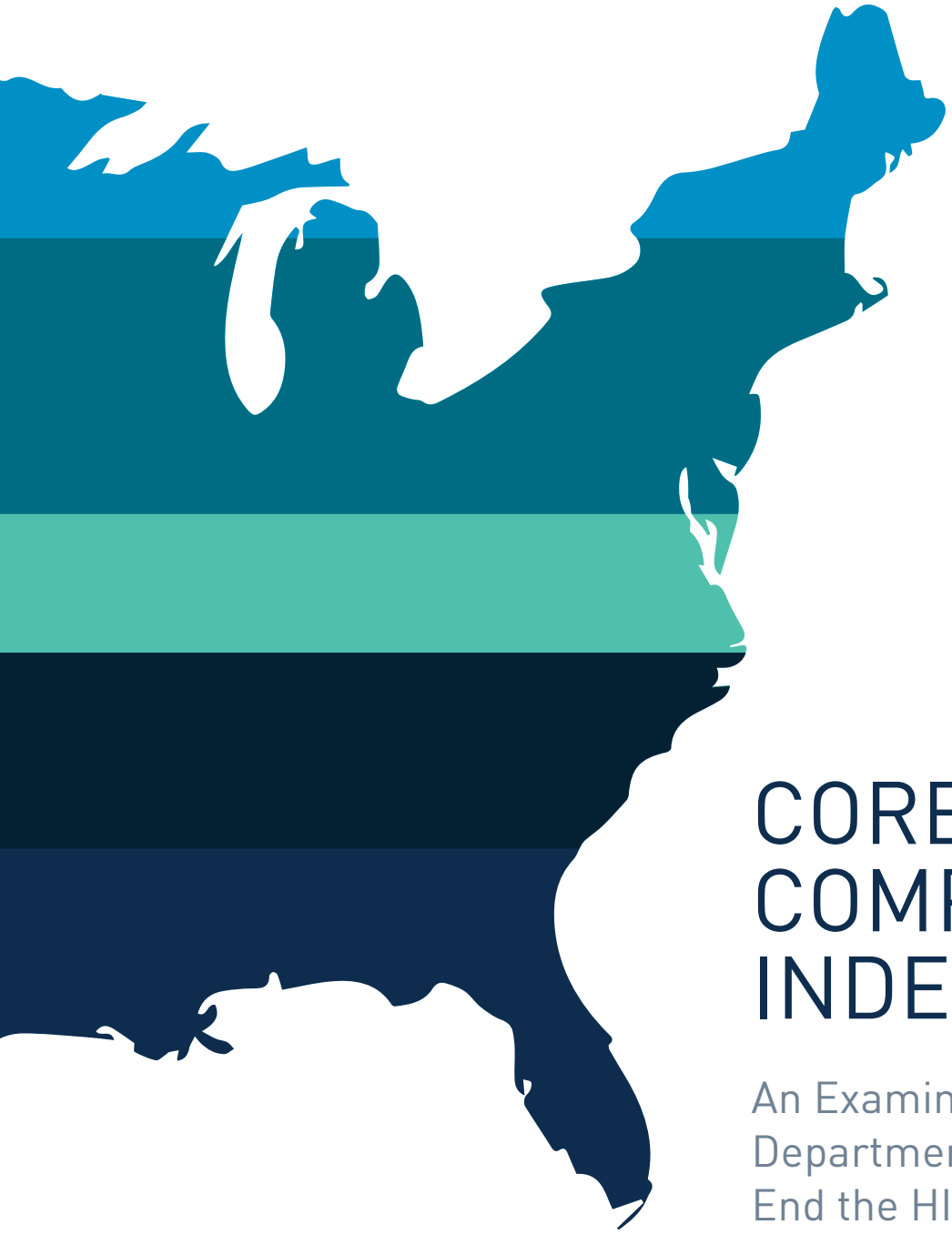


CORE COMPETENCIES INDEX

An Examination of Health Department Efforts to End the HIV Epidemic

CHAIR'S CHALLENGE

READY TO END THE HIV AND VIRAL HEPATITIS EPIDEMICS

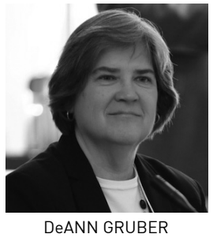
NASTAD

CONTENT

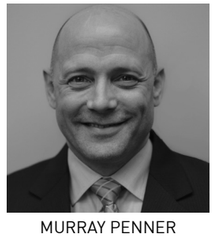
NASTAD

“This is not business as usual. We have a unique opportunity at this moment in history to change the trajectory of HIV and hepatitis forever.”

— NASTAD BOARD CHAIR, DeANN GRUBER, DIRECTOR FOR THE BUREAU OF INFECTIOUS DISEASE, LOUISIANA DEPARTMENT OF HEALTH, MAY 25, 2016.



DeANN GRUBER



MURRAY PENNER

I.

FOREWORD BY DR. DeANN GRUBER & MURRAY C. PENNER

NASTAD believes that we have reached a critically important moment in the history of the HIV epidemic. It is the moment when advances in science and public health practice have revealed a realistic opportunity to focus resources and policies to bring the United States closer to eliminating new HIV infections and support all people living with HIV (PLWH) to lead long and healthy lives.

This clear, focused vision is enabled by the proof that HIV antiretrovirals (ARVs) are working to treat PLWH by suppressing the virus and at the same time prevent HIV transmission. Viral suppression enables PLWH to live healthy lives and reduces the likelihood of transmitting HIV to others. Furthermore, through the wider use of pre-exposure prophylaxis (PrEP) high-risk HIV-negative people can reduce their risk of contracting HIV. When it comes to ending the hepatitis C virus (HCV) epidemic, major recent developments signal that we are at a critical turning point in determining whether HCV will be controlled and virtually eliminated in the United States. New direct-acting antiviral treatments for HCV can cure infection in more than 95 % of patients, a national hepatitis action plan is in place, and a federal panel has concluded that HCV control is feasible in the short term.[1]

In May 2016, NASTAD Board Chair DeAnn Gruber (Louisiana) called on health departments to accelerate the end of the HIV and hepatitis epidemics in the United States – launching NASTAD’s inaugural *Chair’s Challenge*. There is widespread understanding that public health programs working with state and local communities have demonstrated the tools, skills, competencies, and program strategies to support reductions in HIV transmission and deliver high

[1] *The U.S. Department of Health and Human Services (HHS) Viral Hepatitis Action Plan, updated in January 2017, provides a framework for key stakeholders to strengthen the nation’s response to hepatitis. The National Academies of Sciences, Engineering and Medicine Committee on a National Strategy for the Elimination of Hepatitis B and C released the first of a two-phase report in 2016 that concluded HCV control is feasible.*

quality care and treatment to PLWH leading to viral suppression, as well as deliver screening and curative treatments for people with HCV. The challenge is to identify areas that may be falling short of reaching these core competencies or program standards and help improve their performance through resources, policies, technical assistance, and problem-solving support. This first summary report of NASTAD's national assessment focuses on jurisdictional health department **HIV program core competencies**.[2] While many HIV program successes are recognized in the summary report, program and policy implementation challenges exist that need to be addressed to ensure that all HIV programs are on the pathway to end the HIV epidemic in the U.S. Among the deficits reported: **58% of jurisdictions fall below the national average overall across the totality of core competencies needed to support highly effective HIV prevention and care programs**.

