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Folder Title:

Implementing Maximum Prevention, Awareness, Treatment, and Care (IMPACT)

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IMPACT PROGRAM

Handout I

IMPACT Program areas for Individuals Infected and Affected by HIV/AIDS

I. Preventive Program

A. Behavior change interventions for PLWHA

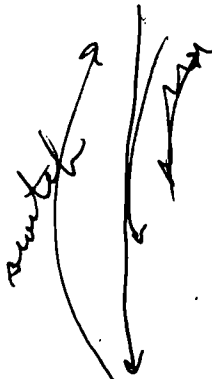
- a) Behavior change communications
- b) Voluntary Counseling and Testing
 - Pre and post-test counseling
 - HIV antibody testing
 - Referral
 - Identification and targeting of:
 - 1) HIV-infected women for MTC intervention
 - 2) HIV-infected individuals for early care
 - 3) Individuals/contacts for TB prophylaxis or treatment
 - 4) Vulnerable children and potential orphans
 - 5) Individuals/couples for family planning services

B. MTCT Interventions

- a) Family Planning Options
- b) Improving Obstetrical Practices
- c) Anti-retrovirals
- d) Alternatives to breastfeeding

II. Care and Support Program

A. Clinical Management

- 
- a) Clinic-based care
 - Basic medical services: improved clinical care for prevalent diseases, treatment of STD, basic nutrition, etc.
 - Clinical management of HIV/AIDS disease: includes prophylaxis and treatment of OI (especially TB)
 - Palliative care
 - Anti-retroviral and other new therapies
 - Laboratory and diagnostic
 - b) Community-based care (e.g. home-based and hospice care)
 - Support and continuation of clinical care initiated at the clinic level
 - Palliative care and care for the dying

B. Psycho-social and economic Support

- a) Care and support of children affected by HIV/AIDS (Orphans etc.)
- b) Psychological support for PLWHA and PABA (i.e. VCT, self support groups, etc.)
- c) Care for the dying
- d) Care and support for care-givers
- e) Social and economic support
 - Social services: shelter, food, clothing etc.
 - Income generating activities, job opportunities etc.

C. Referral Networks

D. Training + guidelines

III. Key Cross-cutting Issues

A. AIDS care networks

B. Considerations for gender and marginalized populations

- C. Health and Human rights issues
- D. Cost issues in resource – constrained settings
- E. Policy considerations

F. Commodities

G. Involvement of PWAs.

**IMPACT Project Care and Support Activities
as of January 31, 2000**

Handout II

ANE:			
Project Description	Care & Support Area	Budget	Status
Consultation and Assessment on Viability of HIV/AIDS and Human Rights Initiative in Cambodia (APCASO). APCASO will assess the viability of a human rights initiative in Cambodia. If the mission agrees with the findings, further funding will be provided to implement activities.	Human Rights	\$26,656	Ongoing
Expanding, Strengthening Networks and Advocacy of PWH/A in India (INP+). This subproject will strengthen INP+ in order to create an effective response to the changing nature of the epidemic and to mitigate its impact on PLWHAs. This will include forming a new structure for INP+ and working with state level networks to improve their knowledge and skills for running PLWHA networks.	Networking	\$103,800	Awaiting host government approval.
TB/HIV Project (Gorgas Institute) FHI is developing a joint project with the Gorgas Institute, UAB to implement a TB/HIV project in Cambodia. A concept paper was prepared in October. The project aims to fully implement DOTS in a squatter area of Phnom Penh. Activities include an assessment of prevalence of active TB and creating and strengthening mechanisms for the diagnosis and treatment through establishing linkages between community based organizations and the National TB Program.	TB	\$400,000 (approx.)	
Counseling Assessment in Vietnam (Ho Chi Minh City AIDS Committee). The Ho Chi Minh City AIDS Committee has submitted a proposal to conduct an assessment on HIV/AIDS counseling and training in Vietnam.	Counseling	TBD	The starting date is planned for the second quarter of FY 2000.

During the first quarter of FY2000, ANE and UNAIDS jointly sponsored a consensus meeting on counseling in Cambodia. The meeting was a step towards improving the quality of HIV/AIDS counseling in the country and was facilitated by Dr. David Miller of UNAIDS/Geneva. The meeting ended with a follow-up plan and recommendations to establish a Technical Working Group on Counseling and a plan to carry out an audit of current counseling services and training in Cambodia.	Counseling		Ongoing
Planning Needs Assessment for Strengthening HIV/AIDS Counseling in Bangladesh, Nepal and Sri Lanka (TISS). This agreement will provide funds and technical assistance to the Tata Institute of Social Sciences (TISS) to design a methodology for assessment of counseling practices in Nepal and Bangladesh, and Sri Lanka in order to help strengthen the HIV/AIDS counseling programs as well as project future needs for training in counseling in these countries.	Counseling	\$20,000	Planned start date: February 1, 2000.
Cambodia:			
Project Description	Care and Support Area	Budget	Status
Community Care and Support for Street Children Affected by HIV/AIDS (Mith Samlanh-FRIENDS). This project will improve access to appropriate care and support, including counseling, basic health care, and referral to necessary services for street children and their families in Phnom Penh. It seeks to improve social reintegration of street children, and will strengthen the capacity of the IA to continue with implementation.	CAA	\$103,911	Ongoing
TBD (Nyemo). This project will provide care and support, including empowerment, for marginalized single HIV+ pregnant women or women with children. Their aim is to help these women prepare for	CAA	TBD	Under development

when they get sick and for the continued care for their children through fostering by other single women.			
Planned study on the household costs for families affected by AIDS who are enrolled in home care projects versus those who are not.	Costing	TBD	Planned
Cote d'Ivoire:			
Project Description	Care and Support Area	Budget	Status
MdM Youth at Risk Project (Medecins du Monde). This project targets at-risk street youth and incarcerated youth in four communes in Abidjan. The project pays school fees for the kids that want to go to school, and helps other youth get apprenticeships with local craftsmen. Youth centers in each of the communes have been renovated and serve as a base for youth health education teams.	CAA	\$103,800	Activities suspended due to coup d'etat
NGO Grants Program (Care and Health Project). Small grants for care and support and networking of PLWHAs have been disbursed to six community-based organizations in Abidjan. This project will be expanded later this year.	Networking	\$48,000	Activities suspended due to coup d'etat
Dominican Republic:			
Project Description	Care and Support Area	Budget	Status
IMPACT collaborated with AIDSMark in conducting a VCT stakeholders' workshop in November to develop a VCT model for the national program. This is the second stakeholders' workshop. As a result of these workshops, IMPACT and AIDS MARK drafted recommendations/next steps for implementing VCT.	VCT	\$30,000	Ongoing

