STATE OF ALABAMA
ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA
Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States

Alabama Department of Public Health
Office of HIV Prevention and Care
DRAFT PRELIMINARY PLAN

Contents

INTRODUCTION

Ending the HIV epidemic has been a dream of those impacted by HIV/AIDS since the beginning of the epidemic. That vision can be reality with the Ending the HIV Epidemic (EtHE) initiative. By recognizing the global call to action, and responding to it, Alabama can energize communities, mobilize resources, and confront challenges that perpetuate a system that is not working equitable for everybody.

Alabama is one of 57 county and state jurisdictions to be identified as carrying the burden of HIV rates in the United States. Because Alabama has a mostly rural state, increased focus will be given to the five highest burden (13.8 rate) counties (Houston, Jefferson, Mobile, Montgomery, and Tuscaloosa)and thirteen emerging (10.8 rate) counties (Bullock, Calhoun, Dallas, Franklin, Lee, Lowndes, Macon, Madison, Morgan, Russell, Talladega, Walker, and Winston) for new HIV infections under the EtHE initiative.

By September 2020, the Alabama EtHE Planning Group representing public health, community-based organizations, academic institutions, health service providers, community members, and businesses, will develop a strategic plan to achieve the national goals of reducing new HIV infections by 90 percent in the next 10 years.

Public Health Structure

Alabama is divided into eight geographically distinct public health districts (PHDs) with the two most populous counties (Jefferson and Mobile) representing single PHDs (Figure 1). The remaining districts encompass 10 to 12 counties each. Each area has authority to provide core public health services to the community including HIV counseling and testing, sexually transmitted disease screening and treatment, maternal and child health, vaccine preventable immunizations, family planning, home health services, oral health, and adult health services.

Figure 1. Alabama Public Health District Map

Source: Alabama Department of Public Health

Section I: Engagement Process

The EtHE Leadership Team was established by the Alabama Department of Public Health (ADPH) administration in response to *Ending the HIV Epidemic: A Plan for America* initiative. This group consists of ADPH administration and the Office of Prevention and Care (OHPC) staff, and leadership from AIDS serving organizations (ASOs).

Collaboration among key stakeholders and broad-based communities is critical to maximizing resources and efficiencies in serving people with HIV (PWH). The finalized EtHE plan will be developed with the contribution of the skills, experience and expertise of a large range of stakeholders and key partners. Medial doctors, staff from ASOs and community-based organizations (CBOs), mental health services, housing services, substance use services, and individuals directly impacted by HIV will assist in the development of the plan. The people involved in the development of the EtHE plan will be reflective of the epidemic in the jurisdiction.

Existing local prevention and care integrated planning bodies
Members of the EtHE planning group have been engaged with the HIV Prevention and Care Planning Group (HPCG) in a variety of capacities, which include attending and presenting at their quarterly meetings and engaging members for participation and/or recommendations for the EtHE planning group. On November 14, 2019, members of the planning group attended the HPCG quarterly meeting (see Appendix A for documentation).

ADPH developed a survey to gather input from ASOs, local planning bodies, and ADPH staff regarding the EtHE planning process. Surveys were distributed in-person at the Alabama Partners in Care fall summit and electronically through ADPH's Learning Content Management System. (See Appendix A for documentation)

Local community partners
ADPH has identified and initiated contact to members within the local community to participate in the planning process. However, due to time constraints on the development of the draft EtHE plan, they were not a part of the planning process.
ADPH understands that the participation of local community partners is critical to the success of the ending the epidemic. The following key stakeholders have been identified and have accepted the invitation to participate on the planning group:

- Faith-based community members
- Epidemiologists
- HIV clinical care providers
- Community health care center representatives
- Housing service providers
- Tribal community representative
- Community-based organizations
- People with HIV

ADPH will continue to work with ASOs and the HPCG to identify local community members to engage in this process. New stakeholders never before engaged will be identified for inclusion and full participation in the planning group to expand knowledge and the breadth of the strategies and solutions to end the HIV epidemic in Alabama.

Local service provider partners

ADPH partners with 11 local HIV service providers. Representatives from Thrive Alabama, Medical Advocacy and Outreach, and University of Alabama at Birmingham (UAB) Center for AIDS Research currently serve on the EtHE planning group. The planning group met on August 7, 2019 and November 20, 2019 to provide an overview of the EtHE application, and to discuss needed stakeholders at the table and short- and long-term goals and accomplishments. ADPH will engage the other ASOs to have at least one representative to serve on the planning group. (See Appendix A for documentation)

Alabama's EtHE plan will be successful only if it continues to be led by community voices. Due to the ASOs and partners being statewide, various mechanisms will be utilized for attendance. In January 2020, a meeting will convene with people from our priority populations living with HIV, those disproportionately vulnerable to the virus, representatives from all ASOs and community partners for further discussion and planning. Community partners and key stakeholders will have the opportunity to have their voices heard throughout this planning process to ensure ADPH accomplishes its goals to ending the epidemic. Over the next nine months, through the strategic planning group, a capstone plan will be developed. ADPH, in partnership with others, will then embark on a journey spanning the next ten years for a transformative system and collaborative response in the delivery of program services with fellow Alabamians to the end the HIV epidemic in Alabama.

Section II: Epidemiologic Profile Snapshot

Approximately 1.1 million people in the United States are living with HIV. The Centers for Disease Control and Prevention (CDC) estimates that 14 percent of these people are unaware of their infection. According to the CDC, approximately 38,000 new HIV infections occur in the United States each year. Between 1982 and 2017, a total of 21,302 cases of HIV infection were reported to ADPH. At the end of 2017, 66 percent (14,054) were known to be living with HIV infection in Alabama. An additional 2,777 Alabama residents are likely infected and unaware of their positive HIV status. During 2017, 657 newly diagnosed HIV infections were reported in Alabama.