As this initial assessment report demonstrates, the foundation has been set, and the tools and strategies are in place to build on the progress made to improve on HIV core competencies and program performance in all jurisdictions. The challenge is in front of us and there is more work to be done, often in the face of obstacles and adversity, to continue that progress and complete the mission of ending the HIV and hepatitis epidemics.

[2] This assessment report is focused on the programs and policies that relate to the HIV Care Continuum; a future NASTAD assessment report will focus on core hepatitis prevention and treatment programs and policies.

[3] NASTAD will use the words "jurisdictions" in place of states or territories in this report. NASTAD members completing the Chair's Challenge assessment included HIV program officials in states and territories (e.g., District of Columbia, Guam, and U.S. Virgin Islands). As of March 22, 2017, NASTAD's membership expanded to include local jurisdictions directly funded for HIV prevention by the Centers for Disease Control and Prevention (CDC). NASTAD's newest members (i.e., Baltimore, Chicago, Los Angeles County, Houston, New York City, Philadelphia, and San Francisco) were not asked to complete the core competency assessment as it was administered and completed prior to NASTAD's membership expansion.

II.

OVERVIEW OF THE ASSESSMENT

The key, initial step in the NASTAD Chair's Challenge was an assessment of jurisdictional health departments that NASTAD conducted in early 2017.[3] The assessment was designed to determine the minimum program and policy building blocks or **core competencies** that must be in place to support highly effective HIV prevention and care programs, and assess where health departments land on the core competencies continuum. Based on the results of this assessment, NASTAD will prioritize technical assistance and capacity building efforts, which support health departments in modernizing programs and policies to meet and exceed these core competencies.

The overarching mission of the Chair's Challenge is to identify needs within jurisdictional health departments' HIV and HCV prevention and care program efforts to strengthen programs and policies across the board to end the HIV and hepatitis epidemics.

ABOUT THE ASSESSMENT

The assessment was designed to determine the minimum program and policy core competencies that must be in place to support highly effective HIV prevention and care programs. The assessment was constructed to address each bar of the HIV Care Continuum and other key elements of HIV prevention and care programs. The assessment specifically requested information related to strategies and practices that jurisdictions use for identifying individuals who are unaware of their HIV status, referring HIV negative individuals into services that assist in keeping them free of HIV, linking PLWH to care, supporting their retention in care, and providing quality treatment and services that lead to viral suppression. Additionally, the assessment examines

social determinants of health, "the bar before the bars," to better understand specific strategies that may facilitate (or impede) progress across each area of the HIV Care Continuum, particularly among key populations (e.g., people of color, LGBTQ individuals, people who inject drugs).

Within each section of the assessment, NASTAD provided examples of highly effective HIV prevention strategies and recommended HIV care and treatment practices that have been demonstrated to have a significant impact on the HIV Care Continuum. NASTAD asked jurisdictional health department respondents to provide information that related specifically to their health department programs as well as to other activities within their jurisdictions. These activities included laws, policies, or programs that may be outside of health departments' direct authority but may have a significant impact on the HIV Care Continuum. For example, health departments may coordinate activities with other external agencies or organizations through agreements, policies, or data collection/sharing, which contribute to monitoring or assuring progress on the HIV Care Continuum.

The assessment was provided to all fifty-nine (59) state and territorial HIV program directors with one response requested from each state and territory.[4] Forty-five (45) state and territorial HIV programs completed the assessment and are the basis for this analysis and summary report. Fourteen (14) state and territorial programs did not complete the assessment before the submission deadline and are not represented in the findings.[5]

[4] *As of March 22, 2017, NASTAD's membership expanded to include local jurisdictions directly funded for HIV prevention by the Centers for Disease Control and Prevention (CDC). NASTAD's newest members (i.e., Baltimore, Chicago, Los Angeles County, Houston, New York City, Philadelphia, and San Francisco) were not asked to complete the core competency assessment.*

[5] *Jurisdictions not responding to the core competencies assessment findings are: Arkansas, American Samoa, Delaware, Florida, Maine, Marshall Islands, Micronesia, Nevada, Northern Mariana Islands, Ohio, Palau, Puerto Rico, South Dakota, and West Virginia.*

[6] *For example, a standard question related to retention of PLWH in care asked, "Does your state systematically share client-level data between public health departments and health care providers for the purposes of retention in care for PLWH?" An example of a program component question asked, "Which of the following examples of efforts to retain and reengage PLWH lost to care has your state successfully employed?"*

[7] *This summary report references groups of jurisdictions (e.g., by HIV prevalence, by federal HIV funding level, by Medicaid expansion status, and by U.S. region) by percentages falling above or below the national core competency index.*

METHODOLOGY USED FOR ASSESSMENT ANALYSIS AND SUMMARY

Core competencies were assessed through two types of questions: **baseline standards** and program components. Baseline standard questions are overarching key elements of a competency, while program component questions assess which standard components a program includes.[6]

In analyzing assessment responses, answers to each set of core competency questions were converted into numerical scores. Baseline standard questions were each worth one point, while the entire program component section was worth one point (each component was worth an equal subdivision of one point). Baseline standard questions with multiple answer options (e.g., 0-25%, 25-50%, 50-75%, 75-100%) were scored by assigning each answer option an increasing percentage of the one point available for the question (e.g., .25, .5, .75, 1).

