 48 for females (compared to 1 in 880 for White Females)[36]; unmet need is 48% and viral suppression is at 55% among Black Females in the EMA in 2018. The number of cases among all women increased in the EMA from 2016 to 2018 by 15%, however the number of cases increased by 17% for Black Females. Among Black Females, linkage to care was lowest among those who lived in counties with the lowest education (73.4%) and lowest health insurance or health care coverage (73.1%).[37]

b) Specific challenges or opportunities for working with the target population:
Challenges for working with the targeted populations are mostly associated with social determinants: poverty, stigma, housing, transportation, access to regular health care. Racism and reluctance to talk about sex and drug use also create barriers to general HIV information and the benefits of early treatment. Lack of targeted prevention messages obstruct awareness of HIV status. Additional challenges are identified as recall challenge. For example, it can be difficult to inform individuals of their status after they have moved because counselors are unable to reach out to them. Furthermore, the inadequate number of public health staff to assist all testing sites in locating and informing individuals of their status also remains an issue.

YBMSM (13-24): It is difficult for YBMSM to be open about their sexual orientation with others due to negative attitudes about homosexuality (including complacency), discriminatory acts, bullying and violence. Nondisclosure can increase stress, limit social support, and negatively affect health. Challenges to working with this population include:[33]

- **Inadequate Sex Education:** Resources of sexual health education are insufficient in many areas in the U.S. Many curricula do not include prevention information for young MSM and bisexual men. In addition, sex education is not starting early enough; in no State did more than half of middle schools meet goals set by CDC. Finally, sex education has been declining over time. The percentage of U.S. schools in which students are required to receive instruction on HIV prevention decreased

from 64% in 2000 to 41% in 2014, according to the School Health Policies and Practices Study.[38]

- **High rates of sexually transmitted diseases (STDs):** Youth ages 20 to 24, especially youth of color, are having the highest STD rates. The likelihood of someone acquiring HIV is greatly increased if a person already has an STD.[39,40]
- **Stigma/homophobia:** Most young people today say they would be comfortable having people with HIV as friends (65%) or work colleagues (66%) but when it comes to other situations, the stigma of the disease is evident, according to Kaiser Family Foundation survey in 2017. Half or more say they would be uncomfortable having a roommate with HIV (51%) or having their food prepared by someone with HIV (58%). Three quarters (73%) responded that they would be "very uncomfortable" having a sexual partner with HIV, which suggested that they are not comfortable discussing their status with others and talking with their partners about ways to protect themselves from HIV and other STDs.[41]
- **Feelings of isolation:** Gay and bisexual high school students may engage in risky sexual behaviors and substance abuse because they feel isolated and lack of support. They are more likely than heterosexual youth to experience bullying and other forms of violence, which also can lead to mental distress and risk behaviors that are associated with getting HIV. In the 2017 Youth Risk Behavioral Survey (YRBS), 33% of gay, lesbian, or bisexual students reported being bullied in the previous 12 months, compared to 19% of all students.[42]

BMSM (25-44): The intersection of being a Black male and MSM make this target group face multiple cultural challenges. Historically, HIV has not been openly discussed in the Black community nor has being gay or bisexual. As a result, many BMSM may delay HIV awareness due to fear of rejection by family or friends for being HIV infected and/or MSM. Conversely, not all MSM identify as gay or bisexual, and may not perceive themselves to be at risk for HIV, thereby further delaying awareness. The "down low" trend in the Black community best exemplifies this challenge. For those who identify as MSM, cultural norms in the MSM community such as "HIV fatigue" may also obstruct awareness. Experience with discrimination related to race and/or sexual orientation can also be a barrier. "Stigma, homophobia, and discrimination put gay and bisexual men of all races/ethnicities at risk for multiple physical and mental health problems and may affect whether they seek and are able to receive high-quality health services, including HIV testing, treatment, and other prevention services."[34] Additional challenges for BMSM include:

- **Smaller and more exclusive sexual networks:** BMSM are a small subset of all gay and bisexual men, and their partners tend to be of the same race. Because of the small population size and the higher prevalence of HIV in that population relative to other races/ethnicities, BMSM are at greater risk of being exposed to HIV within their sexual networks.
- **Lack of awareness of HIV status:** BMSM who have HIV, a lower percentage know their HIV status compared to HIV-positive gay and bisexual men of some other races/ethnicities. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others.