The HIV epidemic affects persons in all gender, age, racial, ethnic, and socioeconomic groups and in every county in Alabama. However, the effect has not been the same for all groups. Disparities remain with gay, bisexual, and other men who have sex with men (MSM), young adults, and racial and ethnic minorities bearing a disproportionate burden of HIV. As the number of persons living with HIV increases and the number of deaths continue to decline, the importance of identifying populations most affected and at risk for HIV infection is paramount. Alabama must be diligent in planning effective HIV prevention and care efforts, and re-engagement initiatives.

African Americans continue to be disproportionately affected by the HIV epidemic compared to other racial and ethnic groups. Although 27 percent of Alabama's population is estimated to be African American according to the 2018 United States Census Bureau's population estimates, 73.8 percent of newly diagnosed HIV cases and 64.2 percent of all PWH were African American as reported by the HIV Surveillance Branch 2019 3rd Quarter Preliminary Report.

Population

The U.S. Census Bureau estimated 4,864,680 persons resided in Alabama in 2018. Alabama is composed of 67 counties, ranging in population from 8,330 (Greene County) to 659,300 (Jefferson County). Alabama is considered largely rural with 55 of 67 counties having a population <100,000. However, Alabama does have four major urban centers located in Jefferson, Madison, Montgomery, and Mobile counties.

Alabama's population can be divided into 3 geographical groupings: major urban centers (>200,000 population), minor urban centers (100,000-200,000 population), and rural areas (<100,000 population). Major urban centers include Jefferson, Madison, Mobile, and Montgomery counties. In 2018, these major urban centers represented 34 percent (1,664,339) of the state's total population and 57 percent (13,527) of cumulative HIV cases reported to ADPH according to the 2019 3rd Quarter HIV Preliminary Report.

Demographics

The 2018 U.S. Census estimates 68.2 percent of Alabama residents are White, non-Hispanic. Non-Hispanic African Americans compose about one-quarter (26.6 percent) of the population in Alabama. The remainder of the population identified themselves as Hispanic (4.2 percent),

Asian (1.3 percent), or Native American (<1 percent). Females account for 51.6 percent and males account for 48.4 percent of Alabama's residents.

Poverty

Following the 2010 U.S. Census, Alabama ranked 42nd nationally in per capita income with 23 percent of the population living in poverty. Alabama's agricultural Black Belt region (Bullock, Butler, Choctaw, Crenshaw, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Perry, Pickens, Sumter, and Wilcox counties) has the highest poverty and unemployment rates in the state. Strikingly, the region also encounters disproportionately high rates of HIV infection. Though only representing 4.6 percent of Alabama's total population, the rate of newly diagnosed HIV infections in the Black Belt region was 12.7 per 100,000 residents in 2017.

Conclusion

The EtHE Epidemiologic Profile snapshot provides guidance for the HIV surveillance, prevention, and care efforts by identifying target populations infected with HIV and at risk of HIV infection. Alabama's HIV-positive population is growing, partially due to awareness via expanded rapid testing and opt-out routine testing and partially due to effective treatment options increasing the longevity of people living with HIV. The African American community bears the brunt of the disease, making up 63.9 percent of prevalent HIV cases and 73.8 percent of newly diagnosed HIV infections in Alabama.

Despite the many challenges facing Alabama regarding its health status and the increasing trends in new HIV infections, opportunities to improve access to care and prevention services for Alabamians living with HIV infection exist. Expanding access to screening and prevention services may decrease new infection rates throughout Alabama.

HIV CASES AMONG PERSONS RESIDING IN ALABAMA AT DIAGNOSIS BY PUBLIC HEALTH DISTRICT AND COUNTY

CHARACTERISTIC	***PRELIMINARY*** 2019 - 3rd Quarter (January 1 - September 30)					
	Newly Diagnosed		Prevalent Cases		Cumulative Cases	
Race/Ethnicity	**Cases**	**% of Total**	**Cases**	**% of Total**	**Cases**	**% of Total**
Black	288	73.8	9612	63.9	14329	64.2
White	93	23.8	4169	27.7	6660	29.8
Hispanic	4	1.0	455	3.0	442	2.0
Multi-race	3	0.8	667	4.4	747	3.3
Other/Unknown	2	0.5	138	0.9	136	0.6
Total	390	100.0	15041	100.0	22314	100.0
Gender	**Cases**	**% of Total**	**Cases**	**% of Total**	**Cases**	**% of Total**
Male	305	78.2	11035	73.4	16856	75.5
Female	85	21.8	4006	26.6	5458	24.5
Total (unknowns excluded)	390	100.0	15041	100.0	22314	100.0
Age (Years)	**Cases**	**% of Total**	**Cases**	**% of Total**	**Cases**	**% of Total**
<13	0	0.0	38	0.3	160	0.7
13-19	11	2.8	102	0.7	1091	4.9
20-24	95	24.4	695	4.6	3815	17.1
25-29	71	18.2	1477	9.8	4197	18.8
30-39	98	25.1	3134	20.8	6836	30.6
40-49	61	15.6	3281	21.8	3909	17.5
≥50	54	13.8	6314	42.0	2306	10.3
Total	390	100.0	15041	100.0	22314	100.0
Adult/Adolescent Exposure (≥13 years)	**Cases**	**% of Total**	**Cases**	**% of Total**	**Cases**	**% of Total**
Men who have Sex with Men (MSM)	161	41.3	6953	46.3	9969	45.0
Heterosexuals	93	23.8	4444	29.6	6086	27.5
Injection Drug Users (IDU)	9	2.3	787	5.2	1895	8.6
MSM/IDU	7	1.8	485	3.2	1092	4.9
Hemophilia/Coagulation Disorder	0	0.0	15	0.1	79	0.4
Mother with HIV Infection	1	0.3	90	0.6	0	0.0
Transfusion/Transplant Recipient	0	0.0	4	0.0	31	0.1
Risk Not Reported/Unknown	119	30.5	2225	14.8	3002	13.6
Total (add pediatric cases to total)	390	100	15003	100	22154	100.0
Pediatric Exposure (<13 years)	**Cases**	**% of Total**	**Cases**	**% of Total**	**Cases**	**% of Total**
Mother with HIV Infection	2	100	31	81.6	138	86.3
Hemophilia/Coagulation Disorder	0	0	0	0.0	8	5.0
Transfusion/Transplant Recipient	0	0	0	0.0	1	0.6
Risk Not Reported/Unknown	0	0	7	18.4	13	8.1
Total	2	100	38	100.0	160	100