El Salvador:			
Project Description	Care and Support Area	Budget	Status
IMPACT supports MOH and NACP in the implementation of a national VCT program. Conducted two training workshops for staff and continues support through monitoring visits. Worked with MOH to develop VCT manual.	VCT	\$45,000	Ongoing
Ghana:			
Project Description	Care and Support Area	Budget	Status
IMPACT voluntary counseling and testing specialist technical assistance planned for the second quarter of FY 2000 to plan VCT service in Ghana.	VCT	\$60,000 (approx.)	Under development
Support to the Ghana Armed Forces (Ghana Armed Forces). This project will train 60 counselors in the armed forces. Often members of the military are far away from home and lack a support network. Training will include information on support and counseling for PLWAs.	Psychosocial Care	\$30,296	Awaiting USAID/W approval
Haiti:			
Project Description	Care and Support Area	Budget	Status
IMPACT will implement a comprehensive situational analysis to determine the magnitude of the problems and needs of orphans and vulnerable children. The results of this assessment will be used to stimulate and strengthen community-based responses. IMPACT will work with local NGOs (TBD) to develop pilot interventions that target the most vulnerable children.	CAA	\$200,000	Beginning February 2000

IMPACT, in collaboration with CARE, will develop/strengthen VCT services in Jeremie and surrounding areas through provider-training, improving referrals among agencies for support and treatment and ensuring quality of counseling and testing services.	VCT	\$70,000	Planned
India:			
Project Description	Care and Support Area	Budget	Status
Strengthening Community Support for Vulnerable Children and Mothers in Mumbai (CCDT). This project will protect children in vulnerable situations to grow into healthy and contributing members of society. The project will provide night foster care for adolescent girls in Mumbai. It will provide temporary substitute group care for mothers and children in crisis situations, as well as community-based day care centers for CAA.	CAA	\$86,000	Ongoing
HIV/AIDS Prevention for Street Children in Delhi (Salaam Baalak Trust). Salaam Baalak Trust will work to reduce the risk of HIV/AIDS exposure and infection among street children and slum dwellers, with a special emphasis on girls through a comprehensive approach including outreach, peer education, health services, and a safe, protective environment.	CAA	\$105,537	Ongoing
Four additional CAA projects are under development.	CAA		Under Development
Kenya:			
Project Description	Care and Support Area	Budget	Status
SWAK: Mobilizing Women Against AIDS (Society for Women and AIDS in Kenya). This project builds the capacity of SWAK to	Networking	\$67,119	Ongoing

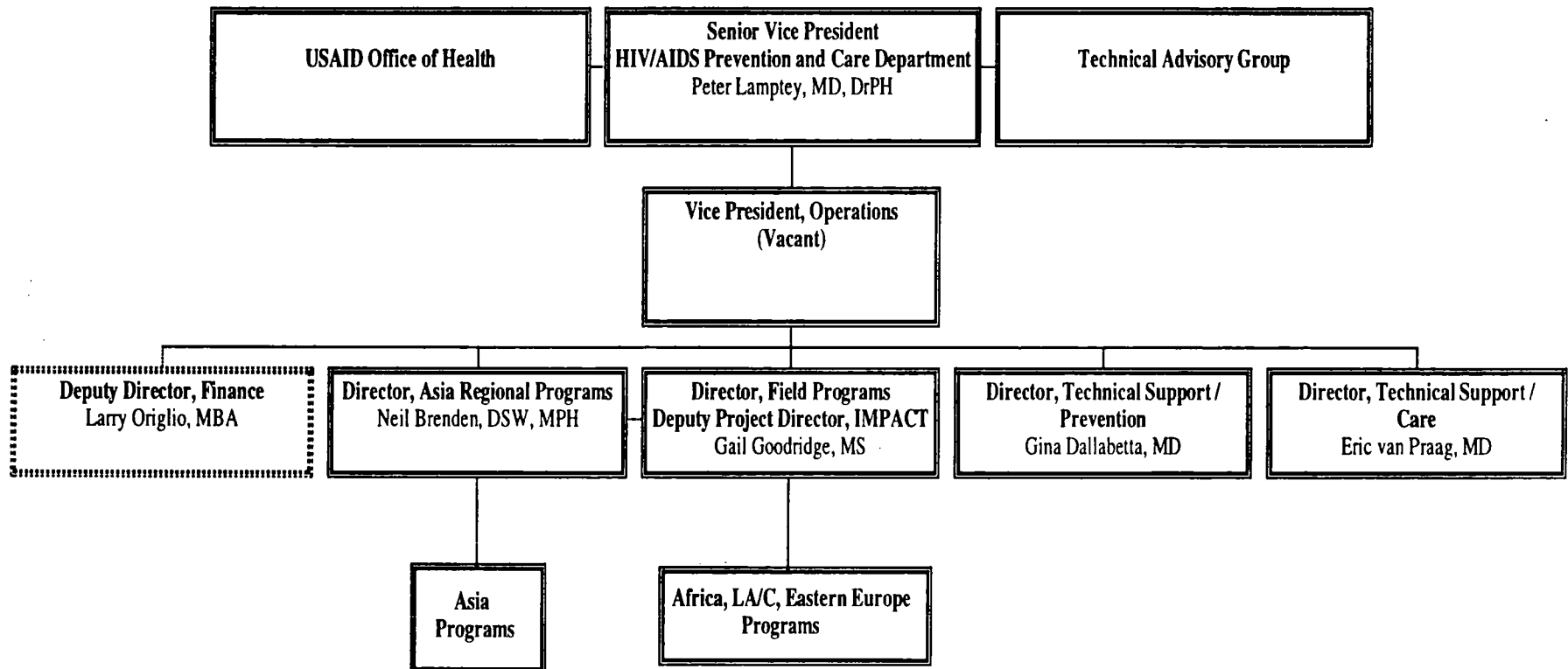
network HIV-affected and -infected women to network and advocate for their rights. It will also train women in home-based care.			
Building Capacity and Sustainability for HIV/AIDS Church-Based Involvement in Kenya (MAP International). This project is working with theological institutions to implement a curriculum including pastoral counseling for HIV/AIDS. It will also work with church leaders to develop non-discrimination policies.	Psychosocial Care	\$55,252	Ongoing
Psychosocial support for PLWHAs including orphans.	Psychosocial Care	\$75,000	Planned
Voluntary Counseling and Testing.	VCT	\$400,000	Planned
Improved Clinical Support System for Home-Based Care.	Community Care	\$50,000	Planned
Strengthening TB Control Program with reference to HIV-related TB.	TB	\$275,000	Planned
Corporate-funded TB intervention in Mombasa using VCT as an entry point.	TB	TBD	Planned
Nigeria:			
Project Description	Care and Support Area	Budget	Status
Community Home- Based Care and Support for PLWHA in Kano State (Society for Women and AIDS in Africa, Nigeria (SWAAN)). This project will provide care and support for PLWHA and PABA in Kao. Activities to be conducted under this project include advocacy, training in conducting home care visits, counseling and facilitating networks among PLWHA and PABA.	Community Care	\$40,000	Ongoing
Community and Home-Based Care and Support, Birnin Kebbi, Kebbi State (Muslim Health Workers Ummah (MUHEWU)). This	Community Care	\$40,000	Ongoing

