Responding to an HIV Cluster or Outbreak: Who do you call? What do you do?

January 28, 2021

Ending
the
HIV
Epidemic

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Cooperative Agreement Award # U69HA33964

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Who We Are

Strengthen & support implementation of jurisdiction Ending the HIV Epidemic (EHE) Plans to contribute to achievement of reduction in new reported HIV cases by 75% by 2025

Tip: Get TAP-in TA and Training by Contacting TAP-in@caiglobal.org

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TAP-in Partnership Structure

NCSD
National Coalition of STD Directors

NATIONAL ASSOCIATION OF Community Health Centers®

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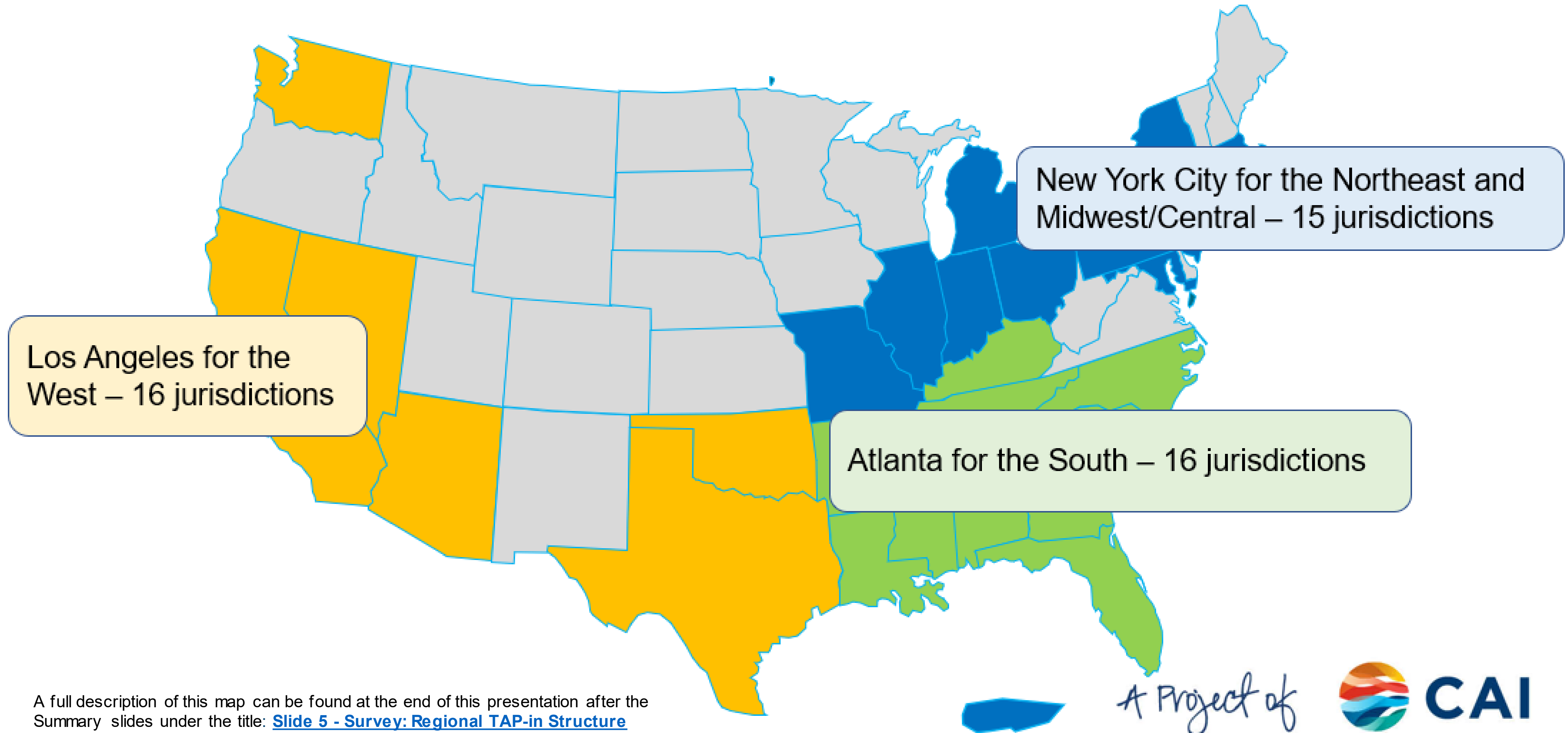
Regional TAP-in Structure

Three regional hubs with a TA Lead and up to three Coaches assigned to each hub



A full description of this map can be found at the end of this presentation after the Summary slides under the title: [Slide 5 - Survey: Regional TAP-in Structure]

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Tip: Get TAP-in TA and Training by Contacting TAP-in@caiglobal.org

Responding to an HIV Cluster or Outbreak: Who do you call? What do you do?

Ending the HIV Epidemic

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Part I: Introduction

Linda Rose Frank, PhD, MSN, ACRN, FAAN, Professor of Public Health, Medicine, & Nursing, Graduate School of Public Health, University of Pittsburgh, Principal Investigator, MidAtlantic AETC

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Session Goals

At the end of this session, the learners will be able to:

Outbreak response

- Identify and define an outbreak or cluster
- Engagement of community partners in jurisdictions
- Approaches to engagement and coordination

Federal, state, and local level response

- Role of specific agencies and partners in an outbreak/cluster
- Importance of sharing and coordination

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Session Goals

At the end of this session, the learners will be able to:

Clinical care and linkage to services

- HIV testing
- HIV treatment
- PrEP
- Substance use treatment
- Mental health intervention
- Support services

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Presenters

William Murphy, CAI
Project Director, TAP-in

Heather Hauck, MSW, LICSW
Deputy Associate Administrator, HAB, HRSA

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Carolyn Kidd, RN, BSN, ACRN, Clinical Nurse Educator, MidAtlantic AETC Regional Partner, West Virginia University

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Pre-Recorded Interviews

Michael Kilkenny, MD, Physician Director, Cabell/Huntington Health Department

Kara Willenburg, MD, FACP, Associate Professor, Section Chief of Infectious Diseases, Marshall University

Amy Atkins, MPA, Director, Office of Epidemiology and Prevention Services, West Virginia Department of Health and Human Resources

Anndrea Rogers, BS, MT(ASCP), Director, WVU Positive Health Clinic, Laboratory Director, WV Bureau for Public Health Rapid Testing Program

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Pre-session poll questions (directed to jurisdictions)

Rating scale: Strongly agree; Agree; Neutral; Disagree; Strongly Disagree

1. I think that substance use is a major problem in my jurisdiction
2. I anticipate that our jurisdiction would be prepared to respond to an HIV outbreak or cluster
3. I have information and knowledge of my state's cluster or outbreak response plan
4. I think that improvements could be made in coordination between state, local and federal resources for HIV and substance use
5. I know who to call to get information about what to do in response to a cluster or outbreak

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Introduction from HRSA Leadership

Heather Hauck, MSW, LICSW
Deputy Associate Administrator, HAB, HRSA

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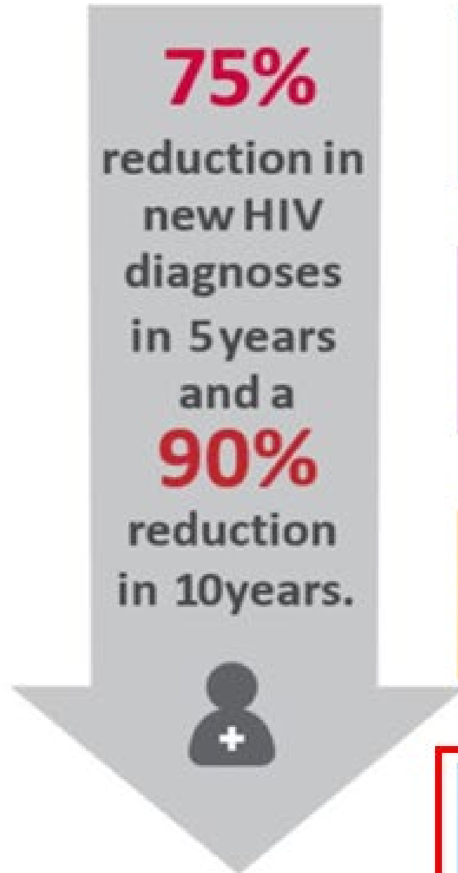
On-line TA meeting

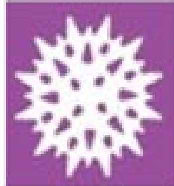
Welcome to
Responding to an HIV
Cluster or Outbreak:
Who do you call?
What do you do?

HRSA
Ryan White HIV/AIDS Program

Four Pillars of Ending the HIV Epidemic



Diagnose
All people with HIV as early as possible.