Data Prepared 09/27/2019

HIV CASES AMONG PERSONS RESIDING IN ALABAMA AT DIAGNOSIS BY PUBLIC HEALTH DISTRICT AND COUNTY

Public Health District	***PRELIMINARY* 2019 - 3rd Quarter (January 1 - September 30)**					
	Newly Diagnosed		Prevalent Cases		Cumulative Cases	
	Cases	% of Total	Cases	% of Total	Cases	% of Total
Northern	36	9.3	1687	11.5	2185	10.0
East Central	107	27.6	2985	20.4	4667	21.4
West Central	34	8.8	952	6.5	1333	6.1
Jefferson	82	21.2	3997	27.3	6054	27.8
Northeastern	21	5.4	1137	7.8	1284	5.9
Southeastern	27	7.0	1018	7.0	1478	6.8
Southwestern	17	4.4	829	5.7	1247	5.7
Mobile	63	16.3	2025	13.8	3533	16.2
Total (does not include unknown)	387	100.0	14630	100.0	21781	100

*****Note: Statistics should be interpreted WITH CAUTION as not all reported cases have been entered into the HIV Surveillance database.**

Effective October 1, 2017 , Public Health Areas have been redistributed as eight Public Health Districts. Unknown cases are only accounted for in state total.

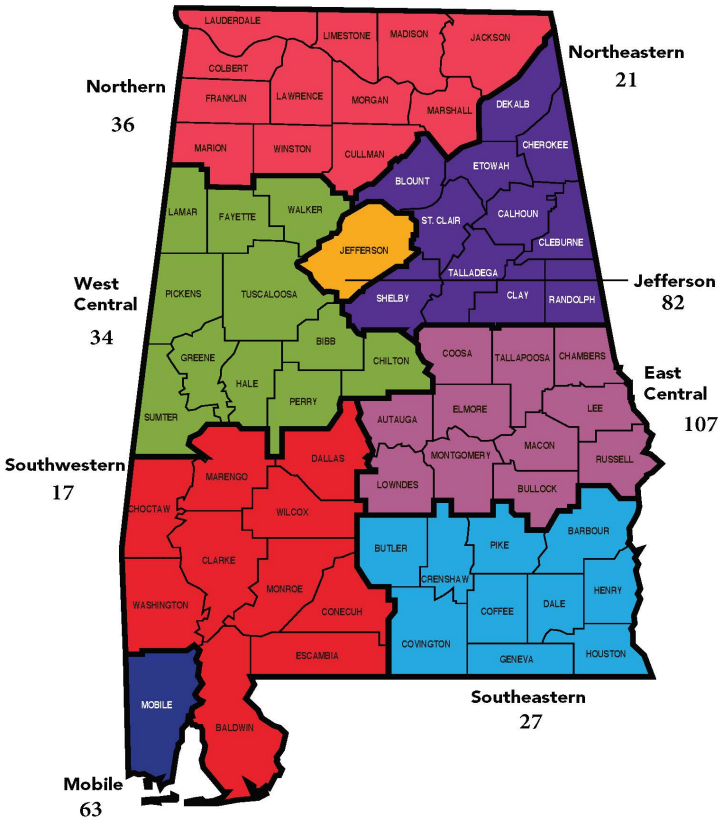
Newly diagnosed HIV includes newly diagnosed HIV infections during the year of interest.

Prevalent HIV includes all persons living with HIV as of September 30, 2019. Cumulative HIV includes all diagnosed HIV (living and deceased) as of September 30, 2019.
Totals include unknown case counts. Females with no risk factor reported are reclassified as heterosexual exposure.
Age among newly diagnosed and cumulative cases is age at diagnosis. Prevalent age is current age among cases living as of September 30, 2019.

Public Health District represents residence at diagnosis among newly diagnosed and cumulative cases and current residence among prevalent cases.

Newly Diagnosed HIV Cases by Public Health District

3rd Quarter (January 1-September 30, 2019)



Data Prepared 09/27/2019

A Plan for America: The Pillars

A plan for systematic and cohesive response is organized by four distinct actionable areas supported by science, practice, and experience in the field.

Pillar One: Diagnose

According to the 2019 3rd Quarter Preliminary Report, 41.3 percent of the newly diagnosed cases and 46.3 percent of the prevalent cases reported male-to-male sexual activity as the primary risk factor for infection. Heterosexual contact was the second leading risk factor for HIV infection, representing 23.8 percent of newly diagnosed cases and 29.6 percent of prevalent cases. The largest number of newly diagnosed HIV infections occurred among teenagers and young adults age 13 to 39 years during 2019 according to the Preliminary Report, with 71 percent of new diagnoses occurring in this age group. In contrast, most persons with HIV infection (i.e., prevalent cases) were 30 years old or older (64 percent of prevalent cases are ≥40 years).