A national average was created for each core competency to establish a **national core competencies index**. Each jurisdiction's score on the competency was divided by the national average to create a normalized score for each core competency. The average performance across all core competencies is the average of these normalized scores. These scores can be understood similar to odds ratios. Scores greater than 1 indicate that the jurisdiction or group is performing at that many times greater than the national average, where scores lower than 1 must be inverted by 1 to understand how many times below the national average the jurisdiction or group is performing. For example, a score of 2.5 indicates that the jurisdiction or group is performing at 2.5 times above the national average; a score of .4 indicates that the jurisdiction or group is performing at 2.5 times below the national average (1/.4=2.5). Scores should not be interpreted as percent increases above or below the national average without performing this transformation on scores below 1.[7]

CORE COMPETENCIES INDEX LIMITATIONS

Jurisdictional health department personnel (NASTAD members) completed the assessment and made their own judgments as to whether their jurisdictional HIV prevention and care programs use the standards of practice or possess the core competencies related to the HIV Care Continuum described in the assessment. Therefore, NASTAD does not recommend or intend to draw comparisons between specific jurisdictions based on the assessment findings.

This summary report does not provide individual jurisdiction scores on core competencies, but instead provides overall descriptions of where jurisdictions land in the aggregate when examining national core competency averages. As an example of summary findings related to a specific core competency, 56% (25 out of 45) of jurisdictions reported standards and program components above the national core competency average for linking PLWH to medical care and supportive services. This report provides overarching analysis of national core competency averages for categories of jurisdictions based on HIV prevalence, level of federal HIV funding, Medicaid expansion status, and region of the country. If a region, for example, scores high or low on a given core competency index, that finding is not necessarily attributable to a specific jurisdiction in that region.

III.

ASSESSMENT SUMMARY FINDINGS

NASTAD analyzed responses in eight major core competency areas and ten corresponding sub-areas:

1. Social Determinants of Health
   - Funding for Populations
   - Sexual Orientation and Gender Identity (SOGI)
   - Stigma and Discrimination
2. PrEP Services for Individuals at High-Risk for HIV Infection
3. Syringe Services Programs/Policies to Support the Health of People who Inject Drugs
4. HIV Diagnosis/Testing
5. Linkage to Care
6. Retention in Care
   - Client-Level Data Sharing
   - Reengagement in Care
7. Treatment and Adherence
   - Monitoring PLWH Outcomes
   - Improving PLWH Outcomes
8. Viral Suppression
   - Viral Suppression Data Sharing and Collection
   - Viral Suppression Communication
   - Viral Suppression Services

NASTAD determined a jurisdiction's position on the aggregated core competency index for each of the eight topics and ten sub-topics, and across all metrics. Additionally, NASTAD analyzed the core competency indices across four categories: 1) **HIV prevalence** or the number of PLWH in the jurisdiction (divided into four groups – high, high-moderate, moderate-low, and low prevalence); 2) **federal funding levels for HIV prevention and care** (divided into four groups – less than $10 million (low), $10 million-$50 million (moderate-low), $50 million-$80 million (high-moderate), and over $80 million (high)); 3) **Medicaid expansion** (divided into whether jurisdictions have or have not expanded Medicaid); 4) **U.S. region** (divided into four groups – North, South, Midwest, and West). Note that this analysis of aggregating jurisdictions into categories may not accurately reflect individual jurisdictional needs or experiences, but may provide information useful for determining general trends and technical assistance priorities.

1. SOCIAL DETERMINANTS OF HEALTH

This section of the assessment examined social determinants of health, "the bar before the bars," exploring issues such as: funding directed towards specific populations; sexual orientation and gender identity (SOGI) data collection/use; and stigma, discrimination, and other concerns that disproportionately impact communities and individuals often face prior to an HIV diagnosis.

Funding for Populations. The assessment asked whether health department HIV programs provide funding to support HIV prevention, care and treatment program interventions that address multiple vulnerable populations: Asian and Pacific Islander, Black, elderly/aging population, gay and bisexual men, Latinx, Native American/American Indigenous, new or recent immigrants, PLWH, people who are homeless, people who are incarcerated, people who inject drugs (PWID), transgender/non-binary individuals, women, young men who have sex with men, and youth.

CORE COMPETENCY INDEX

64%

OF JURISDICTIONS (29 OUT OF 45) RATED ABOVE THE NATIONAL AVERAGE FOR FUNDING HIV-RELATED INTERVENTIONS TO ADDRESS MULTIPLE POPULATIONS.

HIV PREVALENCE Jurisdictions with high HIV prevalence as well as jurisdictions with moderate-low prevalence rated above the national average.
FEDERAL HIV FUNDING High and high-moderate funding jurisdictions rated above the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated above the national average.
REGION Jurisdictions in the North rated above the national average. Jurisdictions in the South rated only slightly below the national average.

Sexual Orientation and Gender Identity (SOGI). Collecting SOGI data of new and returning clients is critical for health department programs, providers, health centers, community-based organizations, and other health care and supportive service organizations to provide a welcoming, inclusive environment of care and to provide high quality care to all clients. Jurisdictions were asked whether their health departments require funded providers to collect and use SOGI data to inform delivery of quality HIV prevention, care and treatment services. Eighty-two percent of jurisdictions (37) require the collection of both sexual orientation and gender identity data, while 13% (6) only collect sexual orientation, not gender identity, and 4% (2) only collect gender identity, not sexual orientation data. SOGI data is most often collected through client enrollment (84%, 38) and recertification (44%, 20) forms.

CORE COMPETENCY INDEX

49%

OF JURISDICTIONS (22), SLIGHTLY LESS THAN HALF OF RESPONDENTS, RATED ABOVE THE NATIONAL AVERAGE FOR COLLECTING AND USING SOGI DATA.

HIV PREVALENCE Jurisdictions with high-moderate HIV prevalence as well as jurisdictions with low prevalence rated above the national average. High prevalence jurisdictions rated slightly below the national average.
FEDERAL HIV FUNDING Low and high funding jurisdictions rated above the national average.
MEDICAID EXPANSION Jurisdictions that did not expand Medicaid rated above the national average.
REGION Jurisdictions in the South and Midwest rated above the national average.

CORE COMPETENCY INDEX

60%

OF JURISDICTIONS (27) RATED ABOVE THE NATIONAL AVERAGE FOR ENGAGING STRATEGIES TO ADDRESS STIGMA AND DISCRIMINATION.

HIV PREVALENCE Jurisdictions with high, high-moderate, and moderate-low HIV prevalence rated above the national average. Low HIV prevalence jurisdictions generally rated well below average.
FEDERAL HIV FUNDING Moderate-low, high-moderate, and high funding jurisdictions rated above the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated above the national average.
REGION Jurisdictions in the North and South rated above the national average.

