

Local Health Department Experiences Implementing High-Impact HIV Prevention: Results from NACCHO's HIV/STI Prevention Sentinel Network Query



Background and Purpose

In 2008, the National Association of County and City Health Officials (NACCHO) developed the HIV/STI Sentinel Network (SN) to gather information about HIV/STD-related policies, service delivery models, operational constraints, and local innovations. SN members responded to periodic electronic queries about national HIV/STD prevention issues and local health department (LHD) priorities for HIV/STD prevention. The queries offer federal, state, and local policymakers and service providers insight into LHD priority activities, operating environments, and needs that may improve policy development and evaluation of activities. In 2012, NACCHO recruited a new group of SN LHDs, which resulted in a nationally representative sample of LHD programs providing HIV/STD services.

At the time of NACCHO's "Local Health Department (LHD) Experiences Implementing High-Impact HIV Prevention" query in 2013, the SN comprised 91 LHD HIV/STD prevention staff in 32 states. Twenty-eight LHDs were located in the South, 26 LHDs were located in the Midwest, 20 LHDs were located in the West, and 17 LHDs were located in the Northeast. Thirty-seven LHDs in the SN represented populations of fewer than 50,000 residents, 32 LHDs represented 50,000–499,999 residents, and 22 LHDs represented populations greater than 500,000.

The query assessed LHD experiences implementing the Centers for Disease Control and Prevention's (CDC's) High Impact HIV Prevention (HIP) approach to reducing new HIV infections. HIP is rooted in the CDC's recognition that, in an era of increasingly strained public and private resources, the ambitious goals articulated in the National HIV/AIDS Strategy (NHAS) are unlikely to be met unless HIV prevention programs become more strategic not only with respect to what they do but also with respect to when, where, for whom, and how they do it. Interventions that have proven to be successful for HIV prevention and are considered to be key components of HIP include HIV testing and linkage to care; anti-retroviral treatment; access to condoms

and sterile syringes; prevention programs for people living with HIV and their partners; prevention programs for people at high risk of HIV infection; substance abuse treatment; and screening and treatment for other sexually transmitted infections.

The purpose of this query was to (1) assess LHDs' awareness of HIP; (2) better understand whether and how LHDs have changed their HIV prevention activities in response to HIP; and (3) identify technical assistance/training opportunities to better support LHDs' implementation of HIP in their communities.

Methods

In July 2013, NACCHO distributed the query to the 91 members of the SN or their designees. The survey remained in the field until the end of August 2013. Twelve e-mail addresses were invalid; therefore, 79 LHDs ultimately received the query. NACCHO sent up to three reminder e-mails to non-responders, depending on when the query was completed. In addition, NACCHO conducted targeted outreach by phone to a geographically diverse group of non-respondents to encourage them to complete the query.

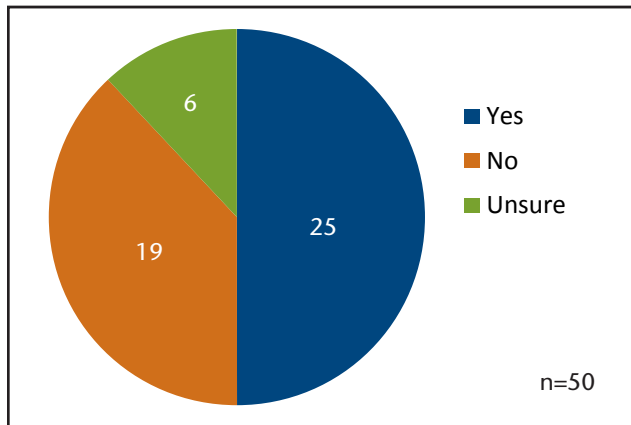
Results

Fifty LHD staff from the SN responded to the query, yielding a response rate of 63.3 percent. Among the respondents, 17 represented Midwest states, 15 represented Southern states, 11 represented Western states, and seven represented Northeastern states.

Funding for LHD HIV Prevention and Treatment Activities

Half of the LHDs surveyed (25) reported that they received funding specifically to support HIV prevention activities; 19 LHDs indicated that they did not receive dedicated HIV prevention funds, and six were unsure whether their LHD received funds for this purpose. (See Figure 1 on next page.)