Pillar Two: Treat

PWH are experiencing increased longevity due primarily to positive HIV and AIDS treatment outcomes. Alabama's AIDS Drug Assistance Program (ADAP) provides continuous access to life-saving treatment and care for low income, uninsured, and underinsured PWH. Alabama's Insurance Assistance Program (AIAP) was launched in 2015, providing cost-effective health insurance to eligible PWH. ADAP is comprised of two main components: 1) full-pay prescription medication and 2) the purchase of cost-effective insurance coverage through AIAP on behalf of eligible individuals. Premium, co-payment, and out of pocket expense assistance is also provided for eligible individuals receiving coverage through the Medicare Part D Client Assistance Program (MEDCAP). These ADAP categories are intended to reduce the morbidity and mortality experienced by PWH, while also helping PWH achieve and maintain viral suppression, thus decreasing the risk of HIV transmission to non-infected individuals. The Ryan White HIV/AIDS Program Part B funding is intended to provide seamless care and support across the HIV care continuum. The percentage of ADAP clients served by each program category as of December 31, 2018 is: ADAP-37 percent, AIAP-60 percent, and MEDCAP-3 percent; and ADAP full-pay prescription program (n=1,199)—37 percent; AIAP (n=1,958)—60 percent; MEDCAP (n=83)—3 percent.

During 2017, 84 percent of the 657 newly diagnosed HIV infections were linked to care within 3 months of diagnosis. Of the 14,054 persons living with HIV in Alabama as of December 31, 2017, 73 percent were retained in care and 62 percent achieved viral suppression (≤200 copies/mL) during 2017.

Pillar Three: Prevent

Without early, primary prevention education, the alarming rate of new infections among adolescents and young adults can be expected to significantly increase the total number of PWH infections in Alabama, as HIV positive individuals are becoming infected at a younger age and living longer. Young adults (20-29 years) are twice as likely to be infected with HIV as the

average Alabama resident and represent over 42.6 percent of all newly diagnosed cases, although this age group accounts for only 13.7 percent of Alabama's population.

Male-to-male sexual contact is the predominant risk factor reported among newly diagnosed HIV cases in young adult Black males. It is imperative to note that many young Black MSM do not identify as being gay or bisexual and only report as exclusively engaging in heterosexual sex with women. Therefore, increased HIV infection rates in young women can be expected to follow. Effective HIV prevention efforts must target young adult Black men, regardless of sexual orientation.

Pillar Four: Respond

The most recent molecular cluster identified in Alabama included 14 cases, with diagnoses dates ranging from January 1, 2016 to June 30, 2019. Cases were identified in five different counties. This cluster was unique in that half of the cases were female. The network consisted of individuals ranging in age from 20-59 years. Ten (71 percent) of clients identified in this network were African American, with MSM and heterosexual contact being the primary modes of transmission. Partner Services was able to successfully complete interviews on thirteen of the fourteen individuals identified, and twelve were virally suppressed. Partner Services interviews resulted in 12 additional named contacts, six of whom were previous positives, and two new positive diagnoses. Of the named partners, four were virally suppressed.

Section III: Situational Analysis Snapshot

In an effort to develop an EtHE plan with a collective vision for the state of Alabama by September 2020, ADPH will be conducting a situational analysis to have an expansive understanding of the epidemic by building partnerships and broad opportunities for input from key stakeholders to ensure construction of a complete picture of the HIV/AIDS epidemic in Alabama, its causes, and potential responses.

Needs Assessment Background

The most current needs assessment was conducted in 2015 to develop an Integrated HIV Prevention and Care Plan for Alabama for 2017-2021. ADPH partnered with the UAB School of Public Health to conduct a statewide, multi-method needs assessment with the goals of 1) identifying and describing HIV prevention and care services that currently exist and those that are needed; 2) enhancing the quality of services for person at higher risk for HIV and PWH and 3) identifying barriers that impede access to existing services.

Methodology

In coordination with the OHPC, the UAB School of Public Health project team conducted a series of focus groups and distributed surveys to identify needs, gaps, and barriers to HIV/AIDS prevention and care services. Three surveys were developed and administered to three stakeholder groups:

- PWHs
- Higher-risk, HIV negative individuals
- Direct Care Providers

Surveys for individuals with HIV/AIDS and higher-risk, HIV negative individuals were distributed in paper/pencil formats and translated into Spanish; direct care providers received electronic surveys.

The following methods were used:

- Developed and conducted a statewide electronic survey that will reach prevention and direct care staff including physicians, nurses, social workers, case managers, and other working in direct patient care;
- Conducted focus groups in various settings; such as support groups and prevention meetings; and
- Worked with the UAB 1917 Clinic Prevention Initiative to collect information from persons at risk for HIV.

Persons with HIV

UAB received 194 completed surveys from PWH (n=194). Respondents largely self-identified as male (n=126, 65.6 percent) and slightly more than half as heterosexual/straight (n=95, 51.3 percent). Approximately one-third self-identified as gay or lesbian (n=64, 34.6 percent). Similarly, the majority of respondents self-identified as Black or African American (n=113, 60.1 percent) or White (n=47, 25 percent). Ninety-six percent of respondents (n=173) reported household income levels below $40,000.

In this survey, respondents were given lists and descriptions of core medical services, mental health and other counseling services, substance abuse services, and support services. From these lists, respondents were asked if, in the last 12 months, they 1) knew about the service 2) needed the service 3) received the service, and 4) if they received the service, did it meet their needs. Gaps in services are represented by the number of people who marked that they needed the service but did not receive the service. The following summaries identify the top three responses to survey questions regarding needs, gaps, and barriers.