Stigma and Discrimination. NASTAD asked respondents whether their health departments engage in specific strategies to address stigma and discrimination among populations at high-risk for and living with HIV. Among the most frequently cited examples included: promoting knowledge about HIV care and treatment advances and empowering vulnerable populations at risk for or living with HIV to get tested and to learn about treatment opportunities (93%, 42); promoting messages about the availability of PrEP for vulnerable populations who are at high-risk for HIV (89%, 40); and training health providers and key stakeholders working with vulnerable populations that experience stigma and discrimination on the knowledge, skills, and tools important to use in serving the needs of these populations (80%, 36). Less frequently cited examples included: providing services for PLWH in mental health facilities or drug treatment programs and/or specific programming for PLWH returning home from these settings (44%, 20); and sponsoring regular health literacy training for all health department and provider staff (31%, 14).

2. PREP SERVICES FOR INDIVIDUALS AT HIGH-RISK FOR HIV INFECTION

NASTAD asked health departments to assess the level of knowledge about Pre-Exposure Prophylaxis (PrEP)—the use of HIV medication for the prevention of HIV acquisition among specific target audiences. Sixty percent of jurisdictions (27) described providers as slightly knowledgeable and 36% (16) as moderately knowledgeable (better than slightly, but below highly knowledgeable) about PrEP. Only 4% (2) described their providers as highly knowledgeable. Similarly, when it comes to their community audiences, 56% (25) jurisdictions described them as slightly knowledgeable and 36% (16) as moderately knowledgeable. Seven percent (3) described their communities as not knowledgeable and only one jurisdiction (2%) described its community as highly knowledgeable. When asked whether there are specific mechanisms in place to link HIV-negative persons to PrEP services or programming, 69% (31) reported that their health department supports providers and agencies that have initiated programs to promote and support PrEP. Twenty-four percent (11) reported that mechanisms exist within the jurisdiction, but fall outside of jurisdictional health department funding and/or programming.[8]

NASTAD asked respondents whether their health departments engaged in specific PrEP programming initiatives. Among the most frequently cited examples included: establishing targeted or localized PrEP educational campaigns (e.g., advertisements, commercials) for people at high-risk for HIV and for providers (67%, 30); and establishing program standards for health department programs and funded providers for referral of high-risk HIV negative individuals into PrEP services (62%, 28). Among the less frequently cited examples included: implementing a jurisdiction-wide education campaign on PrEP including education of providers and consumers (31%, 14); and implementing PrEP drug assistance programs for persons to gain access to treatment with out-of-pocket costs minimized through jurisdictional support or coordination of benefits with other payers (e.g., health plans, insurers) (36%, 16).

[8] *H*ealth departments are limited in using federal funding for PrEP programs for people at high-risk for HIV infection. For example, funding under CDC's flagship HIV prevention program for health departments limits PrEP programming to educational activities only, not for direct services. The Ryan White HIV/AIDS Program (RWHAP) prohibits the use of funds for PrEP medications and related medical services such as physician visits and laboratory costs because the law is focused on care and treatment for people living with HIV. See RWHAP 2016 guidance letter on allowable PrEP support services: https://hab.hrsa.gov/sites/default/files/hab/Global/prepletter062216_0.pdf.

CORE COMPETENCY INDEX

53%

OF JURISDICTIONS (24) RATED ABOVE THE NATIONAL AVERAGE FOR ADDRESSING PREP SERVICES.

HIV PREVALENCE Jurisdictions with high, high-moderate, and moderate-low HIV prevalence rated above the national average.
FEDERAL HIV FUNDING Moderate-low, high-moderate, and high funding jurisdictions rated above the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated above the national average.
REGION – Jurisdictions in the North and West rated above the national average.

3. SYRINGE SERVICES PROGRAMS/ POLICIES TO SUPPORT THE HEALTH OF PEOPLE WHO INJECT DRUGS

NASTAD asked respondents to rate the level of access to sterile syringes for PWID in their jurisdictions. The majority of respondents (53%, 24 jurisdictions) reported limited access. Thirty-one percent (14) reported broad access in some parts of their jurisdictions but limited in others. Only 16% (7) reported comprehensive and consistent access across the entire jurisdiction. NASTAD asked respondents to list programmatic and policy initiatives successfully implemented to support the heath needs of PWID. Among the most frequently cited examples included: conducting HIV and hepatitis C testing at Syringe Services Programs (SSPs), jails/prisons, drug treatment facilities, and/or other venues that specifically target PWID (80%, 36); and supporting law reform that advances public health responses to drug use including syringe access and distribution laws, syringe decriminalization/partial decriminalization laws, naloxone access laws, Good Samaritan overdose protection policies, and supervised injection facilities (62%, 28). Among the less frequently cited examples included: conducting insurance enrollment at SSPs and/or other venues that specifically targets PWID (20%, 9); and working with pharmacies to scale up pharmacy-based syringe access (31%, 14).

CORE COMPETENCY INDEX

47%

OF JURISDICTIONS (21) RATED ABOVE THE NATIONAL AVERAGE FOR ADDRESSING DRUG USER HEALTH PROGRAMS AND POLICIES. MORE THAN HALF FALL BELOW THE NATIONAL AVERAGE, WHICH IS CONSISTENT WITH THE RELATIVELY HIGH PERCENTAGE OF JURISDICTIONS REPORTING LIMITED ACCESS TO STERILE SYRINGES.

HIV PREVALENCE Jurisdictions with high and moderate-low HIV prevalence rated above the national average. Jurisdictions with low HIV prevalence generally fell well below the national average.
FEDERAL HIV FUNDING High-moderate and high funding jurisdictions rated above the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated above the national average, while those that have not expanded Medicaid rated far below the national average for drug user health services.
REGION Jurisdictions in the North and West rated above the national average, while those in the South rated far below the national average, with most reporting restrictive policies or laws that inhibit drug user health services that would be beneficial for HIV prevention and care.

CORE COMPETENCY INDEX

56%

OF JURISDICTIONS (25) RATED ABOVE THE NATIONAL AVERAGE FOR EFFORTS TO INCREASE THE UPTAKE OF HIV TESTING AND DIAGNOSIS.

HIV PREVALENCE – Jurisdictions with high and high-moderate HIV prevalence rated above the national average.
FEDERAL HIV FUNDING – High-moderate and high funding jurisdictions rated above the national average.
MEDICAID EXPANSION – Jurisdictions that expanded Medicaid rated above the national average.
REGION – Jurisdictions in the North and South rated above the national average.