project is designed to mitigate the impact of HIV/AIDS among HIV-positive persons and their families in Birnin-Kebbi. Activities to be implemented include advocacy; training; community mobilization; development, production and distribution of IEC support materials, home-visits; establishment of a counseling center; and HIV/AIDS data management.			
Title: Community Home-Based Care and Support for PLWHA in Osun State (Association for Development Options (ADON)). This project will provide community-level care and support for PLWHA and PAA in Ejigbo, Osun State. The goals of the project are to reduce stigma and discrimination and to encourage PLWHA to seek early entry into care services.	Community Care	\$40,000	Ongoing
Community and Home Based Care and Support for PLWHA in Ibadan, Oyo State (Christian Health Association, Nigeria (CHAN)). CHAN will collaborate with six hospitals and nursing homes to implement care and support activities in Ibadan; these health facilities will test individuals for HIV, make referrals for home care, and provide CHAN with HIV/AIDS data. In addition, linkages will be established for condom programming and agencies involved in micro-credit schemes will provide assistance in developing sustainable income-generating activities for PLWHA and PABA.	Community Care	\$40,000	Ongoing
Community and Home-Based Care and Support, Onitsha, Anambra State (Humane Health Organization (HHO)). This project is designed to provide community level care and support for PLWHA and PABA - counseling, vocational skills, palliative care - and to help reduce stigma and discrimination associated with HIV/AIDS. HHO will work closely with the health institutions in Onitsha that provide HIV screening services and receive referrals from other hospitals in Anambra state.	Community Care	\$40,000	Ongoing
Community and Home Based Care and Support , Abakaliki, Ebonyi (Safe Motherhood Ladies Association (SMLAS)). The goal of this	Community Care	\$40,000	Ongoing

project is to mitigate the impact of HIV/AIDS on PLWHA and PABA among 100 PLWHA in Ebonyi State. Activities under this subproject include collaboration with health institutions, community advocacy, training, home visits, and production of IEC materials.			
Rwanda:			
Project Description	Care and Support Area	Budget	Status
Nazarene Church Home Care (Nazarene Church). This project trained church-leaders and members in home-based care for PLWHAs. The trainees met regularly to support one another and to share experiences.	Community Care	\$7,030	Completed
Title: Pastoral Counseling Manual (World Relief International). This project supported the IA to review, adapt, translate and print an HIV/AIDS pastoral-counseling manual.	Psychosocial Care	\$27,456	Completed
Voluntary Counseling and Testing Service.	VCT	\$100,000 (approx.)	Planned
South Africa:			
Project Description	Care and Support Area	Budget	Status
Siyawela (HOPE worldwide). This project works to provide a continuum of care for children affected by HIV/AIDS in Soweto. This project will improve home-based care, community networking, psychosocial support, and health care for children affected by AIDS. The project will link with existing VCT services in Soweto.	Community Care	\$600,000	Ongoing
Joan MacNeil is conducting an assessment of VCT services and home based care for PLWAs.	VCT/Community Care		Ongoing

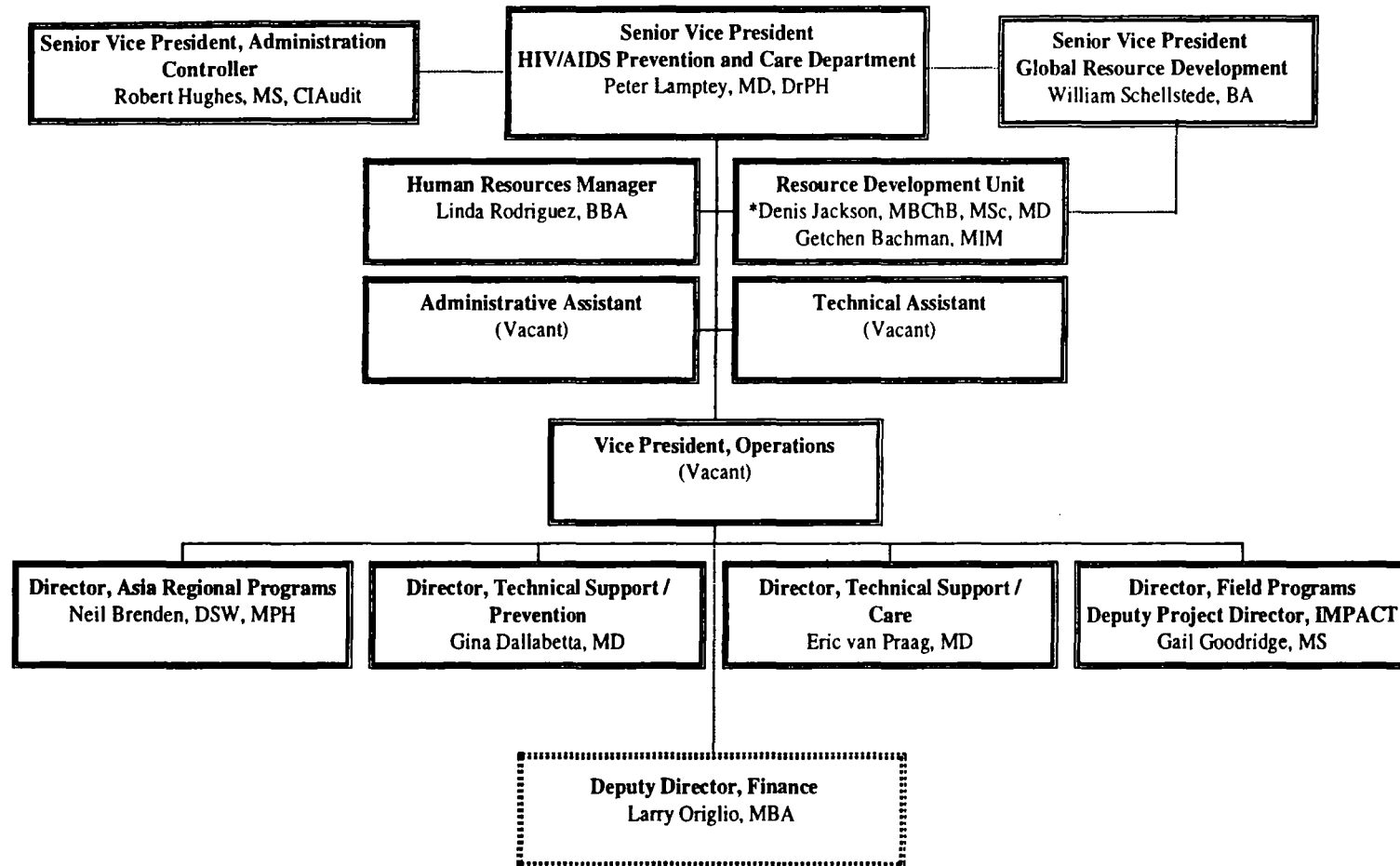
Sara Bowsky is developing an evaluation strategy for CAA projects at the request of the mission.	CAA		Ongoing
Zambia:			
Project Description	Care and Support Area	Budget	Status
Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children (CARE International - Zambia). The goal of the SCOPE-OVC project is to mitigate the impact of the HIV/AIDS epidemic on orphans and other vulnerable children in Zambia through mobilizing, scaling up, and strengthening community-led responses and programs benefiting orphans and vulnerable children.	Community Care	\$2.6 million	LOI signed and project is starting-up. Final subagreement to be signed soon

FHI HIV/AIDS Prevention and Care Department (HIVPAC)