Core Medical Services

Among the eleven (11) core services listed:

The greatest need for core medical services among PWH was:
1. Primary medical care (77.4%)
2. Dental care (74.9%)
3. Medication assistance (72.5%)

The services that were needed but not received (Unmet) were:
1. Specialty care (29.0%)
2. Dental care (28.6%)
3. Home health care (24.1%)

The services that were received but did not meet their needs (Poorly Met) were:
1. Dental care (5.56%)
2. Specialty care (4.35%)
3. Medical case management (4.08%)

Barrier

The most frequent responses for not getting core medical services was cost, followed by lack of awareness (“Didn’t know where to get services”), and stigma (Didn’t want anyone knowing I was HIV+).

Substance Abuse Counseling

Among the three (3) substance abuse counseling services listed:

The ranking for substance abuse counseling services need for among PWH was:
1. Peer counseling and support for substance abuse (12.4%)

2. Outpatient substance abuse counseling (11.6%)
3. 24 hour-a-day residential substance abuse counseling (7.7%)

Ranking for services that were needed but not received (Unmet) were:
1. Peer counseling and support for substance abuse (28.6%)
2. Outpatient substance abuse counseling (20.0%)
3. 24 hour-a-day residential substance abuse counseling (18.2%)

PWH did not identify any services that did not meet their needs (Poorly Met).

Barrier
The most frequent responses for not getting substance abuse counseling included stigma ("Didn't want anyone knowing I was HIV+"), language/cultural barriers, and cost.

Support Services
Among thirteen (13) support services listed, the greatest need for support services among PWH was:
1. HIV education/risk reduction (58.4%)
2. Non-medical case management (54.4%)
3. Referral to health care/support services (52.9%)

The services that were needed but not received (Unmet) were:
1. Housing (54.8%)
2. Legal services (50.9%)
3. Childcare (50.0%)

The services that were received but did not meet their needs (Poorly Met) were:
1. Legal services (13.3%)
2. Childcare (11.1%)
3. Emergency financial assistance (10.0%)

Barrier
The most frequent responses for not getting support services included lack of awareness ("Didn't know where to get services"), stigma ("Didn't want anyone knowing I was HIV+"), and lack of reliable transportation.

Higher-risk, HIV Negative Individuals
UAB received 736 completed surveys from higher-risk, HIV negative individuals (n=736). The vast majority of respondents self-identified as female (n=528, 72.2%) and heterosexual/straight (n=603, 87.1%). Slightly more than half self-reported as Black or African American (n=355, 51.6%) followed by White (n=272, 39.5%). Approximately 87% of respondents (n=585) reported household income levels below $40,000.

In this survey, respondents were given a list and descriptions of fourteen (14) HIV prevention services that people at higher risk for HIV might utilize. From this list, respondents were asked if, in the last 12 months, they 1) knew about the service 2) needed the service 3) received the service, and 4) if they received the service, did it meet their needs. Gaps in services are represented by the number of people who marked that they needed the service but did not receive the service. The following summary identifies the top three responses to survey questions regarding needs, gaps, and barriers.

Need for Services

The greatest need for core medical services among higher-risk, HIV negative individuals was:
1. HIV testing (49.5%)
2. Primary medical care (47.3%)
3. Condoms (42.2%) T

The services that were needed but not received (Unmet) were:
1. Mental health services/counseling (37.8%)
2. Hepatitis C testing/Vaccinations (35.3%)
3. Syringe (needle) exchange (33.7%)

The services that were received but did not meet their needs (Poorly Met) were:
1. Mental health services/counseling (6.7%)
2. Primary medical care (5.1%)
3. HIV/STD health education (4.5%)

Barrier

The most frequently cited barriers to services were stigma ("Afraid of what other people might think"), no health insurance, and lack of awareness ("Didn't know where to go").

Direct Care Providers

UAB received 45 completed surveys from Direct Care Providers, the majority of whom represented HIV/AIDS service organizations (n=27, 64%). Further, the vast majority of these service organizations had been providing HIV/AIDS care-related services for more than 10 years (n=37, 95%).

The five most frequently cited services these agencies provide included:
- HIV education (information on living with HIV) (n=37, 97%)
- HIV prevention (education, counseling, or testing) (n=37, 97%)
- Referral for health care/support services (n=30, 79%)
- Transportation services to medical care (n=30, 79%)
- Treatment adherence and counseling (n=30, 79%)

The vast majority of agencies identified providing HIV/AIDS services in urban areas (n=31, 82%) and walk-in services or same day appointments (n=30, 91%). Additionally, responding agencies accept a wide variety of payment options.

Clinics noted the following racial/ethnic compositions of patients they serve:
- Black or African American (n=37, 100%)
- White (n=35, 95%)
- Hispanic/Latino (n=30, 81%)

Clinics identified the following HIV risk factors as prevalent among the clients they serve:
- MSM population (n=35, 97%)
- Low income (n=34, 94%)
- HIV-positive sex partners (n=33, 92%)

Based on the situational analysis and survey results, the challenges offer opportunities for some early intentional responses across the pillars cited below and highlighted in the preliminary draft plan.

Pillar One: Diagnose
ADPH will work to overcome barriers to diagnosis by increasing routine testing sites and raising awareness on the importance of getting tested and encouraging individuals to take control of their health.

Pillar Two: Treat
ADPH will work to overcome barriers to treatment by increasing linkage to care activities among PWH, increasing patient centered care, and raising public awareness on available support services.