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

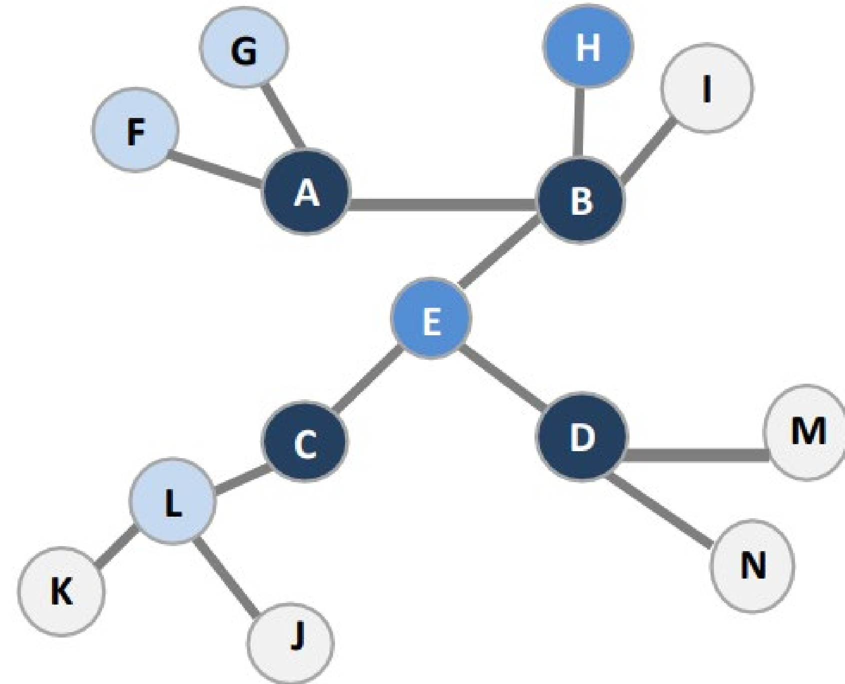
Prevent
New HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).

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

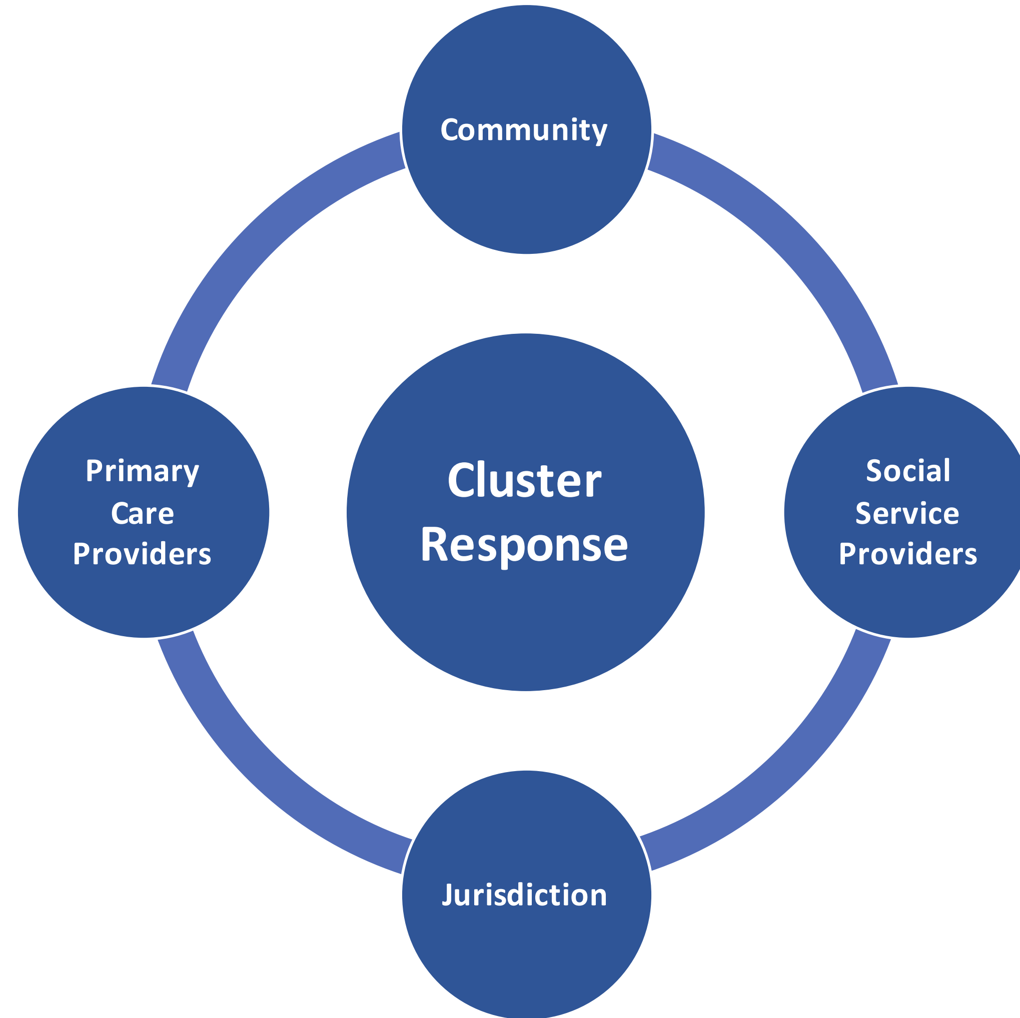
A full description of this chart can be found at the end of this presentation after the Summary slides under the title: Slide 17- Four Pillars of EHE

Cluster Response

Why do we need a robust public health response to clusters?

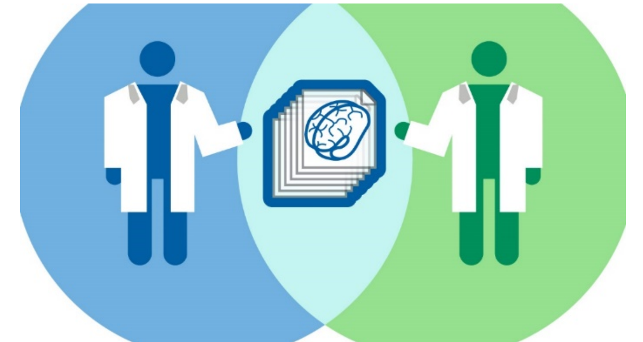


Cluster Response and Community



Cluster Response and Data Sharing

Data sharing is crucial step to cluster response and assures compatibility between data bases operated by internal and external partners.



EHE Technical Assistance for Cluster Response

HRSA HAB is funding technical assistance to help jurisdictions to build the capacity for cluster response.

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Asset Mapping and Engaging Stakeholders

Partners and Relationships for Organizations Involved in HIV Responses

Institutions
Federal Govt
Local Govt
Providers
Other

Other potential partners: IHS, PACE Program, HUD

CDC (DHAP, DSTDP, DVH, Injury, CSTLTS)
Capacity Building Asst. Provider
Community Based Org
Community Advisory Boards
NIH (CFARs, others)
HIV Planning Groups
Local HD
AETC
State HD
Academic Institutions
Tech Transfer Centers
AIDS Service Org
Behavioral Health Provider
RWHAP Provider
HRSA (HAB, BPHC)
Health Center
HHS, HRSA, and SAMHSA Regional Offices
SAMHSA

• Funding Relationship
Collaborative Relationship

A full description of this chart can be found at the end of this presentation after the Summary slides under the title: **Slide 23 - Partners and Relationships for Organizations**

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Part I: Introduction

Linda Rose Frank, PhD, MSN, ACRN, FAAN, Professor of Public Health, Medicine, & Nursing, Graduate School of Public Health, University of Pittsburgh, Principal Investigator, MidAtlantic AETC

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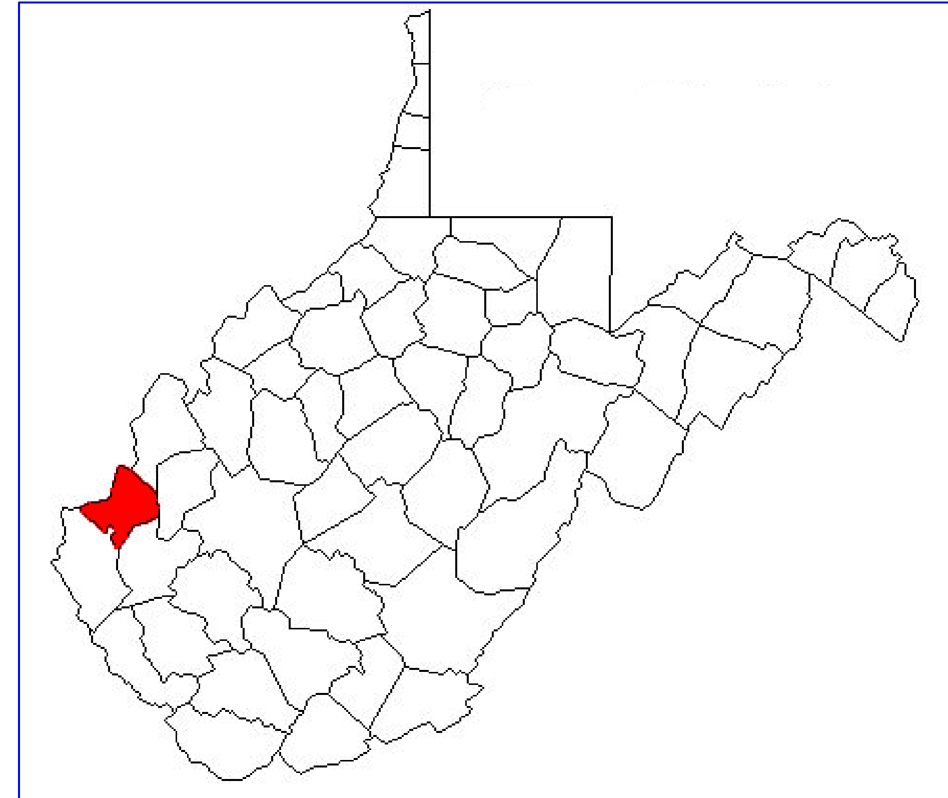
What Happened?