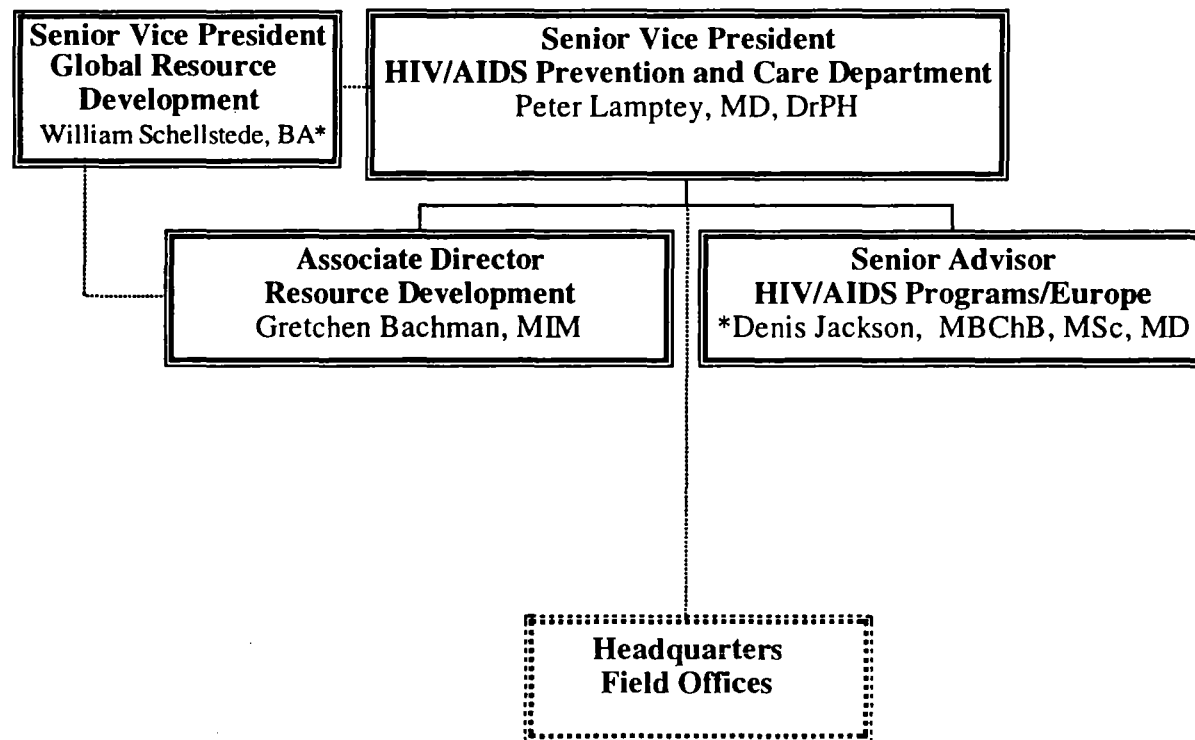
Director's Office

FHI HIV/AIDS Prevention and Care Department



Resource Development Unit

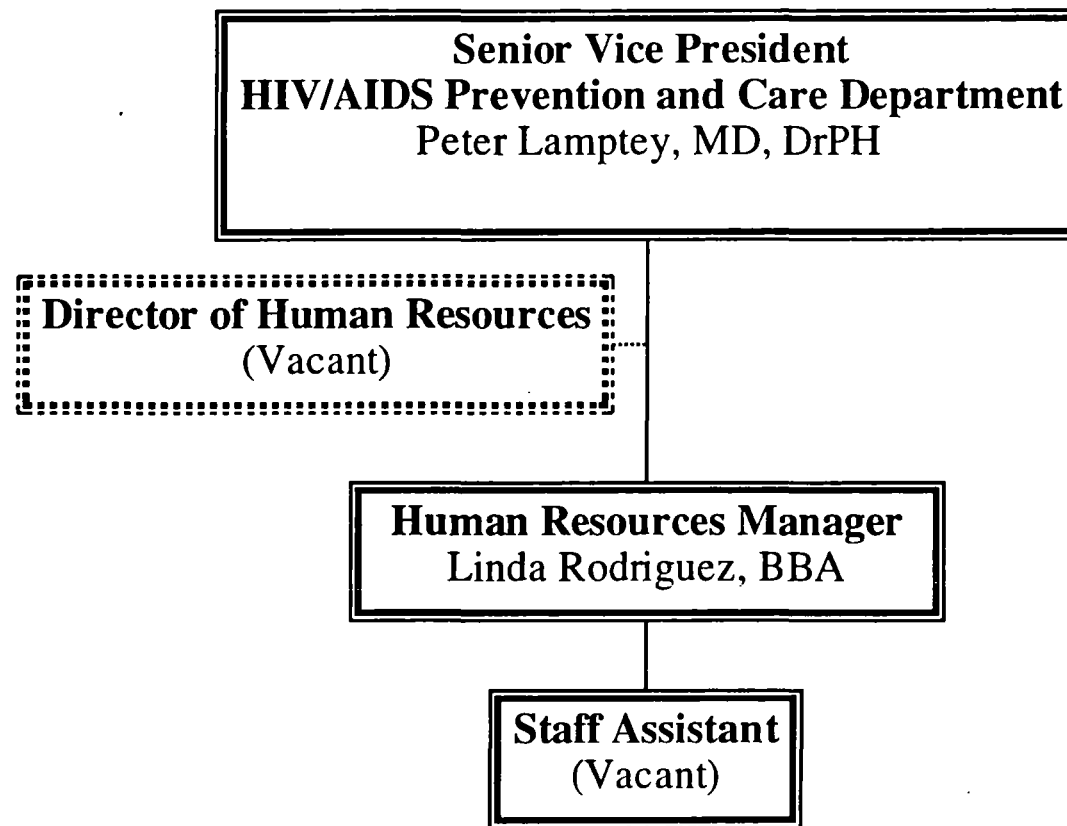
HIV/AIDS Prevention and Care Department



* Team Leader,
HIV/AIDS Prevention & Care Department
Resource Development Team

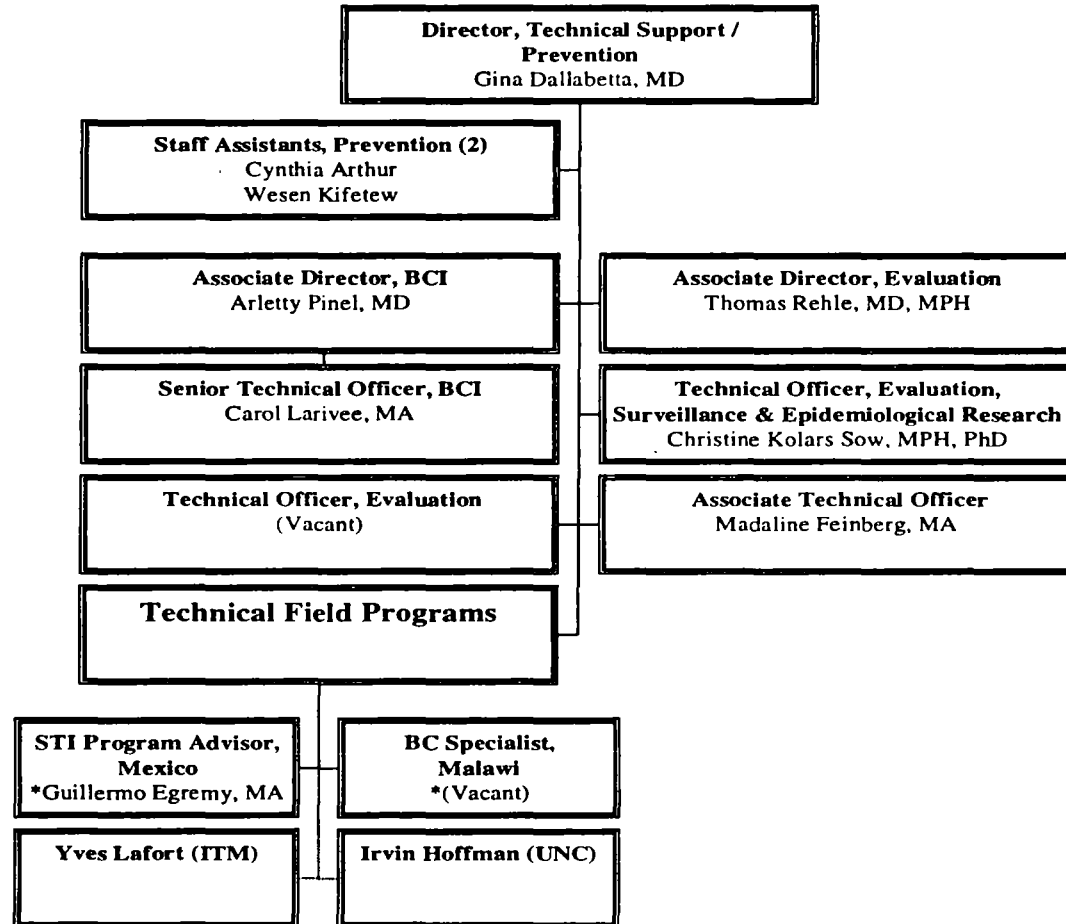
Human Resources Unit

FHI HIV/AIDS Prevention and Care Department



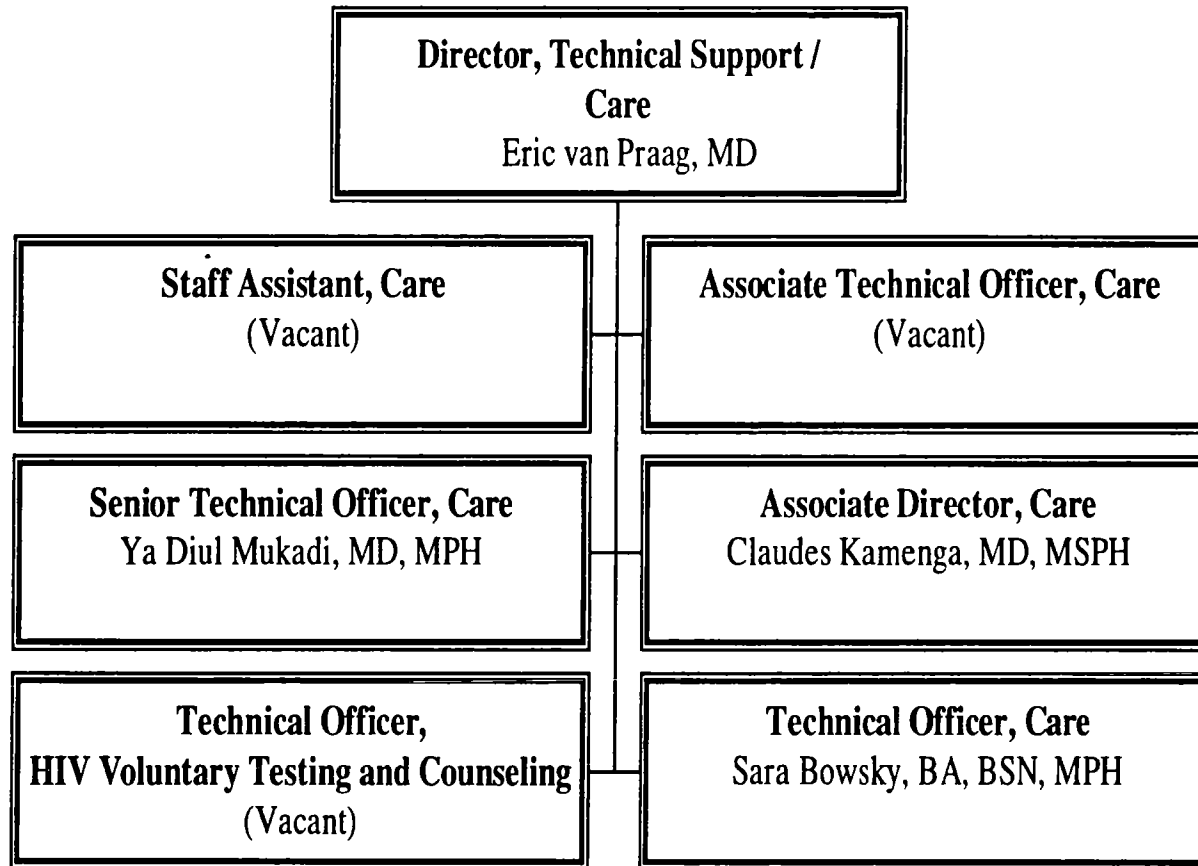
Technical Support / Prevention Group

FHI HIV/AIDS Prevention and Care Department



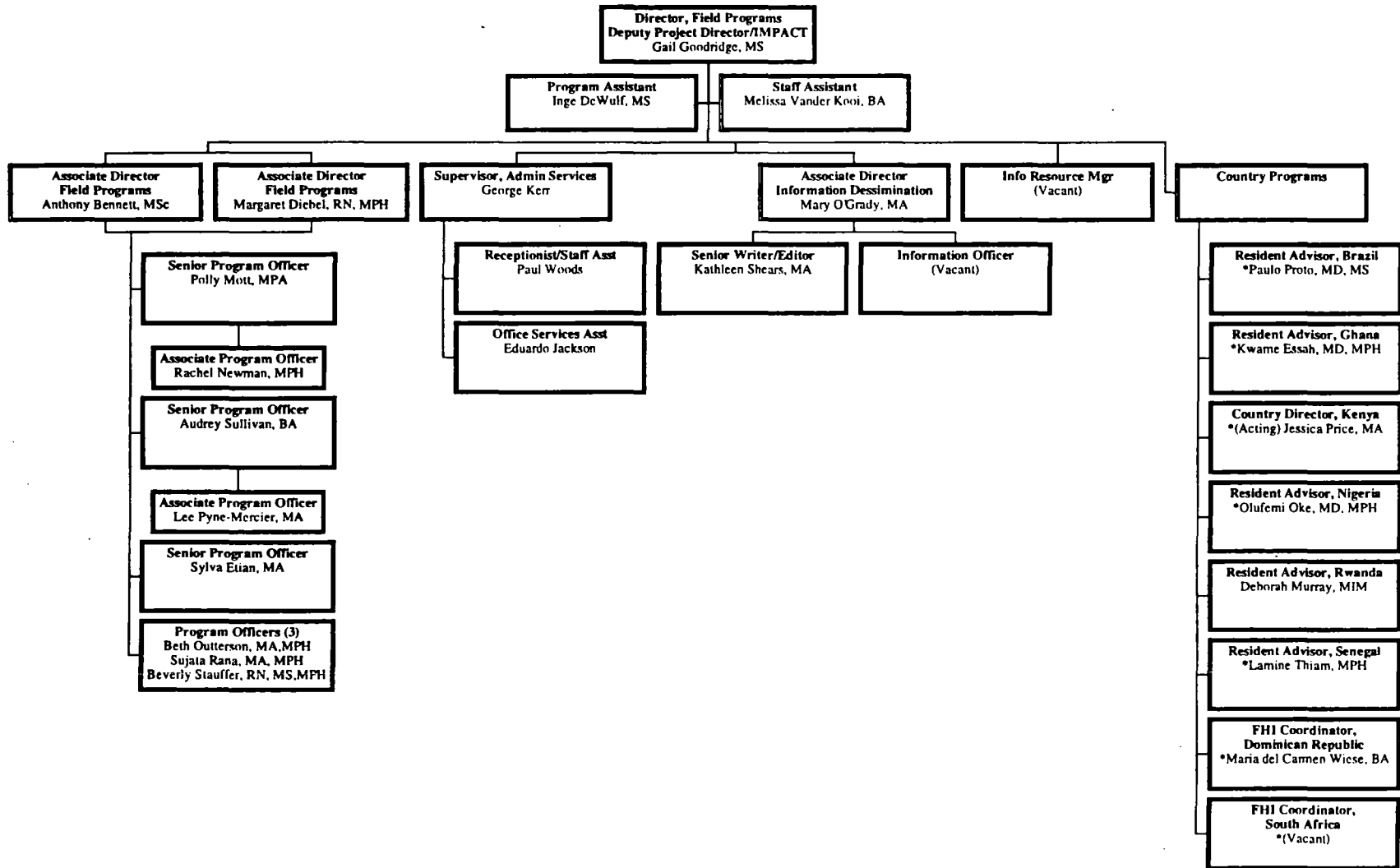
Technical Support / Care Group