Pillar Three: Prevent
ADPH will work to overcome barriers to prevention by expanding the network of prescribers of Pre-exposure prophylaxis (PrEP) through increased knowledge and capacity to medical providers.

Stigma is highly associated with HIV risk and strongly influences the success or failure of HIV prevention efforts. HIV-related stigma and health disparities are most commonly identified as significant barriers to seeking and accessing HIV screening, accessing culturally appropriate healthcare and support services, utilizing HIV treatment or prevention regimens, and staying retained in care. Stigma is a barrier to all four pillars, therefore, ADPH must promote public awareness campaigns, educational activities, and community outreach to inform and educate residents and healthcare providers on HIV prevention and care services.

Section IV: Preliminary EtHE Plan

Pillar One: Diagnose

Goal: Reduce new infections.

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 75%.

Activities and Strategies:

1. Increase routine testing in ERs, acute settings, rape crisis centers, etc.
2. Increase community awareness events focused on the importance of knowing one's status, where to get tested and frequency of testing, and methods of prevention in 19 counties to reach the targeted populations, which include men who have sex with men (MSM), especially youth and MSM of color; transgender individuals; and persons of color regardless of gender.
3. Increase public awareness campaigns focused on getting tested and treated in 19 counties to reach the targeted populations.

Pillar Two: Treat

Goal: Increase access to care and improve health outcomes for people living with HIV.

Objective 1: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 75%.

Activities and Strategies:

1. Increase educational activities focused on getting treated in 19 counties to reach the targeted populations.
2. Increase patient centered care.
3. Increase linkage to care activities among targeted populations.
4. Increase public awareness campaigns focused on getting treated in 19 counties to reach the targeted population.

Objective 2: Increase the percentage of persons diagnosed with HIV who are virally suppressed to at least 75%.

Activities and Strategies:

1. Increase patient centered care.
2. Increase community engagement and input.

Pillar Three: Prevent

Goal: Increase access to PrEP for the priority populations in 5 years.

Objective 1: Increase the percentage of persons diagnosed with HIV to have access to PrEP to at least 75%.

Activities and Strategies:

1. Increase provider knowledge of PrEP.
2. Increase the number of providers trained to prescribe PrEP.
3. Increase public awareness campaigned focused on PrEP.
4. Decrease stigma surrounding PrEP among high risk negatives persons by increasing knowledge on the medication.

Pillar Four: Respond

Goal: Achieve a more coordinated response to the HIV epidemic.

Objective 1: Reduce disparities in the rate of new diagnosis by at least 20% among gay and bisexual men, young African American gay and bisexual men, and African American females.

Activities and Strategies:

1. Coordinated and improved data collection and dissemination.
2. Increase patient centered care.
3. Increase public awareness campaigns specific to target populations.

Objective 2: Increase capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks in 1 year.

Activities and Strategies:

1. Increase capacity for rapid detection and response to active HIV transmission clusters.
2. Increase community engagement and input in response activities.

Letter of Concurrence, Concurrence with Reservations, or Nonconcurrence:

ADPH will submit a letter, signed by representatives of the EtHE planning group, stating that the EtHE Plan sent forward by the health department demonstrates a collaborative and coordinated approach for HIV prevention, care, and treatment and ensures that prevention services and resources are directed to the areas with the greatest HIV disease burden.

APPENDIX A

Documentation of Engagement

Alabama Ending the HIV Epidemic (EtHE) Leadership Group

Alabama Department of Public Health
The RSA Tower, Suite 1554
Montgomery, Alabama

August 7, 2019

Call-In: 888-822-7517; ID 811026#

1. **Introductions**
2. **Overview of application**
3. **Stakeholders: Who need to be at the table?**
4. **Structure and process**
5. **Vision: Where are we going?**
6. **Mission: What are we here to do?**
7. **Open discussion/Next steps**

Alabama Ending the HIV Epidemic (EtHE) Leadership Group
The RSA Tower, Suite 1554
1:00 p.m. – 2:30 p.m.
Wednesday, August 7, 2019

Call to Order

Dr. Scott Harris called the Alabama Ending the HIV Epidemic (EtHE) Leadership Group to order on 8/7/19 at 1:07 p.m. Vontrese stated that the purpose of today's meeting was to get feedback on engaging others and who to include, expectations and what as a group do we want to accomplish.

Attendees: Adrinda Carter, Laurie Dill, Scott Harris, Allison Hatchett, Sharon Jordan, Vontrese McGhee, Anthony Merriweather, Michael Mugavero, Michael Murphree, Jitesh Palmer (on phone), and Jora White

Overview of the Application, Sharon Jordan

- Jora was thanked for her hard work in putting the application together.
- Sharon indicated that they tried to include all of the highpoints.

Stakeholders

- Keep leadership team small but add someone living with HIV such as Warren or Larry.
- Ron was mentioned as possible for one of the sub-groups.
- Bring Mary Finch onboard.
- Vontrese asked that all continue to think about who else needs to be added so that group is diverse and has a good representation.