4. HIV DIAGNOSIS/TESTING

NASTAD asked respondents whether their health departments support specific strategies to increase the uptake of HIV testing and diagnosis, especially in high priority vulnerable populations. Health departments reported multiple examples of HIV testing activities with a relatively high frequency, which may illustrate the strong emphasis on high-impact HIV prevention and expanded HIV testing strategies.[9] Among the most frequently cited examples included: offering HIV testing to partners of newly diagnosed individuals as a standard of care (98%, 44); partnering with non-health department providers such as community health centers, healthcare for the homeless sites, community mental health centers, and substance use treatment centers to promote rapid point of care HIV testing (91%, 41); and addressing acute HIV infection through the use of 4th generation HIV tests in funded clinics and testing sites (89%, 40). A less frequently cited example was providing guidance to consumers and providers about the proper methods for administering HIV self-testing and providing direction to consumers and providers on what to do once results have been obtained (24%, 11).

[9] To increase awareness of HIV status, CDC established the Expanded Testing Initiative (ETI) in 2007 in partnership with health departments and later incorporated into comprehensive HIV prevention funding for health departments under PS12-1201 (2012-2017).

5. LINKAGE TO CARE

NASTAD asked respondents to estimate the average time a person living with HIV is linked to care (i.e., successfully attending their first appointment) after HIV diagnosis in their jurisdictions. The majority of health departments (51%, 23) estimated 0 – 30 days, followed by 31 – 60 days (31%, 14), 61- 90 days (13%, 6) and 90 days or more (4%, 2).[10] NASTAD asked respondents whether their health departments successfully implemented strategies to link PLWH to medical care and supportive services. Health departments reported multiple examples of linkage to care activities with a relatively high frequency. Among the most frequently cited examples included: ensuring a coordinated system of services from HIV prevention and testing to HIV care (100%, 45); providing transportation funding and support for PLWH to attend clinic visits (100%, 45); and assessing HIV support and vital wraparound services (e.g., emergency housing, case management, food security services) and referral to these services as needed (98%, 44). Among the less frequently cited examples included: supporting task shifting/sharing from physicians to appropriately trained health care providers for ART initiation and maintenance (38%, 17); and supporting and promoting trauma-informed care policies and procedures (38%, 17).

[10] The RWHAP performance measure for linkage to HIV medical care is the percentage of patients who attended a routine HIV medical care visit within 3 months (i.e., 90 days) of HIV diagnosis. The National HIV/AIDS Strategy updated to 2020 includes a performance measure that calls for an increase in the percentage of newly diagnosed persons linked to HIV medical care within one month of HIV diagnosis.

CORE COMPETENCY INDEX

56%

OF JURISDICTIONS (25) RATED ABOVE THE NATIONAL AVERAGE FOR IMPLEMENTING STRATEGIES FOR LINKING PLWH TO CARE AND SUPPORT SERVICES.

HIV PREVALENCE Jurisdictions with high HIV prevalence rated above the national average, but jurisdictions across the prevalence spectrum rated fairly close to the national average for linkage to care approaches.
FEDERAL HIV FUNDING High funding jurisdictions rated above the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated above the national average.
REGION Jurisdictions in the North and South rated above the national average.

6. RETENTION IN CARE

NASTAD asked respondents to rate their jurisdictions' efforts to systematically identify, monitor, and re-engage PLWH who appear to be out of care. A slight majority of jurisdictions (51%, 23) reported that jurisdiction-wide efforts are in place. Forty-four percent (20) noted that multiple retention in care projects are in place; only 4% (2) reported very little effort is in place within their jurisdictions.

Client-Level Data Sharing. NASTAD asked respondents whether client-level data is shared between public health departments and health care providers for the purposes of retention in care for PLWH. Forty percent (18) reported that jurisdiction-wide efforts are in place, while 36% (16) reported that multiple projects are in place throughout the jurisdiction. Eighteen percent (8) assessed that very little information sharing occurs, while 7% (3) said that no information sharing occurs at all related to retention in care for PLWH. For those jurisdictions indicating that client-level data sharing does occur, the types of data sources most often tend to be health department affiliated: surveillance systems (89%, 40); Ryan White Program providers (76%, 34); and ADAPs (69%, 31). Less frequently cited for data sharing sources included external processes: health plan electronic medical records (11%, 5); Health Information Exchanges (13%, 6); and insurance billing records (18%, 8).

CORE COMPETENCY INDEX

56%

OF JURISDICTIONS (25) RATED ABOVE THE NATIONAL AVERAGE FOR IMPLEMENTING STRATEGIES FOR CLIENT-LEVEL DATA SHARING RELATED TO RETENTION IN CARE FOR PLWH. GENERALLY, THERE IS A TENDENCY THAT JURISDICTIONS WITH HIGH PREVALENCE AND HIGH FUNDING LEVELS REPORT COMPLEXITIES WITH DATA SHARING AND DATA COORDINATION WITH EXTERNAL ENTITIES.

HIV PREVALENCE Jurisdictions with low and high-moderate HIV prevalence rated above the national average.
FEDERAL HIV FUNDING Low and high-moderate funding jurisdictions rated above the national average.

MEDICAID EXPANSION Jurisdictions that did and did not expand Medicaid rated just slightly below the national average in the aggregate, but were very close to the average.
REGION Jurisdictions in the South and West rated above the national average.

Reengagement in Care. NASTAD asked respondents whether their jurisdictions successfully engaged in strategies to retain and reengage PLWH lost to care. Among the most frequently cited examples included: measuring retention in HIV care using surveillance systems (91%, 41); providing funding for transportation support for PLWH to attend clinic visits (89%, 40); and providing funding support for case management services to retain PLWH in care and to locate and reengage patients lost to follow-up (84%, 38). Among the less frequently cited examples: measuring retention in HIV care using health information exchanges and/or all-payer claims databases (22%, 10); and establishing retention in HIV care as quality indicator for all health care providers and health settings in the jurisdiction (24%, 11).

7. TREATMENT AND ADHERENCE

NASTAD asked health departments to provide the estimated percentage of viral loads reported among those people living with HIV in their jurisdiction. The percentages varied from 76% – 100% reported by 47% of respondents (21); 51% – 75% reported by 31% (14); 26% – 50% reported by 11% (5); and 0% – 25% reported by 11% (5).

CORE COMPETENCY INDEX

51%

OF JURISDICTIONS (23) RATED ABOVE THE NATIONAL AVE-RAGE FOR IMPLEMENTING STRATEGIES FOR RETENTION AND REENGAGEMENT IN CARE FOR PLWH LOST TO CARE.