HIV Cluster Confirmed in West Virginia Among People Who Inject Drugs

An HIV cluster of initial 28 but now 113 known cases confirmed in Cabell County, West Virginia as of 12/15/2020

Website which updates numbers each month: https://oeps.wv.gov/hiv-aids/pages/default.aspx



What is it?

Cluster: refers to an aggregation of cases grouped in place and time that are suspected to be greater than the number expected, even though the expected number may not be known.

Outbreak: carries the same definition of epidemic, but is often used for a more limited geographic area

Determination of the difference is related to a range of factors including those outlined in CDC's cluster detection and response guidance. For example, smaller clusters may be more likely related to sexual transmission with larger clusters linked to injection drug use.

https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html

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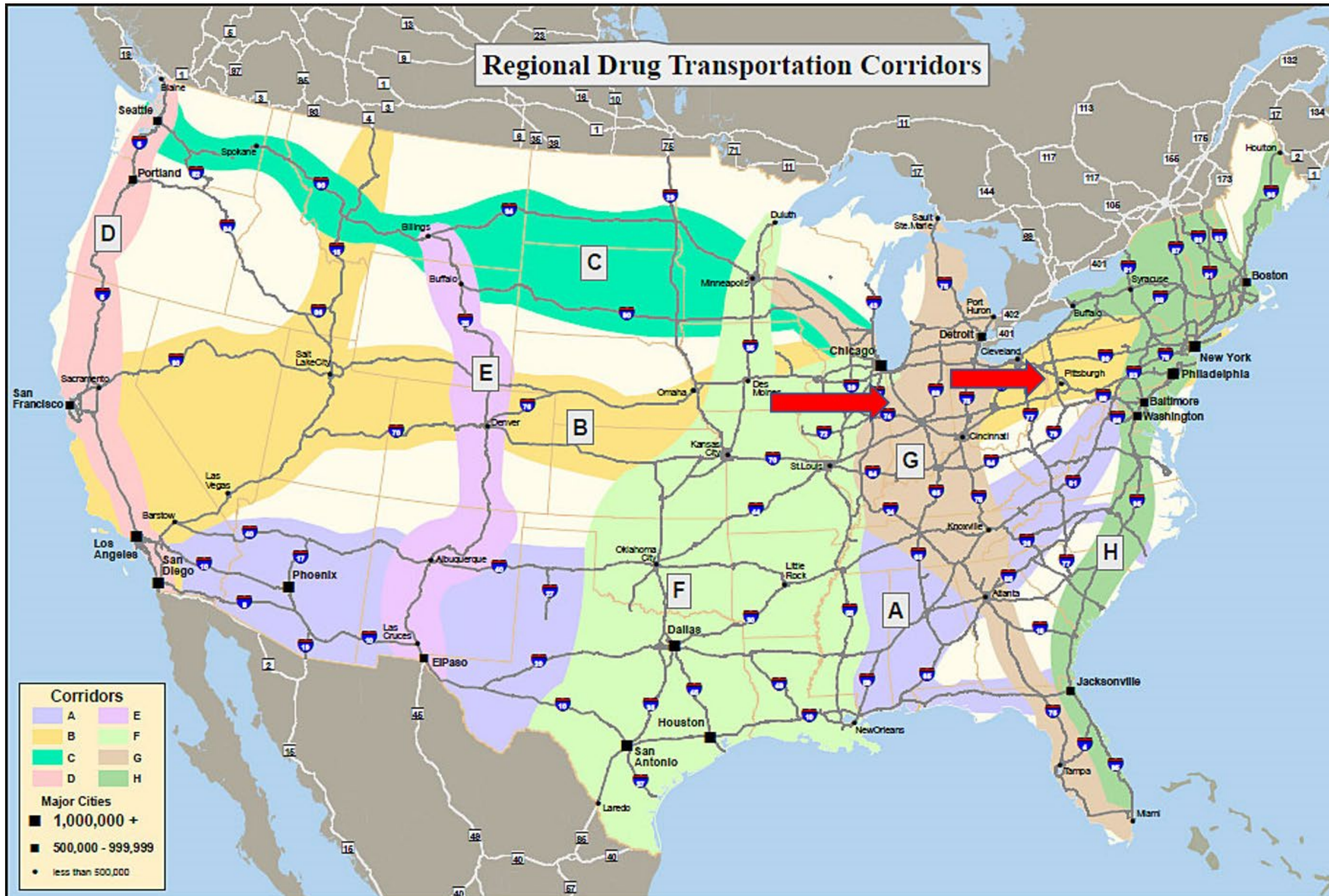
What factors may contribute?



A full description of this map can be found at the end of this presentation after the Summary slides under the title: Slide 27- Contributing Factors

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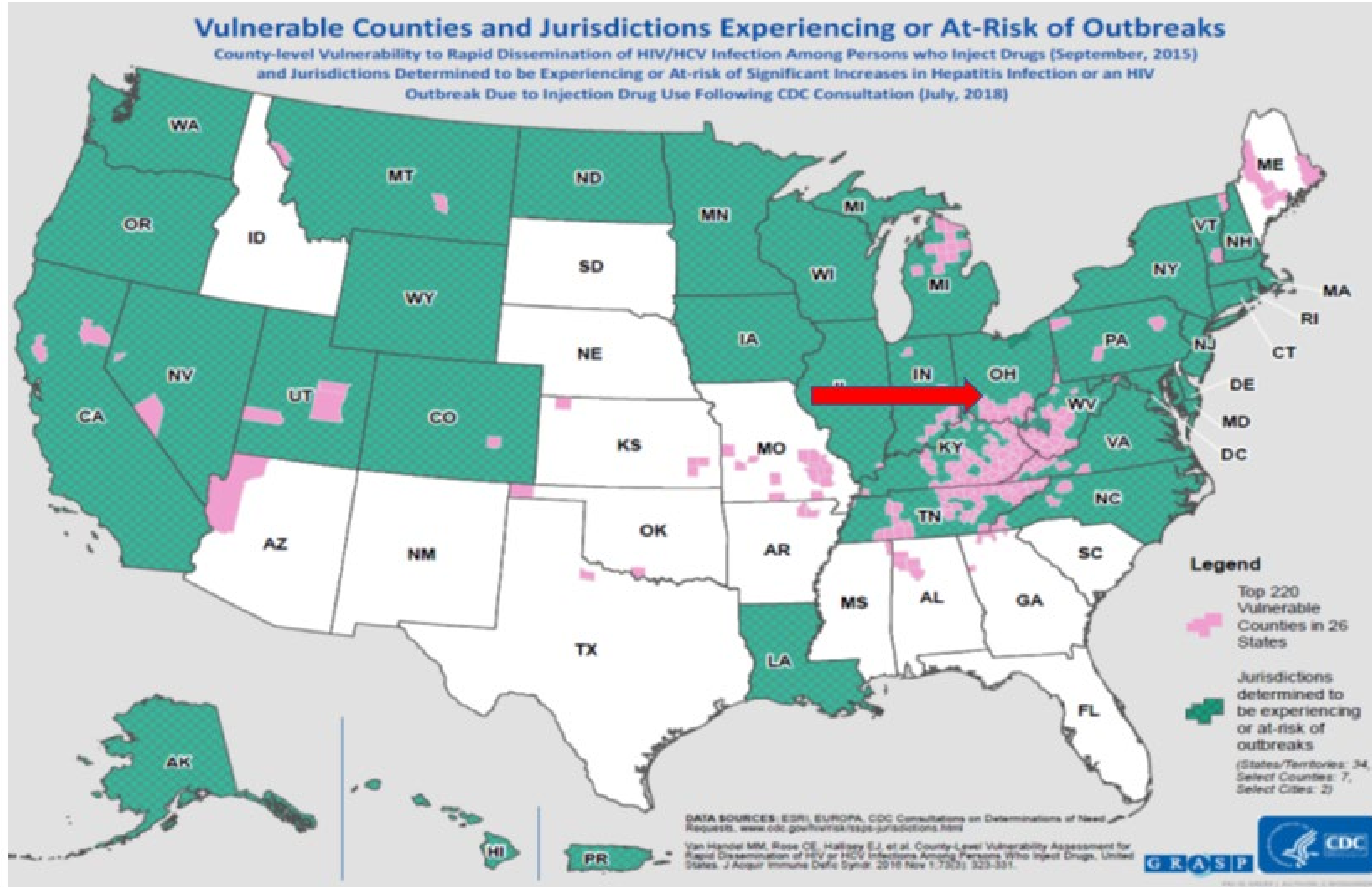
Was there a warning?