Structure and Process

- **Short Term Accomplishments/Goals**
    - Small state level group
        - Start with smaller group with different entities.
        - Smaller groups tend to be more effective.
        - Create sub-groups
    - All HIV testing information/results
        - Involve IT (i.e., current data systems and capabilities)
    - Document/synthesis of where documents are stored
        - Data systems capacity
        - Documents/data feed back to ADPH
    - Monitor effectiveness of testing
        - Define measures
            - Look at metrics that aren't required by funder, but that are beneficial to us
            - Anthony will get with Gavin Graf (???) to get more variables (i.e., # of people that are opting out)

        - Trainings on language (i.e., do you want to get tested vs as part of exam, we'll do testing)
    - At area level, drilling down measures
    - AETC trainings on opt out, diversity, and cultural sensitivity (webinar)

- **Long Term Accomplishments/Goals**
    - What can we do fundamentally differently?
        - ADPH must set the standard
    - Capturing and integrating data
        - DC is a model
        - Link and track PrEP
    - Opt out testing
        - Increase numbers starting with health departments
        - Anthony will get with _____ to pull EHR report and to provide recommendations for protocol and broadening terms to align with opt out.
    - System transformation
    - Improve system of care
        - Getting all system data not just HIV+ numbers
    - Plan (informed) with diversity input
    - Improve monitoring
        - Facilities are more worried about who's coming through the doors rather than who is not and they've missed.
    - Modeling with FQHCs
        - HSI
        - SARA
        - RHI
    - Providing incentives for testing via private doctors and hospitals
        - In rural areas, provide testing through BCO.
    - Seeking champions
    - Indicators for testing and linkage
        - Adding screening to indicators. THRIVE would be a great resource because they are already doing it.
            - Dr. Harris agreed to speak with the Pharmacy Association.
        - Data sharing with Medicaid
            - Dr. Harris wants to wait on their proposal before approaching them.

Vision and Mission

- Tabled until more community representation is present.

Next steps

- Check to see if other states have mandated HIV testing.
    - Team not aware of any, but New York might have something close.
- Vontrese will email Jitesh a copy of what was included in folders provided at today's meeting.
- If there are questions for the clinics, send to Jitesh and he will send to them.

- Anthony will provide a list of providers to see which sites are doing the most, getting a lot of cases, and those sites that we are not talking to.
- Committee was asked if we wanted to contract with someone to facilitate meetings and to develop the strategic plan.
    - Most, if not all in favor of contracting with someone but who?
        - Sharon suggested NASDAD
        - Jefferson County Health Department contracted with CLARIS, which may be a possibility.
        - Any suggestions from CDC?

Alabama Ending the HIV Epidemic (EtHE) Leadership Group

Alabama Department of Public Health
The RSA Tower, Suite 1554
Montgomery, Alabama

November 20, 2019

Call-In: 888-822-7517; ID 811026#

1. **Updates from previous EtHE meeting**

2. **EtHE Revised Budget**

3. **EtHE Program Guidance**

4. **Leadership Team Refocus:**
   i. **Who's missing?**
   ii. **Naming of Expanded Body**
   iii. **Naming of subcommittees**

5. **Draft Plan (due December 30, 2019)**

6. **Open discussion/Next steps**

Alabama Ending the HIV Epidemic (EtHE) Leadership Group
The RSA Tower, Suite 1554
8:30 a.m. – 10:00 a.m.
Wednesday, November 20, 2019

Call to Order

Dr. Scott Harris called the Alabama Ending the HIV Epidemic (EtHE) Leadership Group to order on 11/20/19 at 8:40 a.m.

Attendees: Adrinda Carter, Laurie Dill, Scott Harris, Allison Hatchett, Sharon Jordan, Vontrese McGhee, Mary McIntyre, Michael Mugavero, Michael Murphree, and Jitesh Palmer (on phone)

Updates on previous EtHE meeting

- Dr. Harris had the following updates:
  - He met with Dana (???) Howard with the Hospital Association regarding opt-out testing. She has agreed to speak with leadership. Dr. Harris is very hopeful that there will be additional conversations.
  - He met with Brian Hale, General Counsel for ADPH, about the legal side of opt-out testing. Dr. Harris questioned if there are any states that are doing opt-out testing with no legal issues. Louisiana was mentioned.
  - Dr. Harris has a meeting with Mary Finch with the Alabama Primary Health Care Association next month.
- Dr. McIntyre stated that opt-out testing is on the Medical Association's agenda next month. She extended an invitation to the group to attend the next Data Healthcare Collaborative Group meeting. She will inform us of the next meeting.
- Dr. McIntyre also mentioned the need for a script and staff training for FQHCs. Others mentioned:
  - Developing a toolkit that is available online and providing technical assistance as needed.
  - Getting baseline data on opt-out knowledge and any issues or challenges from ERs.
  - Seeking funding opportunities to incentive FQHCs to increase participation.

EtHE Revised Budget, Vontrese McGhee

- Applied for $1M; however, received $375,000. The first year is strictly planning and includes money for a consultant.
- Collaborative Research and Germaine Solutions were companies submitted by NASTAD as consultants that other states have worked with.
  - Allison stated that Lisa McCormick in B'ham did the Ryan White integration plan.
  - David worked with CLARIS and was pleased. Jefferson County did look at other states including Washington, DC.
- Dr. Harris asked Vontrese to get with Brian Hale to see what the quickest route is to process consultant agreement. She will also speak with Sheila Duncan to see if ALPHA can be a pass through.

EtHE Program Guidance, Vontrese McGhee

- Rough draft due December 30, 2019
- Copy of guidance emailed and handed out at meeting as well as a synopsis.

Leadership Team Refocus, Vontrese McGhee

- Who's missing?
    - APIC attendees participated in a survey regarding help with naming community members that need to be at the table, but they mostly listed persons working with ASOs and CBOs.
    - ADPH has received commitments from ASU, Alabama A & M, person from an Indian tribe, and two clergy.
    - It was suggested that we reach out to the following: Matt Bishop with Gilead, Shannon with Viv, 3-4 persons with HIV, Larry with Selma Air, Quality and ASONA.
    - Michael and Jitesh agreed to work with Vontrese to compile a list.
- Naming of expanded body
    - ADPH will have a brainstorming session.
- Naming of subcommittees
    - ADPH will have a brainstorming session.
        - How many subcommittees?
        - Subcommittees will include a chair and co-chair.
        - How many people will sit on each committee?