FIGURE 1. LHD FUNDING TO SUPPORT HIV PREVENTION ACTIVITIES



Only four LHDs that responded to the query received Ryan White Part A, B, or C funds to provide HIV care and treatment services. Two LHDs received Ryan White Part A funds only; one LHD received both Ryan White Parts A and C funds; and one LHD received only Part C funds. Three respondents were located in counties where organizations/institutions other than the LHD received Ryan White funding. Two members of the SN represented cities that received direct funding from the CDC for HIV prevention, and none of those jurisdictions responded to this query. It thus seems reasonable to assume that most of the funding that LHDs receive for HIV prevention is from state or local sources, although some funds may represent pass-through funding from the CDC or Health Resources and Services Administration (HRSA) that arrives at the LHD from the state health department.

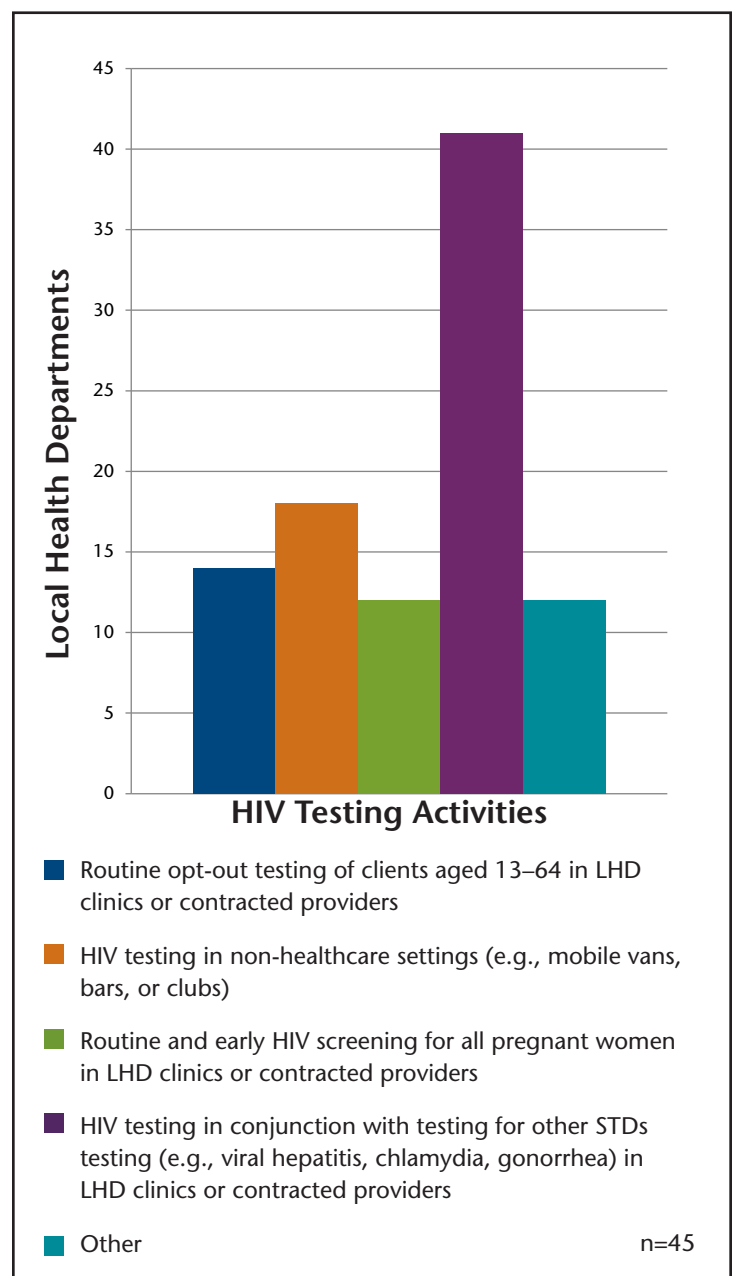
HIV Testing

Forty-five LHDs that responded to the query conducted HIV testing. Respondents noted all areas in which they conducted HIV testing. Of the LHDs that reported providing HIV testing, 41 LHDs reported that HIV testing was most commonly conducted in conjunction with testing for other STDs (e.g., viral hepatitis, chlamydia, or gonorrhea) in LHD clinics or by contracted providers. Eighteen LHDs reported supporting HIV testing in non-healthcare settings (e.g., mobile vans, bars, or clubs); 14 LHDs indicated offering routine opt-out testing to clients between the ages of 13 and 64 in LHD clinics or contracted providers; and 12 LHDs reported providing routine and early HIV screening for all pregnant women in LHD clinics or through contracted providers. Five LHDs responded that they did not conduct HIV testing at all; four of those LHDs were among those that indicated that their LHD did not receive any dedicated HIV prevention funding. (See Figure 2.)