- **Socioeconomic factors:** Having limited access to quality health care, lower income and educational levels, and higher rates of unemployment and incarceration may place some BMSM at higher risk for HIV than men of some other races/ethnicities.[34]

Black Females: Studies state 1 in 9 women with HIV are unaware they have it.[36] People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others. Though the vast majority of HIV transmission in women occurs through heterosexual contact, many patterns of belief related to heterosexual partners continue to impede HIV awareness. As primary care-givers for partners, children, and even aging parents, many women delay seeking self-care in general. Overall, competing demands on time and resources may de-prioritize HIV for this target group. Additional challenges include:

- **Partner's race/ethnicity:** The greater number of PLWH (prevalence) are in Black and Hispanic communities. People tend to have sex with partners of the same race/ethnicity result in women from these communities facing a greater risk of HIV infection with each new sexual encounter.
- **Fear of rejection or retaliation from partners:** many women believe that seeking knowledge of HIV status will be perceived by partners as a sign of distrust or betrayal.
- **Sexual abuse:** women who have been sexually abused may be more likely to engage in sexual risk behaviors (exchanging sex for drugs, having multiple sex partners, or having sex without a condom).
- **Prenatal care:** Pregnant women may also fear potential perinatal transmission and, as a result, delay prenatal care.
- **Sexually transmitted diseases:** such as gonorrhea and syphilis, greatly increase the likelihood of getting or transmitting HIV.

Opportunities to work with all three populations include: (1) Services associated with HIV testing include targeted testing of high risk and highly impacted populations and communities through a mobile testing van and universal/routine testing that is embedded in a primary care visit; (2) Outreach services conducted by community based organizations funded by prevention programs of DPH and the FCBOH for targeted testing in clinical and non-clinical settings; (3) Offering counseling and testing of high risk populations at the EMA's AAOI; (4) Outreach activities for high risk populations and PrEP information sessions with potential providers and consumers; (5) Integrated HIV testing events with community events in parks, college health fairs, and other community venues to reach young people at risk. Examples include testing at Black Pride in Metro Atlanta area, target locations that serve women (WIC offices, women's shelters, etc.); (6) Working with Fulton County's Adolescent Health and Youth Development (AHYD) Program which strives to reduce the number of teen pregnancies and sexually transmitted infections among youth living in Fulton County; and (7) Partner with Walgreens to host testing events on National HIV Testing Day.

c) Specific strategies that will be utilized with the target population.

- **Providers:** Require 100% of RWPA providers to implement at least one strategy annually in each of the three CLAS component categories: (1) Governance, Leadership, and Workforce; (2) Communication and Language Assistance; (3) Engagement, Continuous Improvement and Accountability.
- **Cultural competency:** Conduct outreach to Spanish-speaking communities. Provide linguistics services to 100% of Spanish speaking clients. Conduct supporting training for provider staff and partner agencies (e.g., pharmacies, specialty vendors, etc.) on culturally and linguistically appropriate care for LGBT, non-English speaking populations, Blacks and Hispanics, precariously housed and homeless, formerly incarcerated, substance users, individuals with mental health problems, and lower socioeconomic populations.
- **Service expansion:** Expand resources and clinic hours in underserved geographic areas to provide PLWH with more access to care options. Provide assistance for 100% of clients with vision and/or hearing impairments. Continue to provide child care services and other support services such as medical transportation, grocery vouchers and psychosocial support (including Patient Navigators).
- **Increasing testing:** Increase HIV testing in geographical areas with high burden of disease among priority populations by utilizing mobile HIV testing units in zip codes with high HIV incidence and prevalence.
- **MAI strategies:** Direct MAI funds to providers supportive services in addressing barriers experienced among target populations. Established supportive service categories include: OAHS, non-medical case management, referral for health care and supportive services, emergency financial assistance, and medical transportation.
- **Resource allocation:** Continue to allocate resources to increase appointment scheduling flexibility and for walk-in (no appointment) clinics. Increase efforts to improve HIV care access, retention, and treatment adherence among underserved individuals.
- **Build partnerships:** Maintain partnerships with youth leaders, adult allies, and youth-serving organizations for policies and programs which recognize young peoples' rights to scientifically and medically accurate sexual health information. Partner with existing community clinics to provide HIV services in targeted areas. Expand evening and weekend clinic hours to allow more options for accessing care. Develop and implement awareness communications plan to inform PLWH in targeted communities about available HIV services.
- **Anti-stigma campaign:** Continue to implement anti-stigma campaign inclusive of print and digital media and marketing. Georgia's "Speak Out HIV" campaign was developed to empower young MSM to reduce the stigma associated with HIV, particularly the stigma around getting tested, disclosing status and remaining engaged in care. Speak Out Ambassadors use their story and presence to engage peers via participation at outreach and special events, social media and other outlets. "Ask the HIV Doc", a YouTube series featuring three well-known HIV physicians who address popular topics and answer question posed by channel subscribers. "Empower Trans" series was released in Spring 2016 and features six transwomen who share everyday experiences from living with HIV to using PrEP. This popular series can also be viewed on YouTube.

3) **Planned efforts to remove legal barriers to routine HIV testing in medical settings:** The Public Policy committee of the PC provides comment and educational forums on laws which potentially impact PLWH. State law was amended to clarify that minors do not need consent of a parent or guardian to get an HIV test. The Georgia Code further allows minors to consent to treatment for HIV/AIDS without the permission of a parent or guardian. This means that if a minor is at risk of HIV/AIDS, they can speak to a provider and consent to testing and treatment without parental consent. The law also applies to the request for PrEP, although this is not absolutely guaranteed.