Draft Plan

- Rough draft due December 30, 2019.
- Reach out to certain ASOs and CBOs to write report on current activities and strategies.
    - Dr. Dill agreed to send hers in by pillar.

Open discussion/Next step

None discussed due to CFAR/ADPH/MAO Quarterly meeting.

Preserving and Protecting the Public's Health

Alabama Department of Public Health (ADPH)
Meeting Sign-In Sheet

EtHE Statewide Leadership Team
November 20, 2019, 8:30 a.m.
Alabama Department of Public Health, RSA Tower, Suite 1586

Name	Agency/Location	Signature
Vontrese McGhee	ADPH HIV	Vontrese McGhee
Scott Harris	Admin	
Laurie Dill	MAO	
Adrinda Carter	ADPH HIV	Adrinda C. Carter
Michael Mugavero	UAB	
Allison Hatchett	ADPH	Allison R Hatchett
Sharon Jordan	ADPH	
Michael Murphree	MAO	Michael Murphree
Mary G. McIntyre	ADPH/ADMIN	Mary G McIntyre

HPCG Quarterly Meeting Agenda
Thursday November 14, 2019

AIDT's Training Center
1 Technology Court
Montgomery, Alabama 36116

9:30 - 9:50
Registration and Sign-in
Welcome / Introductions and Housekeeping / Ground Rules

9:50 – 10:00
Ending the Epidemic/Survey Findings
Vontrese McGhee

10:00 – 11:15
Kathleen Connolly
PREA training

11:20 -11:30
Break

Lunch - Presentation
11:30 – 12:00
John Milam
INSTI

12:15 – 1:00
Voncile Williams
Janssen

1:05 -1:15
Break

1:20 – 2:05
Allison Hatchett
HPREP

2:15 – 2:30
Funded Projects:
Tiffiny Jackson
Alethia House

2:35 – 2:50
Melissa Parker
Health Services

2:55 – 3:10
Julia Sosa
Whatley Health Services

Announcements /Questions/ Comments/ Concerns
Clean up and adjourn
Next Meeting: TBA, 9:30 AM

Integrated HIV Surveillance and Prevention Programs for Health Departments
Grant# 5NU62PS924533-02-00 January 1, 2019 – December 31, 2019
CFDA# 93.940

HPCG Quarterly Meeting

Member Sign In Sheet

11/14/19

	Name	Email	District	Absent	
				Excused	*Unexcused*
1.	Ka'Lawn Hambrite	kalawn.hambrite@adph.state.al.us	ECD		
2.	Jora White	jora.White@adph.state.al.us	Central Office		
3.	Glennis Parris	glennistparris@gmail.com	N Eastern		
4.	Rasheeda Johnson	Rasheeda@mewc-bsu.org	Jefferson		
5.	Jacqueline Snell	jacqueline.Snell@adph.state.al.us	Southeast		
6.	Richie Hailey	rh1813.rh80@outlook.com	Northern		
7.	Curtis Newkirk	Cnewkirk86@gmail.com	South		
8.	Sue Jones			X	
9.	Cynthia Boykin	boykinmissinglink@yahoo	Mobile/		
10.	LYDIA CHATMON	SELMAAREDUCATOR@GMAIL.com	SOUTHWEST		
11.	Marvellus Sr Drayton	Doitagain68@gmail.com	Northeastern		
12.	Chevenka Thompson	cthompson@thrivealabama.org	Thrive		
13.	Steve Dellinger	steve.dellinger@jcdh.org	West Central/Jefferson		
14.	Tiffany Jackson	tjackson@SpecialFundsCare.com	Jefferson		
15.	Aaliyah Pegram	AALIYAH@THEZENITHBIZ	Lawrence		
16.	Willie Willis	willisw@auburn.edu	South West		
17.	Skyla Fields	Skcampbell@UABmc.edu	Jefferson		
18.	Diane Glass	dglass@mchd.org	mobile		
19.	Kendall Maye	Kendall.Maye@adph.state.al.us	SW		
20.	Tom Roberts	Tom.roberts@ADPH.STATE.A	NE		
21.	Charlotte Petonic	cpetonic@ua.edu			
22.	Trevis Smith	trevis.smith@aidsalabama.org	B'ham		
23.	Brenda Perry	brenda.perry@region2mh.alabama.gov	West Central	X	

	Name	Email	District	Absent	
				Excused	*Unexcused*
23.	Brittney Washington-Ball	brball@whatleyhealth.org	West Central	X	
24.	Shakina Wheeler-Cox	shakina.wheeler@adph.state.al.us	West Central		
25.	Warren Dates			X	
26.	Melissa Parker	melissaparker@hscal.org	Northeast		
27.	Mike Fortham			✓	
28.	Tiffinie Chase	tiffinie.chase@aidsalabama.org	Mobile		✓
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HPCG Quarterly Meeting

Visitor Sign In Sheet

11/14/19

	Name	Organization
1.	Kasonya Hale	Central Office ADPH
2.	James Duke	ADPH
3.	Martha Robinson	ADPH
4.	Adrinda Carter	ADPH
5.	John Milam	Medical Laboratories
6.	Vontrese McGhee	ADPH
7.	Shan [illegible]	ADPH
8.	Marna Strickland	ADPH
9.	Ross Timothy	ADPH
10.	Kim Edens	ADPH
11.	Kathleen Connolly	UACAR
12.	[illegible] James	Five Horizons
13.	Vonnie Williams	Janssen
14.	Sequoya Cael	UAB Family
15.	Maya Cook-Heard	UAB Family Clinic
16.	Alison R Hatcher	ADPH