Interventions to Support Linkage, Retention, and Re-Engagement in HIV Care

Over half of LHDs that responded to this query (26) implemented interventions to improve retention in HIV care. Case managers and motivational or strengths-based

FIGURE 2. HIV TESTING ACTIVITIES CONDUCTED BY SN LHDs



Note: SN respondents were asked to check all activities that applied.

counseling were the most commonly reported techniques employed by LHDs to support retention in care for HIV-positive clients. Respondents also reported the use of other interventions to improve retention in HIV care, including LHD staff accompanying clients to medical appointments/care coordination (10 LHDs) and peer navigators (four LHDs).

The majority of LHDs that responded to this query (31) reported that they conducted activities to re-engage HIV-positive clients who had fallen out of HIV care. Twenty-two LHDs indicated that they used disease intervention specialists to locate and counsel people who had tested positive for HIV and who were not in care. Eleven LHDs used the

Anti-Retroviral Treatment and Access to Services (ARTAS) program or other interventions to support links to care.

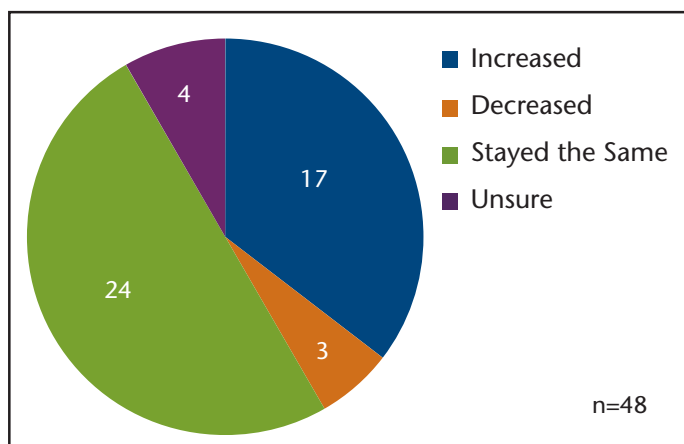
Query respondents that indicated their LHD did not provide retention in HIV care support services identified barriers to implementation. Among the 14 respondents that reported not actively assisting clients with HIV retention in care, six respondents identified a lack of sufficient staff or other resources as impeding their ability to provide interventions for retaining clients in HIV care. In other instances, LHDs indicated that they did not support interventions for retention in HIV care because another entity funded by HRSA or the state conducted such activities or because the state health department managed retention in care directly.

Eleven LHDs reported that they did not try to link or re-engage HIV-positive clients who had fallen out of HIV care and treatment, and eight LHDs were unsure if they conducted such activities. Reasons cited by respondents for not providing re-engagement services included insufficient staff or other resources; lack of information needed to identify these persons; reliance on the state health department to manage links and re-engagement; and having a memorandum of understanding with another LHD to conduct HIV case follow-up and management.

Condom Distribution

Nearly all of the LHDs (48) that responded to this query answered that their LHD distributed condoms. Among the LHDs that distributed condoms, condom distribution either stayed the same (24 LHDs) or increased (17 LHDs) since 2012. Only three LHDs reported decreases in condom-distribution efforts since 2012, and four LHDs were unsure whether their LHD had changed the number of condoms distributed. (See Figure 3.)

FIGURE 3. TRENDS IN CONDOM DISTRIBUTION AMONG SN LHDs SINCE 2012



Policy Changes

Respondents also indicated whether any recent policy changes in their jurisdiction had improved their ability to deliver HIV prevention, care, and treatment services.

Seven LHDs reported benefitting from policy changes that improved their ability to deliver HIV prevention, care, and treatment services. Examples of such policy changes reported by LHDs were (1) improved alignment or integration of HIV planning bodies and the state plans and priorities they develop; and (2) changes in state/local laws or regulations that support the use of HIV surveillance data for public health action, including reporting required for all CD4 and viral load test results, or authorization of LHD staff to use surveillance data for outreach to persons not in HIV care.

The majority of respondents (32 LHDs) did not indicate that they had benefitted from any HIV/STD-related policy changes in their jurisdiction. Eleven LHDs were unsure of whether any relevant policy changes had occurred that impacted their work, meaning there could have been policy changes, but the LHD was unsure if they had any impact, or the LHD was unsure if any policy changes had occurred.