HIV PREVALENCE Jurisdictions with moderate-low, high-moderate, and high HIV prevalence rated above the national average. Jurisdictions with low HIV prevalence rated significantly below the national average.
FEDERAL HIV FUNDING Jurisdictions with moderate-low, high-moderate, and high funding rated above the national average. Jurisdictions with low HIV funding rated significantly below the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated just above the national average.
REGION Jurisdictions in the South were in the only region that rated above the national average for reengagement in care.

CORE COMPETENCY INDEX

53%

OF JURISDICTIONS (24) RATED ABOVE THE NATIONAL AVE-RAGE FOR IMPLEMENTING STRATEGIES TO IMPROVE MONITORING PLWH OUTCOMES.

HIV PREVALENCE Jurisdictions with moderate-low, high-moderate, and high HIV prevalence rated above the national average. Jurisdictions with low HIV prevalence rated significantly below the national average.
FEDERAL HIV FUNDING The same is true for funding with moderate-low, high-moderate, and high HIV funding rating above the national average. Jurisdictions with low HIV funding rated significantly below the national average.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid rated above the national average and those jurisdictions that have not expanded Medicaid ranked well below the national average for monitoring outcomes.
REGION Jurisdictions in the North, South, and Midwest rated above the national average.

Monitoring PLWH Outcomes. NASTAD asked health departments to list agencies or providers that they pursue regular communications/relationships with to improve treatment coverage, monitoring, and outcomes for PLWH. Among the most frequently cited entities included: jurisdiction Medicaid program (73%, 33); community health centers (64%, 29); providers prescribing ART (62%, 28); university medical centers and other hospital systems (56%, 25); and health plans and insurers (56%, 25).

Improving PLWH Outcomes. NASTAD asked respondents to list examples of strategies for improving treatment coverage, monitoring, and outcomes for PLWH that their jurisdiction successfully employed. Among the most frequently cited examples included: offering support for medication adherence through patient education about treatments and importance of keeping clinic appointments (87%, 39); and enhancing and streamlining services to support the non-medical needs of PLWH (82%, 37). Among the less frequently cited strategies included: incentivizing performance for providers, including Medicaid managed care plans, built into reimbursement structures for achieving or sustaining undetectable viral loads (11%, 5); and incentivizing patients (for example with gift cards or non-cash rewards) for adherence milestones, keeping appointments, achieving or sustaining an undetectable viral load (16%, 7).

8. VIRAL SUPPRESSION

Viral suppression of HIV is the ultimate target for individuals living with HIV and for communities seeking to end the epidemic. As an overarching question, NASTAD asked respondents whether their health department tracks or evaluates the reasons why PLWH are not virally suppressed, either individually or in the aggregate. Just slightly over half the jurisdictions responded "No" (53%, 24) and just under half responded "Yes" (47%, 21).

CORE COMPETENCY INDEX

56%

OF JURISDICTIONS (25) RATED ABOVE THE NATIONAL AVERAGE FOR IMPLEMENTING STRATEGIES TO IMPROVE PLWH OUTCOMES.

HIV PREVALENCE Jurisdictions with high-moderate and high HIV prevalence rated above the national average.
FEDERAL HIV FUNDING Jurisdictions with high-moderate and high HIV funding rated above the national average.
MEDICAID EXPANSION Jurisdictions that did not expand Medicaid were grouped slightly above the national average.
REGION Jurisdictions in the South and West rated above the national average.

CORE COMPETENCY INDEX

36%

OF JURISDICTIONS (16) RATED ABOVE THE NATIONAL AVERAGE FOR IMPLEMENTING VIRAL LOAD DATA SHARING AND COLLECTION. THIS IS THE LOWEST SINGLE RATING AMONG ALL OF THE CORE COMPETENCIES AND AN AREA TO HIGHLIGHT THAT IS IN NEED OF SUBSTANTIAL IMPROVEMENT.[11]

HIV PREVALENCE Jurisdictions with low, high-moderate, and high HIV prevalence rated above the national average. Jurisdictions in the moderate-low prevalence group tended to rate lower than average in the aggregate.
FEDERAL HIV FUNDING Jurisdictions with high funding rated above the national average, while those with high-moderate funding were sharply below the national average for viral load data sharing and collection.
MEDICAID EXPANSION Jurisdictions that did not expand Medicaid were above the national average, while jurisdictions that expanded Medicaid rated just below the national average in the aggregate. These jurisdictions tended to cite obstacles in data sharing with their Medicaid programs.
REGION Jurisdictions in the South and Midwest rated above the national average.

Whether this reality is due to resource limitations or data-sharing obstacles, basic information about gaps or deficits in viral suppression is not closely monitored in the majority of jurisdictions.

Viral Suppression Data Sharing and Collection. Respondents were asked to identify all agencies and programs inside or outside their health department that supply data to capture the viral load suppression rate across the jurisdiction. In general, viral load data sharing and collection was relatively weaker with programs outside of health departments in many jurisdictions compared with internal program data sharing. This is a deficiency when considering the importance of capturing and monitoring this information in order to demonstrate progress in the HIV Care Continuum and in readying health systems to end the HIV epidemic. The agencies/programs referenced in the order of percentage included: surveillance (96%, 43); Ryan White Program funded clinics and providers (84%, 38); ADAP (71%, 32); non-Ryan White Program funded clinics/providers (40%, 18); university medical centers and other hospital systems (40%, 18); Medicaid (27%, 12); Department of Corrections (22%, 10); Medicaid managed care plans or Special Needs Plans (13%, 6); Health information exchange (13%, 6); health plans and insurers (13%, 6); Medicare Part D plans (11%, 5); and pharmacies (9%, 4).

[11] *According to the CDC, while all 50 U.S. states and D.C., Guam, Puerto Rico and the Virgin Islands require laboratories to report CD4 and viral load test results as of December 2015, a smaller number of jurisdictions (33) had met CDC's specific criteria for the collection and reporting of CD4 and viral load test results in terms of timing or completeness for CDC's most recent HIV Surveillance Supplemental Report (July 2016).*

CORE COMPETENCY INDEX

53%

OF JURISDICTIONS (24) RATED ABOVE THE NATIONAL AVERAGE FOR IMPLEMENTING VIRAL LOAD DATA COMMUNICATION STRATEGIES.

HIV PREVALENCE Jurisdictions with high-moderate and high HIV prevalence rated above the national average.
FEDERAL HIV FUNDING Jurisdictions with low and high funding levels rated above the national average, while those with high-moderate funding were sharply below the national average for viral load communication strategies.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid were above the national average, while jurisdictions that did not expand Medicaid rated significantly below the national average in the aggregate.
REGION Jurisdictions in the North, Midwest, and West rated above the national average.