A full description of this map can be found at the end of this presentation after the Summary slides under the title: **Slide 28- Warning?**

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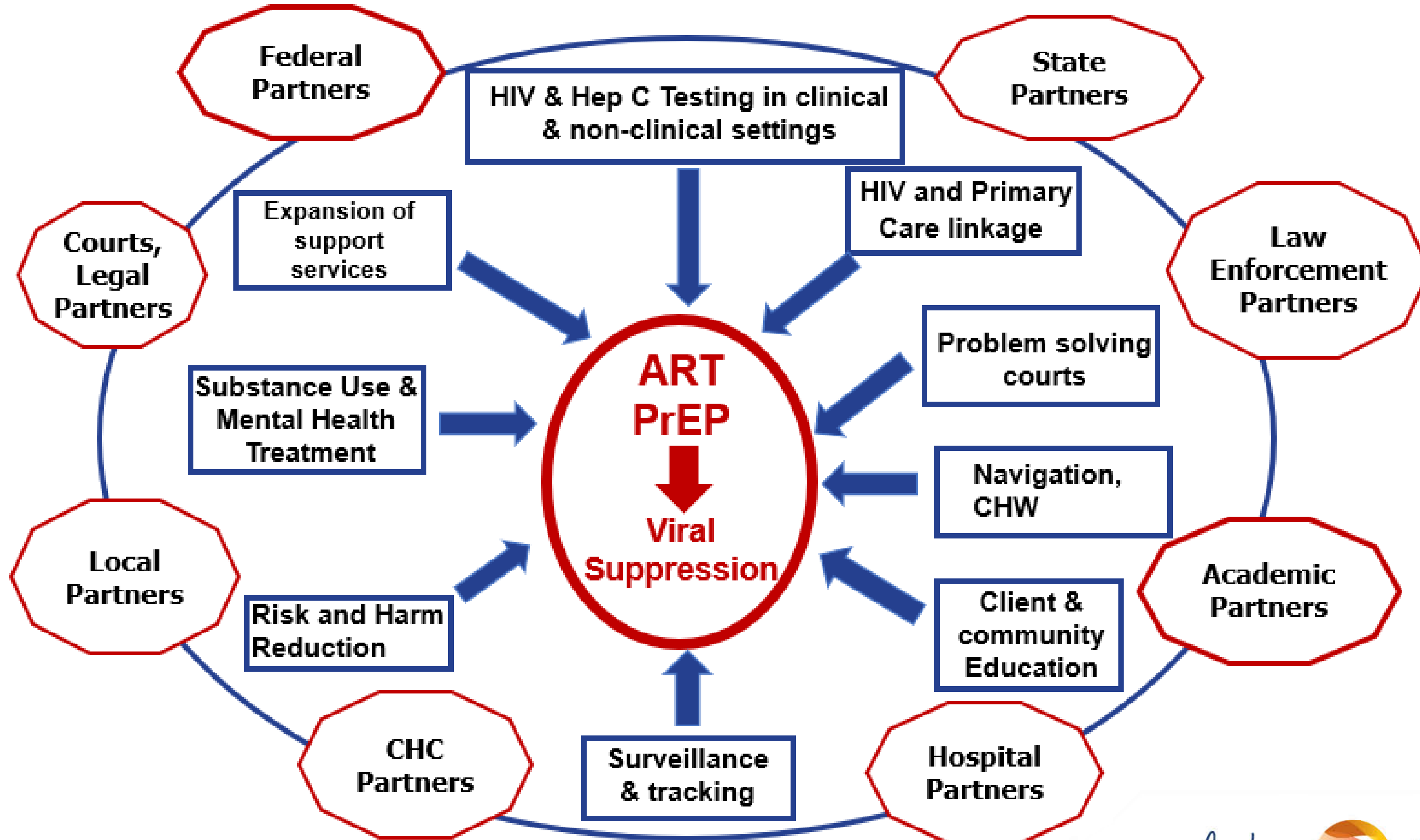
MidAtlantic AETC Critical Incident Model



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MidAtlantic AETC Model for Capacity Development in a Cluster/Outbreak

Drivers
- Local needs
- Risk populations
- Service gaps
- Quality gaps
- Access gaps
- State policies
- Federal policies

Workforce Planning
- Surveillance
- Existing policies
- Knowledge gaps
- Skill gaps

Workforce training
- HIV testing
- HIV treatment
- Harm reduction
- PrEP
- Contact tracing

Workforce organization
- Community mobilization
- Agency mobilization
- State outbreak response plan
- Federal response plan

Output
- Enhanced outreach
- Practice change
- Policy changes
- New partnerships
- Enhanced communication
- Linkage to prevention
- Linkage to treatment
- Community engagement

Frank, L. 2021

Part II: What happened at the onset of this cluster/outbreak?

What are considerations in response?

What is the major goal?

- Primary goal is to mitigate the cluster/outbreak

Who do you engage?

- CDC notification
- State Health Department
- HRSA Ryan White
- Training resources

What are considerations in response?

Who are priority partners?

- Local Health Department
- HIV Care Providers
- Community Health Centers
- Substance Use Treatment Programs
- Mental/Behavioral Health Program
- Social Service Organizations

How do you keep it going?

- Ongoing communication via meetings, calls and emails with partners

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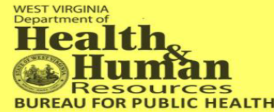
THIS IS AN OFFICIAL WEST VIRGINIA HEALTH ADVISORY NUMBER WV155-03-22-19
Distributed via the WV Health Alert Network – March 22, 2019



HEALTH ADVISORY #155

Increase in New HIV Infections Among Persons Who Inject Drugs

TO: **West Virginia Healthcare Providers, Hospitals, and other Healthcare Facilities**

FROM: **Catherine Slemp, MD, MPH, Commissioner and State Health Officer**
West Virginia Department of Health and Human Resources, Bureau for Public Health

DATE: **March 22, 2019**

LOCAL HEALTH DEPARTMENTS: Please distribute to community health providers, hospital-based physicians, infection control preventionists, laboratory directors, and other applicable partners.

OTHER RECIPIENTS: Please distribute to association members, staff, etc.

The West Virginia Bureau for Public Health is investigating an increase in newly diagnosed human immunodeficiency virus (HIV) cases in the state among persons who inject drugs (PWID). Historically, male-to-male sexual contact has been the predominant reported risk factor for becoming infected with HIV. Since 2018, we have seen an increase in the number of newly diagnosed cases of HIV with injection drug use (IDU) reported as a risk factor statewide.

Since January 2019, the Bureau for Public Health has been actively investigating an increase in newly diagnosed cases of HIV among PWID in Cabell County. Based on a five-year average (2013-2017), the expected number of HIV diagnoses for all reported risk factors in Cabell County per year is eight. In 2018, a total of 17 PWID were diagnosed with HIV in Cabell County, including seven diagnosed in the 4th quarter of 2018. Since January 1, 2019, an additional 13 PWID have been diagnosed in Cabell County, bringing the total number of new diagnoses among PWID to 30 since January 1, 2018. Public health partnerships are critical to preventing outbreaks of HIV. Your efforts and collaboration with the Bureau for Public Health will continue to prevent further infections and provide a healthier future for our communities.

We encourage all healthcare providers, hospitals and other healthcare facilities throughout West Virginia to:

- Screen all patients for history of injection drug use. All persons who inject drugs should be:
  - Tested for HIV, hepatitis C virus (HCV), hepatitis B virus (HBV), syphilis, gonorrhea and chlamydia at least once a year.
  - Encouraged to refer their sex or needle sharing partners for testing.
  - Referred to harm reduction programs where available.
  - Provided education about safe injection practices.
  - Provided or referred to substance use disorder treatment, including medication-assisted treatment (e.g. behavioral health services and support combined with methadone, buprenorphine, or naltrexone).
  - Referred for pre-exposure prophylaxis (PrEP) if at high-risk for sexual transmission of HIV. More information on PrEP is available at https://www.cdc.gov/hiv/risk/prep.

This message was directly distributed by the West Virginia Bureau for Public Health to local health departments and professional associations. Receiving entities are responsible for further disseminating the information as appropriate to the target audience.
Categories of Health Alert messages:
Health Alert: Conveys the highest level of importance. Warrants immediate action or attention.
Health Advisory: Provides important information for a specific incident or situation. May not require immediate action.
Health Update: Provides updated information regarding an incident or situation. Unlikely to require immediate action.

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Michael Kilkenny, MD
Physician Director
Cabell/Huntington Health Department

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Michael Kilkenny, MD, Physician Director, Cabell/Huntington Health Department

Follow link to hear and receive closed-captioning video of Michael Kilkenny, MD talking about the initial response at timestamp 32:32. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

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Kara Willenburg, MD, FACP
Associate Professor
Section Chief of Infectious Diseases
School of Medicine, Marshall University

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Kara Willenburg, MD, FACP, Associate Professor, Section Chief of Infectious Diseases, Marshall University

Follow link to hear and receive closed-captioning video of Kara Willenburg, MD talking about the initial outbreak at timestamp 38:20. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

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Part III: What did the State Health Department do?

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THIS IS AN OFFICIAL WEST VIRGINIA HEALTH ADVISORY NUMBER WV162-10-09-19
Distributed via the WV Health Alert Network –

HEALTH ADVISORY #162

Human Immunodeficiency Virus (HIV) Infections Among People Who Inject Drugs -- Additional Area Seeing Increase, Others Vulnerable

TO: **West Virginia Healthcare Providers, Hospitals, and other Healthcare Facilities**

FROM: **Catherine Slemp, MD, MPH, Commissioner and State Health Officer**
West Virginia Department of Health and Human Resources, Bureau for Public Health

DATE: **October 9, 2019**

LOCAL HEALTH DEPARTMENTS: Please distribute to community health providers, hospital-based physicians, infection control preventionists, laboratory directors, and other applicable partners.

OTHER RECIPIENTS: Please distribute to association members, staff, etc.