HIV Surveillance Data

Forty-one LHDs reported that they had access to HIV surveillance data, either through direct reporting by labs/providers to the LHD or through a data-sharing agreement with the state health department. Respondents used HIV surveillance data in a number of ways, including to track community outcomes (e.g., community viral load or rates of linkage to care) (16 LHDs) and to direct public health outreach and action (e.g., identifying persons out of care and seeking to find and re-engage them) (14 LHDs). Twenty LHDs also reported using HIV surveillance data for other activities, such as targeting high-risk groups for HIV testing, tracking HIV testing rates, or evaluating HIV testing programs.

Seven LHDs indicated that they did not have access to surveillance data; of these, five LHDs were not pursuing such access, and two LHDs were unsure whether efforts were underway at their LHDs to gain access to HIV surveillance data.

Technical Support and Assistance

LHDs who responded to the query generally looked to their state health departments for HIV/STD prevention-related technical assistance (TA) (40 LHDs). They also frequently sought TA from AIDS Education Training Centers (17 LHDs) and from other LHDs (e.g., peer-to-peer assistance) (14 LHDs).

When asked whether they would be interested in receiving TA about HIV/STD prevention from NACCHO or CDC's Division of HIV/AIDS Prevention, 22 LHDs indicated interest in receiving education or training on structural interventions, including those directed toward policy changes; 18 LHDs reported interest in TA on strategies to decrease individual and community viral loads; and 15 LHDs desired to receive TA focused on collecting, analyzing, and using data to support service planning, resource allocation decisions, impact monitoring, and quality improvement activities. One LHD also reported interest in pre- and post-testing counseling, and another LHD reported interest in TA on obtaining third-party reimbursement for HIV testing.

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Discussion

The query results illustrate the impact of CDC's HIP initiative on a range of LHD HIV prevention programs. Respondents disproportionately represented jurisdictions with small (fewer than 50,000 residents) to medium-sized (50,000–499,999 residents) populations. Of the respondents to this query, 36 LHDs were from states with locally governed health departments, five LHDs represented health departments from shared governance states, and nine LHDs represented LHDs that were units of a state health agency.

Resource-allocation decisions made by state health departments are important determinants of LHDs' ability to support a diverse package of HIV prevention activities, including those prioritized under the HIP framework. Given the disproportionate representation of small and medium-sized jurisdictions that responded to this query, LHDs that responded to this query were less likely to receive direct federal funds to provide HIV prevention and care services because they served populations with lower HIV incidence. While funding is one important factor for local implementation of HIP, access to local-level surveillance data, staff capacity, and the local political environment also shape LHDs' ability to implement an HIV prevention program effectively in their jurisdictions.

The HIP framework provides additional flexibility to support the use of local-level information to target prevention interventions to achieve the maximum impact on the HIV epidemic. Because implementation of HIP depends highly on local circumstances, LHDs should collaborate with state health departments, federal public health agencies, community-based organizations, and national organizations that support this work to define what HIP should look like in jurisdictions with less concentrated epidemics.

The significant number of invalid e-mail addresses that could not be updated during the distribution of this query suggests that some LHDs in the SN are experiencing changes in HIV staff capacity, such as layoffs, internal job reassignment, or attrition. This query thus seems to corroborate other research findings, including NACCHO's economic surveillance surveys (<http://naccho.org/topics/infrastructure/lhdbudget/upload/survey-findings-brief-8-13-13-2.pdf>), which demonstrate that the economic downturn has had a substantial impact on the LHD workforce. Although unexpected, this finding is

nonetheless important, because staff capacity issues may be central to successful local implementation of HIP. An LHD with significant staff turnover will find it difficult to sustain and build on investments through targeted prevention strategies. Staff expertise will remain relatively shallow, and critical prevention resources will need to be diverted to training new staff to conduct HIV prevention activities. HIP principles must be incorporated into program design and staff development to ensure sustainability during times of workforce or organizational changes.

LHDs that responded to this query indicated that they received TA from various sources. They also identified topic areas where additional TA would be useful. In particular, LHDs expressed interest in TA to assist them in implementing structural interventions, including policy training and strategies for reducing community viral load. NACCHO can help to translate national policy decisions to assist LHDs as they apply those policies to their work. To improve the utility of future SN efforts, NACCHO will consider supporting a targeted recruitment effort to include larger jurisdictions more heavily impacted by the HIV epidemic and those that receive direct HIV prevention and care funding. Additionally, efforts to disseminate the data collected in this query will be considered through existing communications and information channels.

Next steps for leveraging the results of this query include identifying opportunities to help LHDs meet the TA needs identified in this query.

Acknowledgments

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The mission of the National Association of County and City Health Officials (NACCHO) is to be a leader, partner, catalyst, and voice for local health departments.

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