Viral Suppression Communication. Respondents were asked to select the strategies their health department uses to communicate the importance of viral load suppression to providers across the jurisdiction, including those who are not experienced in HIV treatment or care for PLWH. The examples of communication methods included: sessions at state conference for providers (49%, 22); provider emails or newsletters (44%, 20); outreach materials at provider group settings (40%, 18); direct communication with hospital groups (27%, 12); and messaging at medical schools and nursing schools in the jurisdiction (22%, 10).

Viral Suppression Services. Respondents were asked what services their health department HIV program provides or funds to assist providers and clients in achieving and sustaining viral suppression. Among the most frequently cited services included: medical case management (93%, 42); housing supportive services (78%, 35); non-medical case management (78%, 35); and treatment adherence monitoring (76%, 34).

CORE COMPETENCY INDEX ACROSS ALL METRICS

When examining all core competency topics and sub-topics across the board, NASTAD found that **42%** of the jurisdictions (19 out of 45) rated above the national average across all core competencies needed to support highly effective HIV prevention and care programs. Based on the results of this self-assessment, NASTAD's technical assistance and capacity building efforts will be prioritized to address the deficits identified and tailor support to health departments to modernize programs and policies to meet and exceed these core competencies. Across all metrics, overall trends in the four major jurisdiction groups included the following findings: **HIV prevalence** – Jurisdictions with moderate-low, high-moderate, and high HIV prevalence rated above the national average, while those grouped under low prevalence rated significantly below the national average in the aggregate. **Federal HIV funding** – Jurisdictions with moderate-low, high-moderate, and high funding levels rated above the national average, while those with low funding levels were sharply below the national average across the board. **Medicaid expansion** – Jurisdictions that expanded Medicaid were above the national average across most of the core competencies, while jurisdictions that did not expand Medicaid rated below the national average in the aggregate. **Region** – Jurisdictions in the North rated above the national average, the only region of the country to rate above the line.

Jurisdictions in the South rated slightly below the national average overall, and rated higher than those grouped in the Midwest and West.

CORE COMPETENCY INDEX

56%

OF JURISDICTIONS (25) RATED ABOVE THE NATIONAL AVERAGE FOR IMPLEMENTING VIRAL SUPPRESSION SERVICES.

HIV PREVALENCE Jurisdictions with moderate-low, high-moderate, and high HIV prevalence rated above the national average, while those grouped under low prevalence rated significantly below the national average in the aggregate.
FEDERAL HIV FUNDING Jurisdictions with moderate-low, high-moderate, and high funding levels rated above the national average, while those with low funding levels were sharply below the national average for viral suppression service approaches.
MEDICAID EXPANSION Jurisdictions that expanded Medicaid were above the national average, while jurisdictions that did not expand Medicaid rated below the national average in the aggregate.
REGION Jurisdictions in the North rated above the national average.

IV.

COMMENTARY AND RECOMMENDATIONS

NASTAD's analysis of the assessment findings reveals many robust initiatives underway across jurisdictional health department HIV prevention and care programs to improve progress along the HIV Care Continuum. In the open-ended comments sections of the questionnaire, many respondents provided detailed examples of highly effective HIV prevention services and standards of care practices for HIV care and treatment across the spectrum, usually without regard for the level of HIV prevalence, federal funding, changes in Medicaid eligibility, or geographic location. **Table 1** provides highlights of reported jurisdictional success stories in all the core competency areas drawn from jurisdictional health department responses. These and other highlighted examples are assets that will help build the portfolio of technical assistance and peer-to-peer assistance modalities that NASTAD intends to recommend to jurisdictions to raise standards and HIV core competencies in the coming years.

The findings revealed relative core competency strengths among many health department HIV programs in serving high priority populations, dealing with social determinants of health, and in providing innovative services and strategies along many of the bars of the HIV Care Continuum. For example:

64% of jurisdictions (29 out of 45) rated above the national average for funding HIV-related interventions to address multiple populations.

60% of jurisdictions (27) rated above the national average for engaging strategies to address stigma and discrimination.

56% of jurisdictions (25) rated above the national average for strategies to increase the uptake of HIV testing and diagnosis, for linking PLWH to care and support services, for client-level data sharing related to retention in care for PLWH, for improving PLWH outcomes, and for implementing viral suppression services.

Health departments in jurisdictions across the spectrum have developed and instituted effective HIV prevention and care program competencies to support reductions in HIV transmission and deliver high quality care and treatment to PLWH leading to viral suppression.

Identified Areas for Improvement. While many assets are noted in the summary report, significant deficits also exist that need to be addressed to ensure that all jurisdictional HIV programs are on the pathway to end the HIV epidemic in the U.S. Among the deficits reported:

58% of jurisdictions (26) fall below the national average overall across the totality of core competencies needed to support highly effective HIV prevention and care programs.

64% of jurisdictions (29) fall below the national average when it comes to data sharing and collection for viral suppression. This is an unacceptably high percentage of jurisdictions that suggests intensive work is needed to overcome barriers to data sharing that can be used to ensure progress in helping PLWH achieve and sustain viral suppression.

53% of jurisdictions (24) fall below the national average when it comes to providing SSPs and attention to the prevention and health care needs of drug users. Jurisdictional health department HIV programs and the communities they serve continue to need innovative strategies for overcoming barriers to implementing effective drug user health services due to legal hurdles, poor to non-existent funding, and discriminatory political barriers.

Additional insights from NASTAD's assessment analysis that will inform technical assistance priorities and recommendations include:

- **Data across systems.** Access to data across systems, especially Medicaid data, is still a challenge for many jurisdictions because data is not easily shared between programs/funding streams. As Ryan White Program clients have moved their medical care to other coverage, including expanded Medicaid programs, it can be difficult for Ryan White Program case managers to know whether these clients are going to their appointments or adhering to treatments. The lack of viral suppression data sharing and collection has been noted as a critical concern.

- **Medicaid expansion.** Typically, there are better outcomes (average across metrics) in Medicaid expansion jurisdictions, except for sharing and collecting viral load data. Medicaid expansion has been an important development for providing HIV care and treatment to uninsured and underinsured PLWH, but it has also provided coverage to address PrEP for HIV-negative individuals and for providing coverage that helps support the multiple health needs of drug users. As the rationale for expanding Medicaid in more jurisdictions to provide coverage for a growing number of individuals in need has become increasingly urgent, so has the national political environment threatened the future of Medicaid expansion. Advocacy to expand Medicaid in more jurisdictions may shift rapidly to defending the program from elimination or severe reduction.