HIV has long been present across West Virginia, although at low levels. With the state's opioid and now broader substance use epidemic, West Virginia has been increasingly vulnerable to HIV outbreak(s) among persons who inject drugs (PWID). The sharing of injection drug equipment as well as high-risk sexual practices associated with substance use generate this vulnerability.

The West Virginia Bureau for Public Health (BPH) actively monitors HIV diagnoses across the state and works with local and federal partners to prevent, investigate and respond to increases. In addition to the Cabell County increase previously reported, BPH has now identified an increase in HIV diagnoses among PWID in Kanawha County (for more information visit www.hivawarewv.org). Although state and local health officials are still investigating, epidemiologic evidence suggests the increase in HIV among Kanawha County residents is distinct from the Cabell County cluster and indicates increased and recent local transmission (e.g., the Kanawha County increase is not simply an extension of the Cabell County cluster).

New HIV infections among PWID are clearly increasing in West Virginia. From 2014 to 2019, the proportion of new HIV diagnoses in West Virginia attributable to injection drug use (IDU) has increased over five-fold from 12.5% to 64.2%, primarily driven by the Cabell County and now Kanawha County increases. The emergence of HIV among PWID in more than one part of the state and the vulnerability of other West Virginia counties to HIV transmission indicate that enhanced surveillance and prevention activities are warranted statewide. **As a result, the BPH is asking all healthcare providers to increase vigilance for potential HIV infection, especially among PWID, to increase testing, to encourage prevention efforts, and to rapidly report new HIV infections to BPH. Prevention, prompt identification of cases and linkage to care improves clinical outcomes and is critical to reducing HIV transmission.**

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Amy Atkins, MPA
Director, Office of Epidemiology and Prevention Services, West Virginia Department of Health and Human Resources

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Technical Assistance Provider innovation network (TAPin)

Amy Atkins, MPA, Director, Office of Epidemiology and Prevention Services, West Virginia Department of Health and Human Resources

Follow link to hear and receive closed-captioning video of Ms. Amy Atkins talking about what the State Health Department did at timestamp 43:13. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

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Anndrea L. Rogers, BS, MT(ASCP)
Director, WVU Positive Health Clinic
Laboratory Director, West Virginia Bureau for Public Health Rapid Testing Program

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Anndrea L. Rogers, BS, MT(ASCP), Director, WVU Positive Health Clinic, Laboratory Director, WV Bureau for Public Health Rapid Testing Program

Follow link to hear and receive closed-captioning video of Ms. Anndrea Rogers talking about outreach to do HIV testing at timestamp 49:59. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

Part IV: What was it like working with the CDC?

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Michael Kilkenny, MD, Physician Director, Cabell/Huntington Health Department

Follow link to hear and receive closed-captioning from the 2nd video of Michael Kilkenny, MD talking about what it was like working with the CDC at timestamp 53:12. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

Part V: How did collaborations and linkage for patients happen?

Kara Willenburg, MD, FACP, Associate Professor, Section Chief of Infectious Diseases, Marshall University

Follow link to hear and receive closed-captioning video of Kara Willenburg, MD talking about how collaborations and linkage for patients happened at timestamp 59:20. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

Part VI: What have been the opportunities for continued Intervention to improved coordination and care?

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Michael Kilkenny, MD, Physician Director, Cabell/Huntington Health Department

Follow link to hear and receive closed-captioning from the 3rd video of Michael Kilkenny, MD talking about the remarkable reduction of new HIV cases 2019 at timestamp 1:08:01. https://targethiv.org/library/tap-in-responding-hiv-cluster-or-outbreak-who-do-you-call-what-do-you-do.

How do you enhance networks and collaboration?

Jeannette Southerly, RN, BSN, ACRN, Regional Coordinator, MidAtlantic AETC Regional Partner, West Virginia University

Carolyn Kidd, BSN, ACRN, Clinical Trainer, West Virginia Regional Partner, MidAtlantic AETC

What are key considerations in community engagement?

- Critical communication pre cluster/outbreak
- Knowing the community
- Working with “influentials”
- Building coalitions
- Building trust
- Convening groups
- Technology
- Best practices, lessons learned

What are clinical challenges in cluster/outbreak response?

- Increase uptake of HIV testing
- Recognition that change is difficult for clients and systems
- Stigma reduction through education
- Hesitancy to adopt PrEP as a viable intervention by providers through education of providers
- Addressing existing health disparities and access to care through coordination and policy changes
- Education about confidentiality, HIPAA, how to assure clients

How do you address system challenges in cluster/outbreak response?

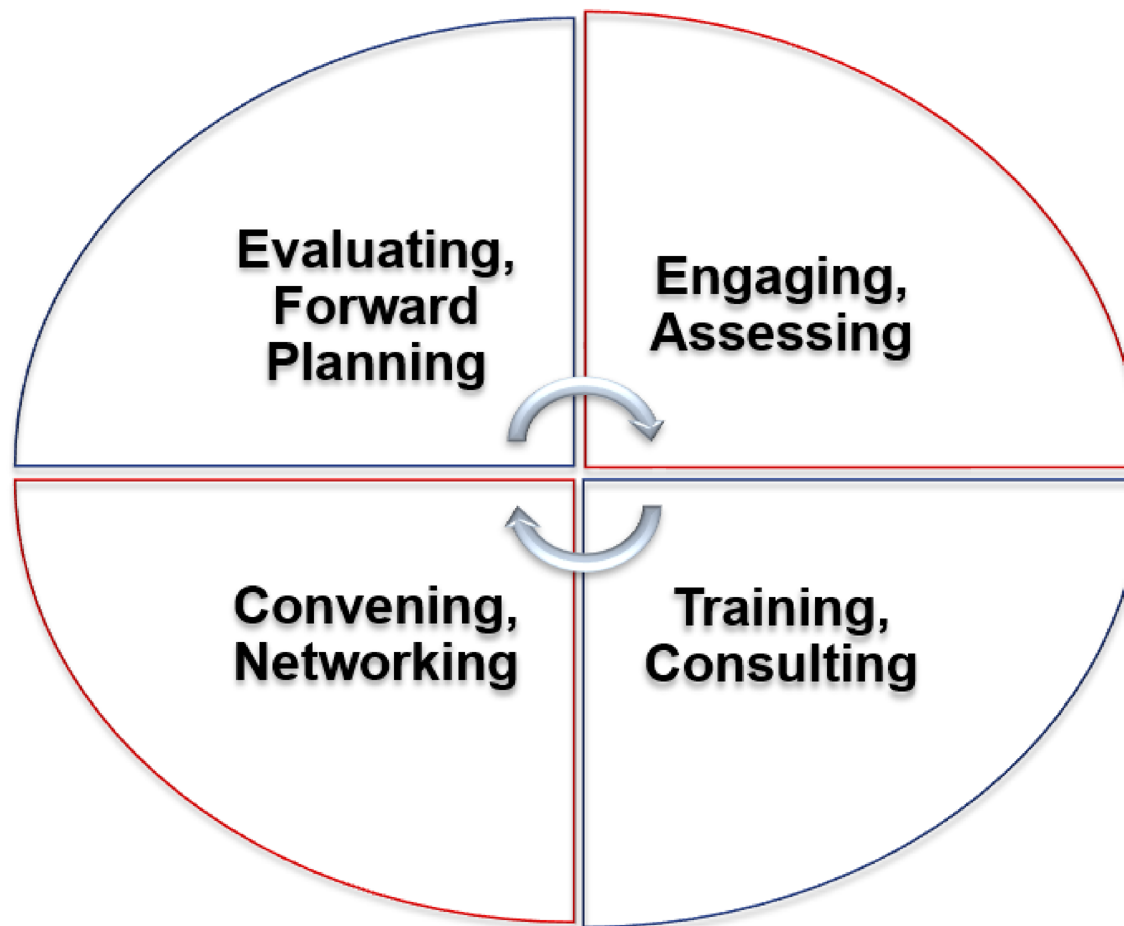
Focus intervention on important services	Enhance access to services	Plan for structural barriers
• Transportation • Homeless shelters • Food	• Online pharmacy and mail order • Telehealth • Peer support • Adherence education	• Geography, weather • Internet access and computers

https://www.ruralhealthinfo.org/toolkits/hiv-aids/1/rural-barriers

Example: MidAtlantic AETC Critical Incident Intervention in the West Virginia Outbreak

- Engaged with CDC and offer AETC assistance
- Participated in in calls, meetings, working groups
- Marketing relevant AETC training
- Offer to work on response plan future outbreaks

- WV Health Dept
- Cabell Co Health Dept
- CDC representatives on ground
- Weekly DOH and CDC calls
- Needs assessment training
- Identified clinicians for preceptorships



- Engage with other federal training centers
- Network with Cabell county to train addiction centers, first responders
- Work with local CHC to conduct training
- Participate in Opioid Steering Committee
- Offered use of MAAETC resources

- Rapid test training
- Linkage to care TA
- Stigma training
- Preceptorship
- Link to MAAETC training
- Link to the AETC NCCC

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How can you prepare and plan for clusters/outbreaks?

- Working with state response planning
- EHE Jurisdictional plans
- Linking with training resources
- Ongoing coalition building
- Developing communication networks
- Resource acquisition and mobilization
- Interprofessional response team development
- Involving consumers, families

AETC AIDS Education & Training Center Program
MidAtlantic

Part VII: What are available resources?