FHI HIV/AIDS Prevention and Care Department



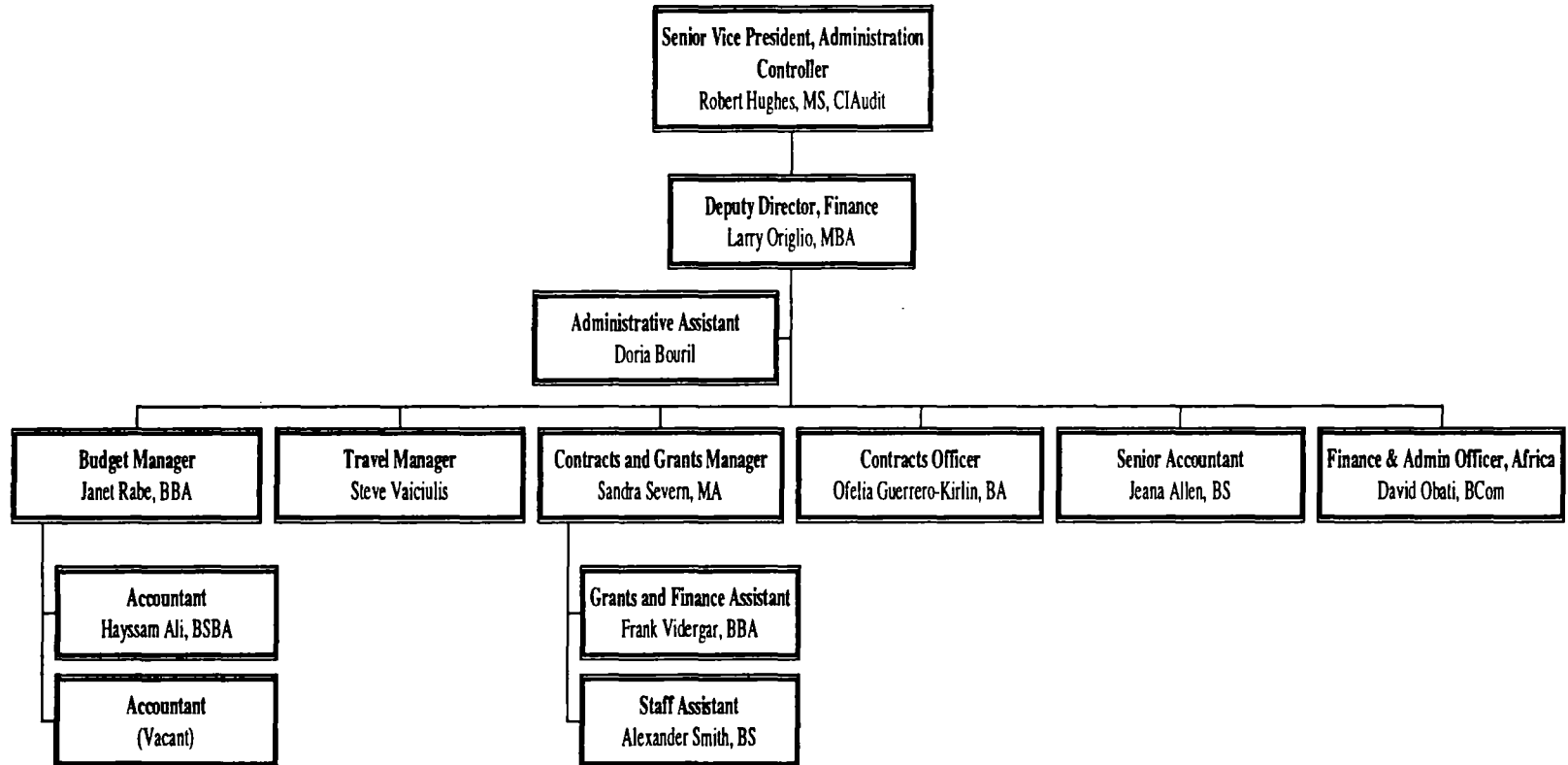
Field Programs Group

FHI HIV/AIDS Prevention and Care Department



Finance Group

FHI HIV/AIDS Prevention and Care Department





Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333
November 9, 1999

Todd Summers
White House Office of National AIDS Policy
736 Jackson Place NW
Washington DC, 20503

Dear Colleagues:

Attached is a revised draft version of the Implementing Maximum Prevention, Awareness, Treatment, and Care for HIV positive persons in the United States (IMPACT) Plan for your review. This is the version that came out of the meeting we held jointly on October 18th in Atlanta. As you will recall, we only had time to cover the first two goals on that day, so this version only reflects comments and suggestions regarding:

- I Increase number of infected individuals who know their HIV status as early after infection as possible
- II Increase number of HIV-infected individuals who utilize health care and prevention services

However, written comments that were received prior to the meeting for the rest of the goals have already been incorporated into the text. I have also enclosed a "working" memo from our contractor, summarizing the changes made.