- **Regional differences.** On the whole, the four U.S. regions did not reveal major differences in the overall core competency index, with one exception: the South as a region has an exceptionally low index rating for addressing SSPs and drug user health issues. Jurisdictions in the South, as well as other areas of the country, reported challenges in overcoming key barriers including discrimination from providers, limited access to behavioral health services, requirements for a prescription to access clean syringes at pharmacies, and lack of community support as well as political opposition.

- **Syringe Services Programs.** Respondents identified providing technical assistance for jurisdictional initiatives related to SSPs and drug user health as high priorities. Funding legislative changes were at the center of health departments' activities. Many health departments indicated that legislative changes are currently being drafted to establish SSPs or that the health department is implementing new programming stemming from recent legislative changes. Some pointed out that recent legislative changes had not appropriated funds for SSP services and that the changes had onerous criminalization elements.

- **PrEP uptake.** In their comments, ten jurisdictions indicated that the lack of jurisdictional funds that would provide health departments the ability to establish PrEP assistance programs was a major barrier for PrEP implementation. The cost of the medication, the clinical services, and laboratory tests continue to be barriers across the country and access to insurance and insurance coverage were also mentioned as barriers in jurisdictions that have not expanded Medicaid. Twenty-one jurisdictions indicated that provider unwillingness to prescribe PrEP was a major barrier to PrEP implementation. Technical assistance and capacity building within health departments to engage providers on PrEP is an identified need.

Next Steps in the Process. The objective of the NASTAD Chair's Challenge is to support all jurisdictional HIV prevention and care programs to build successful initiatives and policies that help PLWH achieve viral suppression and make definitive progress toward ending the HIV epidemic. With that objective in mind, NASTAD will be working with health departments to provide tailored technical assistance recommendations for improvements so that jurisdictions can consider ways to better assure HIV prevention and care program performance and outcomes. NASTAD will enlist jurisdictional health department peers that have achieved successful implementation of core competency elements to help deliver peer-to-peer support to their colleagues across the country through in-person visits, meetings, webinars, and other communications.

As this assessment report demonstrates, the foundation has been set, and the tools and strategies are in place to build on the progress made to improve on HIV core competencies and program performance in all jurisdictions.

The challenge is in front of us and there is more work to be done, often in the face of obstacles and adversity, to continue that progress and complete the mission of ending the HIV and hepatitis epidemics.

Thank you to all NASTAD members who completed the core competencies assessment and contributed their jurisdictional success stories to this report.

Murray C. Penner, Executive Director
DeAnn Gruber, Louisiana, Chair
May 2017

TABLE 1

HIGHLIGHTS OF JURISDICTIONAL SUCCESS STORIES ACROSS CORE COMPETENCIES

SOCIAL DETERMINANTS OF HEALTH	**District of Columbia** initiated new training of health department staff on deconstructing homophobia and transphobia. **Louisiana** has a program examining institutional racism, homophobia and transphobia.
PREP SERVICES	**New York** provides continuing education credits for PrEP webinars, video and face-to-face technical assistance for pharmacists, medical providers and nurses, and has produced and distributed PrEP quick reference badge cards for medical providers. **Wisconsin** maintains and regularly updates a PrEP Provider List of medical practices and clinics where clients can be referred for PrEP. This list is included in training materials given to new HIV testing providers, and distributed jurisdiction-wide to HIV testing sites.
SYRINGE SERVICES PROGRAMS (SSP) AND DRUG USER HEALTH	**California** established a Syringe Exchange Program (SEP) Certification program that allows jurisdictions to request authorization for operating an SEP in areas where local authorization is not possible. Applicants must submit plans for syringe collection and sharps waste disposal, referrals, data collection, and community relations. **Hawaii** has a longstanding, large, jurisdiction-wide, jurisdiction-funded SSP with a rigorous annual evaluation (legislatively mandated) that has been important in justifying need for, and effectiveness of, and for countering opposition to the program. **New Mexico** has a new state law in 2016 that allows distribution of naloxone by non-clinicians, trained/certified lay people (i.e., outreach workers) and pharmacists. Statewide harm reduction program supported by state law and funding since 1997.
HIV DIAGNOSIS/ TESTING	**Iowa** has a program that uses rebate dollars to fund full-time testers at health centers where those positions would otherwise not be available. **Massachusetts** has a program in Boston where a medical center located in a high-prevalence area does automatic, opt out HIV testing for any blood sample that is taken from a patient for any reason. It is all done in-house so additional staff have not been required.
LINKAGE TO CARE	**Colorado** has a "Critical Events Services" Program that provides comprehensive services for PLWH experiencing events that prevent them from reaching or maintaining viral suppression. **Oregon** has a Rapid ADAP Entry program that allows for newly diagnosed individuals to take advantage of ADAP regardless of their insurance status.
RETENTION IN CARE	**Georgia** will soon be implementing a list-based date to care pilot with nine public health districts. **Texas** uses HIV surveillance data and provider medical records to identify and target two types of out-of-care individuals: 1) PLWH recently diagnosed who are not in care within six months of their initial diagnosis; and 2) persons who have no evidence of care within the prior year.
TREATMENT AND ADHERENCE	**Hawaii** has a state-funded program that provides coverage of HIV-related labs and medical visits for PLWH who might otherwise forego or postpone medical visits/labs. **New Jersey** plans for 2017 include: piloting "Icaps" and "Iconnect" to improve medication adherence; a Medical-Legal Partnership to intervene with issues, such as eviction, that impact retention; a Self-Management component for medical case managers and community health workers; expansion of Telehealth in rural communities, and a RWJ medical student mentoring program for YGM who are not virally suppressed.
VIRAL SUPPRESSION	**District of Columbia** is expanding population-focused strategies, particularly among men who have sex with men of color and transgender persons of color, through collaboration with pharmacies, developing a cross-jurisdictional regional health system, and exploring new health care delivery methods with mobile and at-home care. **Illinois** has a partnership between the health department and Medicaid for data analyses measuring viral suppression and other outcomes across payer sources. **Oregon** has an ADAP Pharmacy Benefits Manager monitor ART regimens that do not meet treatment guidelines and conduct outreach to patients with irregular fill histories as part of medication therapy management.

CHAIR'S CHALLENGE

READY TO END THE HIV AND VIRAL HEPATITIS EPIDEMICS

NASTAD