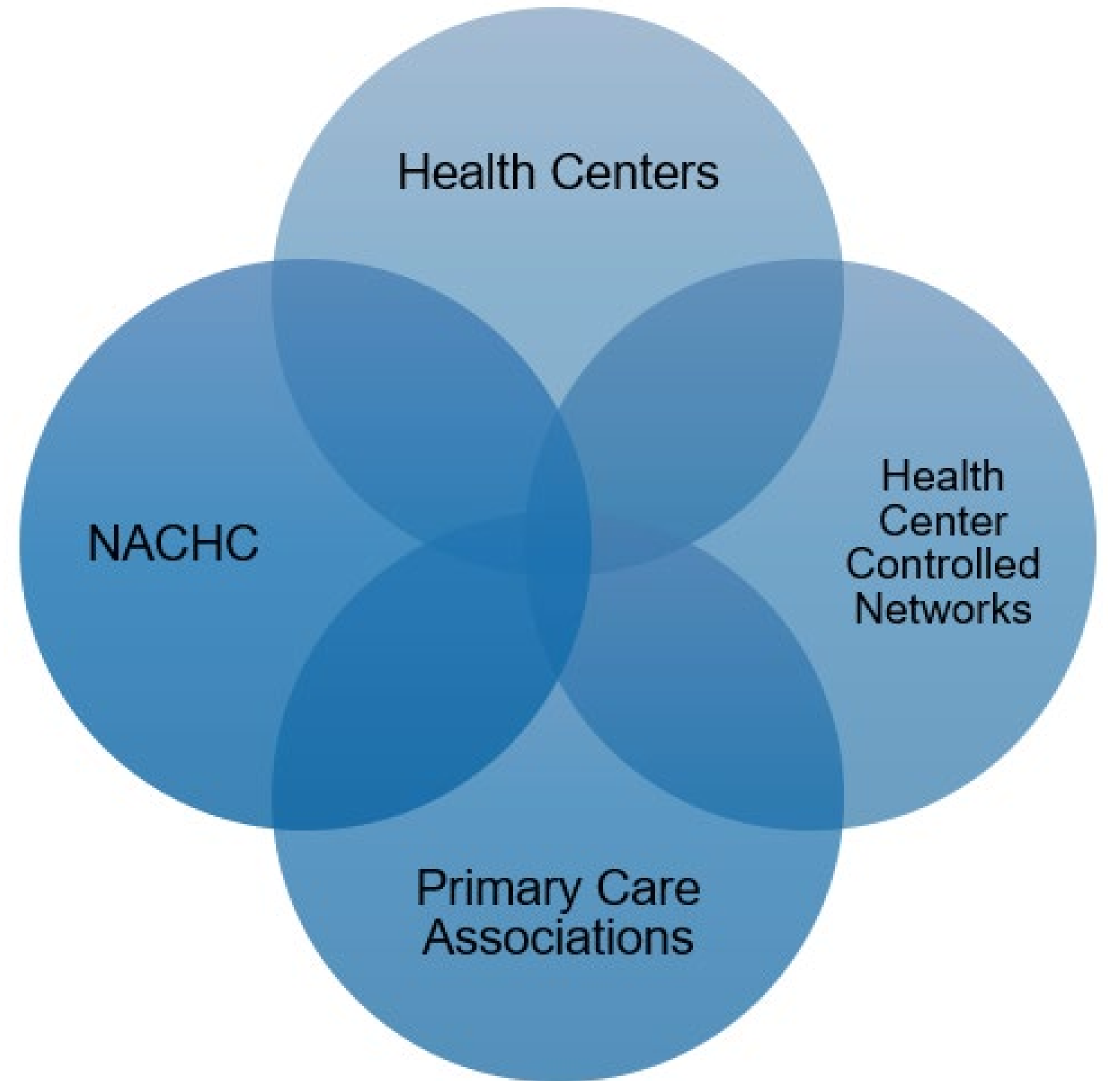
NATIONAL ASSOCIATION OF
Community Health Centers

Russell Brown,

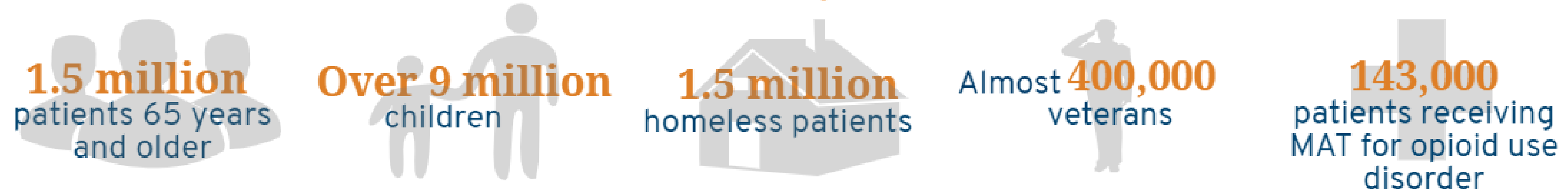
Director, Grants Administration and Division Operations
National Association of Community Health Centers

The National Infrastructure

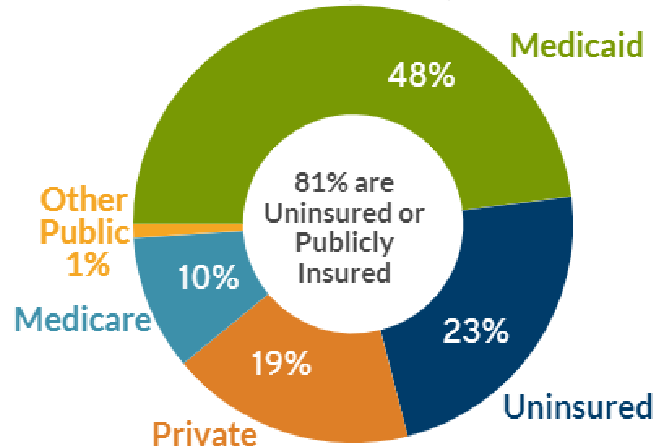
NACHC works in coordination with all health service delivery organizations to form a comprehensive approach to serving America's most underserved and vulnerable populations.



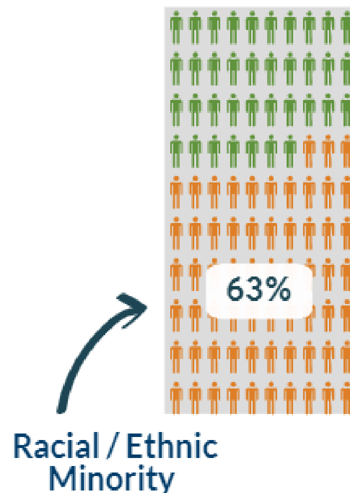
Who Do Health Centers Serve?



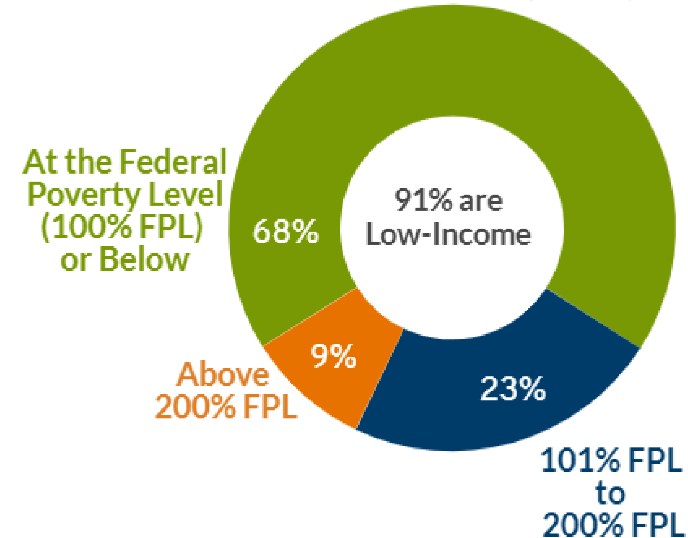
Most Health Center Patients Are Uninsured or Publicly Insured (2019)



Most Health Center Patients Are Members of Racial & Ethnic Minority Groups (2019)



Most Health Center Patients Have Low-Incomes (2019)



NATIONAL ASSOCIATION OF Community Health Centers®

A full description of this chart can be found at the end of this presentation after the Summary slides under the title: Slide 59 – Who Do Health Centers Serve?

@NACHC

Health Center Services

- Health Services related to:
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - Obstetrics
- Diagnostic Laboratory and Radiologic Services
- Dental Screenings
- Pharmaceutical Services
- Referrals to Other Providers
- Patient Case Management
- Enabling Services: Translation, Transportation, Outreach, and Health Education

Health Centers and HIV

According to the 2019 UDS data set:

- Approximately 1 out of every 100 patients is a person living with HIV
- 3% of new infections were in health centers
- HIV patients have on average 4 visits per year, indicative of viral load suppression
- New UDS measurement for 2020 on PrEP and linkage to care

Who is NACHC?

Founded in 1971, NACHC serves as the leading national advocacy organization in support of community-based health centers and the expansion of health care access for the medically underserved and uninsured.