We look forward to continuing our discussion of the additional 3 goals as soon as possible. Staff from Melissa Shepherd's office are attempting to arrange a meeting for later in November. It is my hope that our efforts will generate a comprehensive plan that will provide knowledge, services and treatment to individuals at increased risk for HIV infection and will facilitate the coordination between the different federal agencies involved. Please feel free to call me at (404) 639-8890 if you have any questions or concerns.

Sincerely,

Ronald O. Valdiserri, M.D., M.P.H.

Deputy Director

National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention

Enclosures

cc:
Dr. Helene Gayle
Dr. Joe O'Neill

MEMO

To: IMPACT Planning Group
From: Aspen International
Subj: Revised IMPACT plan
Date: November 1, 1999

This memo will describe the types of changes we made and how we went about making them. It also outlines some ideas for presentation of the plan that we did not incorporate into this set of revisions, and includes suggestions for next steps for the plan.

We made a variety of textual and structural changes in the plan, while maintaining much of the original language. We think that these changes address the other agencies' comments, make it easier to follow the document's flow, and eliminate redundancies and some uses of scientific jargon. We view this effort as creating a new "draft" document for your consideration; if you like the direction in which we have taken this document, we can make additional changes (some of which we discuss below) to further improve it.

1. Revising the plan

The major changes we made to the document are summarized below:

- **Incorporated agency comments, including written comments and comments delivered during the October 18th meeting.**
- **Imposed a uniform structure on the document, and made other structural changes to improve the flow.** As directed, we eliminated the plan's division of objectives into "Implement/Evaluate" objectives and "Research" objectives. We then rearranged objectives, grouping objectives relating to research at the start of each goal, followed by objectives related to the implementation of activities. The logic behind this was to first present the research activities that would identify specific problems, thus, providing the data upon which implementation activities could be based. When appropriate, we added dissemination steps highlighted by a box to emphasize the importance of disseminating information learned in research and through program operation to the field. We also removed redundancies, grouped similar items together, and deleted explanatory information.
- **Simplified the language and terminology.** Keeping in mind that an eventual audience for the plan will be partners who may not have a technical background, and in response to the HRSA written comment that the document has an "overly scientific structure and tone," we reduced technical jargon, simplified sentence structure, and eliminated references to some internal programs and acronyms.

- **Indicated activities that were ongoing.** In response to agency comments, we highlighted activities that were already underway by indicating the responsible agency in *italics*. See section 3, below, for a discussion of the difficulties we encountered in carrying out this step.

2. Specific changes

Specific changes we made to the document include the following:

- Added a brief introductory paragraph to each goal explaining its context and purpose and highlighting the objectives.
- Incorporated written comments from HRSA, NIH (2 sets of comments), and IHS
- Incorporated comments from participants at the October 18th meeting
- Modified selected terminology:
 - ◆ Changed “routinize HIV testing” to “promote voluntary HIV testing and counseling on a routine basis” (in response to comments from HRSA and Dr. Eisenberg);
 - ◆ Changed “mobilize” to “support” or “establish partnerships;”
 - ◆ Changed “high risk individuals” to “individuals who engage in high risk behaviors” (in response to comments about “population profiling”);
 - ◆ Changed “remove barriers” to “reduce,” “lower,” or “counter” barriers.
- Throughout the document, more than one term was used to express the same concept. In an effort to make the language consistent, we made the following word choices:
 - ◆ “ART” instead of “HAART;”
 - ◆ “accepted treatment guidelines” instead of “practice guidelines,” or “standard of care;”
 - ◆ “special populations” and “underserved populations” instead of “vulnerable populations;”
 - ◆ “HIV status” instead of “serostatus;”
 - ◆ “substance abusers” instead of “IDUs;”
 - ◆ “implementation of treatment guidelines” instead of “application of guidelines.”
- Deleted references to “funding” in the document under the assumption that the IMPACT plan is a blueprint outlining what needs to be done, not how to get funding to do it. Frequent use of the word “funding” could distract readers of the plan from focusing on the substance.

3. Issues requiring further attention

- **Clarify the meaning of the terms “primary prevention” and “secondary prevention” in light of confusion expressed about these terms in agency comments.**
- **Identifying ongoing activities.** The only way that we could identify if an activity was actually in progress was through the agencies’ written and verbal comments. We integrated these comments as best as we could given the fact that some of the comments were vague and did not refer to specific programs. Identifying all of the ongoing activities would require more extensive research than we could do in the time frame we had to revise the plan.
- **Addition of hepatitis.** Should hepatitis be added each time infections related to HIV are listed, e.g., STDs, TB?

IMPACTusa

Goal 1: Increase the number of infected individuals who know their HIV status as early after infection as possible.

CDC has estimated that there are approximately 250,000 HIV-infected people in the U.S. who do not know they are infected. The objectives for Goal One are designed to heighten public awareness about the benefits of knowing one's HIV status and to increase access to and use of testing and counseling services. Research activities include surveillance to refine relevant epidemiological data, and behavioral studies and knowledge assessments of HIV- infected individuals and health care providers to help determine barriers to testing. Action items include broad-based communication campaigns, and structural and behavioral interventions that promote the implementation of testing and counseling services on a routine basis.

Lead agency: CDC **Collaborators:** HRSA, NIH, SAMHSA, HCFA, IHS, DOJ
Non-federal partners: state health agencies, provider organizations, managed care organizations, businesses, unions, faith communities, legislators, community-based organizations, national minority organizations, media

Objectives and Action Items

1. **Establish baseline number of people who are infected but who do not know their HIV status and update the baseline regularly.**
2. **Refine epidemiological information about the HIV-infected population, including newly infected individuals.**
 - Use innovative techniques such as the "detuned" assay to determine whether there is an increase in the number of newly infected individuals among those who are diagnosed as HIV-infected.
 - Revise EPI profiles to include characteristics of newly infected individuals for community planning group jurisdictions.
 - Collaborate with HRSA on data recording systems to profile populations, including populations that are not in care systems.
 - Support state partners in development and implementation of epidemiological information from new cases surveillance program.
 - Reexamine who is considered to be at high risk for HIV infection.

3. Conduct research to identify the factors that influence people who engage in high risk behaviors to seek testing, including factors that act as barriers.

- Determine the characteristics of individuals who engage in high risk behaviors who do not seek HIV testing.
- Determine the characteristics of individuals who get tested late after infection.
- Identify the motivating factors related to testing that are relevant for different groups of individuals who engage in high risk behaviors.
- Identify characteristics of individuals who do not carry out a decision to be tested and determine why they do not follow through.
- Explore the validity of the theory that individuals who engage in high risk behaviors will be more likely to be tested if they perceive a benefit to testing, such as post-exposure prophylaxis (PEP).
- Identify community level barriers to testing (e.g., use results of HRSA survey of community health centers to determine the availability of HIV testing in these locations).
- Determine barriers to testing that are the result of discrimination.

4. Survey providers and managed care organizations to determine knowledge, attitudes, practices, risk assessment activities, barriers and facilitators related to HIV testing and counseling.