Areas of Focus:

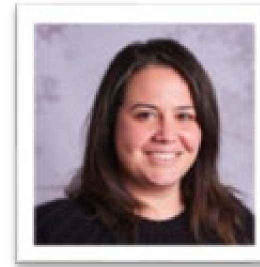
- Training and Technical Assistance
- Clinical Affairs
- Workforce Development
- Quality Improvement
- Informatics
- Public Health/Primary Care Partnerships

Ending the HIV Epidemic (EHE) Systems Coordination Provider (SCP)

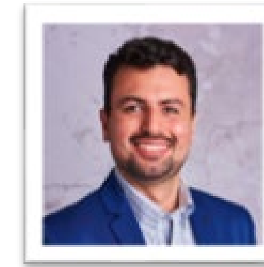
Project Team

Amy Killelea
Senior Director
Health Systems & Policy

Bianca Ward
Associate Director
Health Care Access



Dori Molozanov
Manager
Health Systems Integration



Edwin Corbin-Gutierrez
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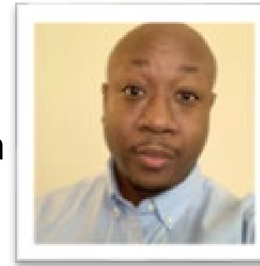
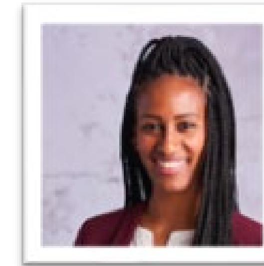
Helena Dessie
Senior Associate
Health Systems Integration

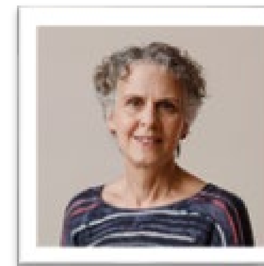
Jennifer Flannagan
Manager
Health Systems Integration



Kendrell Taylor
Manager
Prevention



Mahelet Kebede
Senior Manager
Health Care Access



Eve Mokotoff
Consultant
Cluster Response

SCP Objectives

Support the coordination of efforts across federal EHE funding streams within jurisdictions

COORDINATE EHE EFFORTS

DISSEMINATE INNOVATIVE APPROACHES

Share promising approaches and strategies across EHE jurisdictions to advance innovation

FORGE PARTNERSHIPS

Assist in forging partnerships with key stakeholders across systems and communities

Coordinate EHE Efforts: Respond

- State and local health department collaboration
  - Facilitate a meeting series with HD staff to bridge historical and philosophical differences across RWHAP and HIV surveillance/prevention programs
  - Share peer approaches to align program goals, strategies, activities, and indicators
- Internal collaboration within each health department
  - Share models showcasing collaboration with STD Partner Services, HIV prevention programs, and with other programs that have outbreak response experience

Data Sharing and Integration

- Well-integrated program design
  - Troubleshoot database compatibility challenges and share solutions across jurisdictions
  - Share promising approaches to provide comprehensive support services
- Analysis of state laws, rules or practices
  - Review data security, legal and ethical considerations around data sharing and confidentiality guidelines
  - Updating NASTAD's template data-sharing agreement/memoranda of understanding
  - Conduct policy analysis to inform program design safeguards in the context of HIV criminalization laws
- Cross-state health information exchange
  - Share peer processes and documents

Partnerships and Engagement

- Share peer HD approaches to plan community engagement activities
  - Community engagement process mapping
  - Defining communities beyond demographics
  - Engaging leaders selected by the community
  - Exercise/activity templates
- Support communication planning in the context of governmental and medical distrust
  - Community participation frameworks
  - Anti-stigma language principles
  - Gather common community concerns across jurisdictions

Linda Rose Frank, PhD, MSN, ACRN, FAAN,
Professor of Public Health, Medicine,
& Nursing, Graduate School of Public Health,
University of Pittsburgh,
Principal Investigator, MidAtlantic AETC

AETC Program

Mountain West
Midwest
New England
Northeast/ Caribbean
NCCC
NCRC
Pacific
South Central
MidAtlantic
Southeast

WA, OR, MT, ID, WY, ND, SD, MN, WI, MI, IA, NE, IL, IN, OH, NV, CA, UT, CO, KS, MO, KY, WV, VA, PA, NY, ME, AZ, NM, OK, AR, TN, NC, SC, MS, AL, GA, LA, TX, FL, AK, HI, Guam, PR, VI, N Mariana Islands, Am Samoa

NH, MA, NJ, CT, MD, VT, DE, RI, DC

A full description of this map can be found at the end of this presentation after the Summary slides under the title: Slide 69 - AETC Program

www.aidsetc.org

Outbreak content for training and TA

- HIV treatment
- HIV prevention
- PrEP
- Early start
- Treatment adherence
- Psychosocial co-morbidities
- Infectious diseases co-morbidities
- Metabolic co-morbidities
- Coordination of clinical services

AETC AIDS Education & Training Center Program MidAtlantic

Standardized Training Methods

Clinician intervention	Capacity building	Adult learning principles guide intervention
• Clinical mini-residencies • Clinical consultation • Clinical practice education groups • Case based learning • Best practices • HRSA performance	• Clinic technical assistance • Longitudinal training • System technical assistance • Facilitate development of medical homes	• Participation • Repetition • Relevance • Transference • Feedback

What methods of TA can be provided

- Building new relationships and networks
- Calling upon existing relationships and networks
- Convening groups
- On-site and distanced-based intervention
- Developing learning collaboratives
- Use of Telemedicine
  - Grants.gov
- How to use surveillance data
- Technology assessment and enhancement
  - Grants.gov
- Longitudinal support
- Resources: HRSA, NCCC, SAMHSA, NIDA, NIH, AETCs

AETC AIDS Education & Training Center Program MidAtlantic

Federal Training Resources

- Addictions Technology Transfer Center; (HRSA-funded)
- AIDS Education and Training Centers; (HRSA-funded)
- Area Health Education Centers; (HRSA-funded)
- Geriatric Education Centers; (HRSA-funded)
- Pediatric Environmental Health Specialty Units; (CDC-funded)
- Primary Care Associations; (HRSA-funded)
- Public Health Training Centers; (HRSA-funded)
- School of Public Health MCH Training Programs; (CDC-funded)
- STD and Reproductive Health Training and Technical Assistance Centers; (CDC-funded)
- STD/HIV Prevention Training Centers; (CDC-funded)
- Telehealth Resource Centers (HRSA-funded)

AETC AIDS Education & Training Center Program MidAtlantic

Technical Assistance Provider
innovation network

Technical Assistance Provider innovation network (TAP-in)

A Project of CAI

Technical Assistance Provider innovation network

TA Purpose

Strengthen and support implementation of jurisdiction EHE Plans to contribute to achievement of reduction in new reported HIV cases by 75% by 2025

Overarching Principles:

1. Partner with jurisdictions
2. Tailor TA to local context
3. Identify most efficient and effective actions and strategies (less can be more)
4. Foster innovation, work across silos, and maximize meaningful community participation
5. Leverage existing resources
6. Employ Implementation science and adult learning theories, frameworks, and strategies
7. Use data and information to continuously improve

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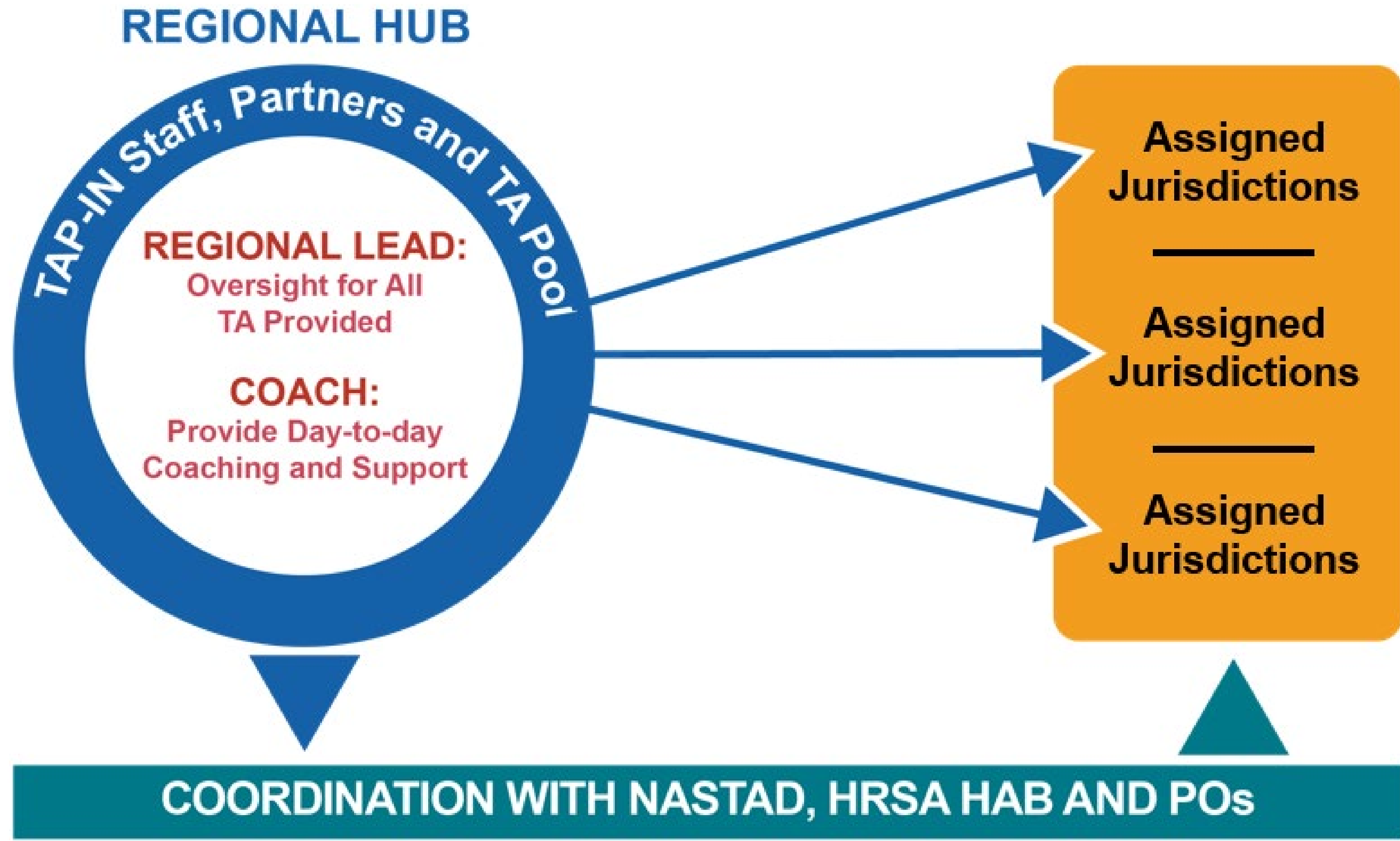
Technical Assistance Provider innovation network



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Tip: Get TAP-in TA and Training by Contacting TAP-in@caiglobal.org

Post-session poll questions (directed to jurisdictions)

Rating scale: Strongly agree; Agree; Neutral; Disagree; Strongly Disagree

Regarding HIV cluster and outbreak response:

1. I know more about the procedures for cluster and outbreak response
2. I know more about resources available to assist
3. I developed some new ideas for follow-up
4. I need more information
5. I know who to call in a cluster or an outbreak response

Technical Assistance Provider innovation network

Q&A
Moderated by Linda Rose Frank

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Summary for HIV Outbreaks Among PWID

Cluster/Outbreak preparedness and detection:

- Assess capacity to detect increase in HIV above expected, evaluate evidence of recent transmission of HIV.
- Develop standards to assess outbreak occurrence, threshold for outbreak response plan to be initiated.
- Establish capacity (local providers, hospitals, clinics, health departments) to provide HIV care and treatment.
- Develop protocols to refer identified persons to HIV medical care, mental health and substance use treatment.

https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-checklist.pdf

Technical Assistance Provider innovation network (TAPin)

Summary for HIV Outbreaks Among PWID

Cluster/Outbreak investigation:

- Create a case definition for confirmed, probable, and possible cases.
- Establish and implement a contact tracing plan.
- Increase capacity for HIV testing in the affected area, particularly venues frequented by PWID
- Ensure HIV testing methods and algorithms can detect and confirm both chronic and acute infections with HIV and can generate data to assess genetic relatedness of infections.

https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-checklist.pdf

Summary for HIV Outbreaks Among PWID

Cluster/Outbreak response

- Involve public safety, especially law enforcement, early.
- Involve CBOs that can provide appropriate services to enhance the response.
- Provide or refer to HIV treatment and support services including case management, mental health treatment, and assistance procuring health care coverage.

https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-checklist.pdf

Technical Assistance Provider innovation network

Summary for HIV Outbreaks Among PWID

Cluster/Outbreak response

- Provide or refer to organizations that provide access to sterile injection equipment to prevent new infections, where state and local law allows.
- Provide or refer to organizations that offer access to medication-assisted treatment, counseling, and support to treat substance use disorder and to prevent drug injection.
- Minimize the number of steps, visits, locations, and overall effort required to access care, locating multiple services in a single location.

https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-checklist.pdf

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Technical Assistance Provider innovation network | Ending the HIV Epidemic

Charts, Graphs, and Table Descriptions

Slide 5 - Survey: Regional TAP-in Structure

United States map depicts three regions for the regional TAP-in TA structure for the 47 EHE jurisdictions: West with Los Angeles office for 16 EHE jurisdictions in AZ, CA, NV, OK, TX, WA; South with Atlanta office for 16 jurisdictions in AL, AR, KY, GA, FL, LA, NC, SC, TN, MS; Northeast/Central with New York City office for 15 jurisdictions in DC, MA, MD, NJ, NY, PA, PR, IL, IN, OH, MO, MI.

Slide 17- Four Pillars of EHE

(EHE)
The goal of EHE is a 75% reduction in new HIV diagnoses in 5 years and a 90% reduction in 10 years. The Ending the HIV Epidemic initiative focuses on four key strategies that, implemented together, can end the HIV epidemic in the U.S.: Diagnose, Treat, Prevent, and Respond. These strategies are known as the Pillars of EHE.
Pillar 1 is Diagnose
All people with HIV as early as possible.
Pillar 2 is Treat
People with HIV rapidly and effectively to reach sustained viral suppression.
Pillar 3 is Prevent
New HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
Pillar 4 and the focus of this webinar is Respond
Quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Slide 23 - Partners and Relationships for Organizations

This visual representation of partners and funding and collaborative relationships for organizations involved in HIV cluster responses show interactions among various institutions, including:

- Federal Government – CDC (DHAP, DSTDP, DVH, Injury, CSTLTS; HRSA (HAB, BPHC); HHS, HRSA, SAMHSA Regional Offices; NIH (CFARs, others); SAMHSA
- Local Government – Local and State health departments
- Providers – AIDS service organization, community-based organization, behavioral health provider, RWHAP provider, Health Center
- Others – AETC, HIV Planning Groups, Capacity Building Assistance Provider, Tech Transfer Centers, Community Advisory Boards, Academic Institutions
- Other potential partners include: IHS, PACE Program, HUD

Slide 27 – Contributing Factors

This slide shows the U.S. map depicting regional drug transportation corridors throughout the United States as provided by the Justice Department.

Virtually every interstate and highway in the United States is used by traffickers to transport illicit drugs to and from distribution centers and market areas throughout the country, and every highway intersection provides alternative routes to drug markets. However, analysis of current seizure data reveals eight principal corridors through which most illicit drugs and drug proceeds are transported to and from market areas. For a full description of the corridors visit the Justice Department website at: https://www.justice.gov/archive/ndic/pubs11/18862/transport.htm

Charts, Graphs, and Table Descriptions – cont.

Slide 28- Warning?

U.S. map depicting Vulnerable Counties and Jurisdictions Experiencing or At-Risk of Outbreaks of County-level vulnerability to rapid dissemination of HIV/HCV infection among persons who inject drugs (September 2015) and jurisdictions determined to be experiencing or at-risk of significant increases in hepatitis infection or an HIV outbreak due to injection drug use following CDC consultation (July 2018)

- A large arrow points to an area of western Kentucky, northeastern Tennessee, southern Ohio, far western Virginia and West Virginia – a large clustered area where the borders of these 5 states meet. This area, according to the legend, reflects the top 220 vulnerable counties in 26 states.
- The legend also indicates states whose jurisdictions are determined to be experiencing or at-risk of outbreaks. (States / Territories: 34, Select Counties: 7, Select Cities: 2)
- Data sources: ESRI, EUROPA, CDC consultations on determinations of need requests, www.cdc.gov/hiv/risk/ssps-jurisdictions.html
- Van Handel MM, Rose CE, Hallisey EJ, et al. County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections Among Persons Who Inject Drugs, United States. J Acquir Immune Defic Syndr. 2016 Nov 1; 73(3): 323-331.

Slide 59 – Who Do Health Centers Serve?

Health centers now serve more than 30 million patients including:
1.5 million patients 65 years and older
Over 9 million children
1.5 million homeless patients
Almost 400,000 veterans
143,000 patients receiving MAT for opioid use disorder

Most Health Center Patients Are Uninsured or Publicly Insured (2019)
A Pie chart separated into 5 sections shows:
Medical 48%
Uninsured 23%
Private 19%
Medicare 10%
Other Public 1%
Center of the chart states 81% are Uninsured or Publicly Insured

Most Health Center Patients Are Members of Racial & Ethnic Minority Groups (2019)
A Column chart single column using people icons to fill in shows 63% of group is Racial/Ethnic Minority

Most Health Center Patients Have Low-Incomes (2019)
A Pie chart separated into 4 sections shows:
At the Federal Poverty Level (100% FPL) or Below - 68%
101% FPL to 200% FPL - 23%
Above 200% FPL 9%
Center of the chart states 91% are Low-Income

Charts, Graphs, and Table Descriptions – cont.

Slide 69 - AETC Program

U.S. map depicts AETC program geographic areas. Regional AETCs include:

- The MidAtlantic AETC serves Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia through its central office and local partners.
- The Midwest AETC serves Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin through its central office and local partners.
- The Mountain West AETC serves Alaska, Colorado, Idaho, Montana, Oregon, North and South Dakota, Utah, Washington, and Wyoming through its central office and local partners.
- The New England AETC serves Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont through its central office and local partners.
- The Northeast/Caribbean AETC serves New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands through its central office and local partners.
- The Pacific AETC serves Arizona, California, Hawaii, Nevada, and the 6 U.S.-affiliated Pacific Jurisdictions through its central office and local partners.
- The South Central AETC serves Arkansas, Louisiana, New Mexico, Oklahoma, and Texas through its central office and local partners.
- The Southeast AETC serves Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee through its central office and local partners.

National Training Centers
AETC National Coordinating Resource Center (NCRC) – Located in New Jersey
National Clinician Consultation Center (NCCC) – Located in California