- Explore whether reimbursement for HIV risk assessment/counseling for individuals who engage in high risk behaviors would increase the use of these practices by providers and managed care organizations.
- Conduct cost-effectiveness studies to clarify the cost benefit ratio of different testing options.

5. Conduct multimedia communications campaign to encourage people to learn their HIV status as early as possible after infection.

- Conduct formative and evaluative research to determine effective communication campaign activities and messages.
- Define the components/sources of stigma associated with HIV infection.
- Determine effective methods for enlisting the private sector in the campaign.
- Design campaign activities and messages using audience segmentation strategies and incorporating the results of formative and evaluative research.
- Craft campaign messages that increase knowledge about the connection between possible high risk exposures and symptoms of acute retroviral syndrome.
- Craft campaign messages to facilitate risk assessments and promote HIV testing by individuals who engage in high risk behaviors. Deliver these messages via interpersonal and multimedia communications channels.
- Establish public/private partnerships to support campaign objectives and activities.

- Develop targeted mass media campaigns to counter the stigma associated with HIV testing and treatment among individuals who engage in high risk behaviors.
- Develop targeted small media materials that address community perceptions (e.g., lack of adequate confidentiality in publicly funded testing sites).

6. Promote the availability of voluntary HIV testing (requiring informed consent) and counseling on a routine basis.

- Work with providers, managed care organizations under contract to care for Medicaid-eligible individuals, to promote the acceptance and increase the availability of risk assessment and HIV testing and counseling as a routine part of medical care. Explore with HCFA the provision of financial incentives in the Medicaid fee-for-service system and managed care contracts to promote HIV risk assessment, testing and counseling. Increase availability of testing and counseling in primary care clinics, community health centers and other HRSA medical care systems.
- Increase the availability of HIV testing in emergency rooms in large urban hospitals, STD clinics and drug treatment services.
- In collaboration with the Department of Justice, Bureau of Prisons, develop guidelines and implement programs for HIV testing and counseling in prisons and jails on a routine basis.
- Increase the capacity of state/local health departments and community-based organizations to provide testing within high-risk communities through the use of mobile vans and storefront clinics.
- Facilitate the licensing of additional rapid tests that can be used to improve screening and speed knowledge of HIV status.
- Facilitate access to existing and future HIV testing technologies.
- In collaboration with HRSA, provide training for physicians in the use of rapid tests through the AIDS Education and Training Center (AETC) network.

7. Implement targeted, community-level interventions to encourage HIV testing among individuals who engage in high risk behaviors.

- Establish and enhance public/private partnerships to foster interventions targeting individuals who engage in high risk behaviors.
- Enlist the support of minority faith communities to influence community norms about HIV testing through teaching about the importance of early HIV diagnosis.
- Educate state legislators and policymakers on the benefits of maintaining anonymous testing options to reach populations who engage in high risk behaviors.
- Promote the removal of structural barriers to testing related to hours of operation, location of testing sites, and availability of transportation. Lessen the need to return for results by encouraging the use of rapid tests and provide incentives for returning for results if rapid tests are not available or preferred.
- In collaboration with community-based organizations, implement culturally competent HIV testing and counseling services.

8. Develop and implement methods for more effective use of the partner notification system to target the partners of newly infected individuals.

Dissemination

- Disseminate campaign messages and materials via print and broadcast media, the Internet, and other venues that will reach individuals that engage in high risk behaviors.
- Provide widespread dissemination of the revised *Counseling and Testing Guidelines* through a variety of channels (e.g., Internet, mail, fax, satellite broadcast, distance learning).
- Use the Internet to disseminate information about confidential/anonymous HIV testing sites. Disseminate information about effective targeted, community interventions to promote testing and counseling through a variety of media (e.g. Internet, mail, fax, distance learning.)

Goal 2: Increase the number of HIV-infected individuals who utilize health care and prevention services.

Despite knowledge of their HIV status, many HIV-infected individuals are not currently receiving health care and prevention services. The objectives for Goal Two are aimed at improving the linkages between prevention and care services, and promoting easy access to integrated care services. Research activities include assessing the effectiveness of referral services and identifying barriers to entry into prevention and care systems. Action items include developing models to address these barriers and enhancing organizational capacity to provide effective referrals and care services.

Lead agency: HRSA **Collaborators:** CDC, NIH, SAMHSA, HUD, IHS

Non-federal partners: community-based organizations, provider organizations, managed care organizations, national minority organizations

Objectives and Action Items

1. Assess effectiveness of referrals to care and prevention services.

- Identify effective methods and models of linking HIV-infected individuals to care and preventive services; identify models in existing grantee mechanisms.
- Assess effectiveness of current linkages and referrals to preventive and care services, focusing on referrals by community-based organizations, public facilities, and providers in the private sector.
- Measure time between counseling (peer or provider) and use of services.

2. Conduct research to identify barriers to providing and accessing HIV-related health care and prevention services.

- Identify structural, cultural, logistical, financial, and legal barriers to care services.
- Continue to assess provider knowledge of appropriate referrals and care services.
- Continue to collect survey data from providers and clients to identify available care services, to determine utility and accessibility of services, and to identify unmet needs.
- Continue to collect survey data from providers, clients, and HIV-infected individuals not using care services, to identify barriers to entering and remaining in care. Study the following potential barriers: denial, substance abuse, confidentiality concerns, health insurance limitations, family obligations, lack of transportation, perception that treatment doesn't work, mental health limitations, and physician fees and productivity and service requirements.
- Determine individual and system factors that motivate special populations (e.g., youth, substance abusers, pregnant women, homeless persons, Native Americans and other minority groups) to enter and remain in care systems.

- Assess whether care services offered to special populations are sensitive to ethnocultural, language, and age differences.

3. Address barriers to providing and accessing care.

- Continue to provide training to providers to improve knowledge and quality of services, lower barriers, and promote the inclusion of prevention services in the practice environment.
- Working with community-based organizations, continue to provide peer counseling and education to clients to improve knowledge of services and lower barriers.
- In collaboration with SAMHSA and HUD, promote the provision of comprehensive, integrated care including systems of supportive care and services (e.g., pharmacy, physical therapy, transportation assistance, housing assistance, substance abuse treatment). Develop and test models to integrate HIV prevention, diagnostic, and treatment services with related medical, social, and mental health services.
- Refocus program guidance and activities on needs of special populations identified by surveillance and other population-based surveys.

4. Increase capacity of public and private health care sectors to link HIV-infected individuals to care and preventive services.

- Establish and enhance Federal and local public/private partnerships (including community-based organizations) to strengthen linkages between prevention and care services.
- Increase public health infrastructure capacity to serve populations with limited access to care.
- Develop standards and protocols for making culturally sensitive referrals and assisting access to services, using practices acceptable to communities and providers.

Dissemination

- Provide widespread dissemination of information about effective models that link HIV infected individuals to care and preventive services, and models that integrate HIV prevention, diagnostic, and treatment services with related medical, social and mental health services. Use a variety of media including the Internet, mail, fax, and conferences as well as existing networks (HRSA and CDC grantees).
- Use established networks (HRSA and CDC grantees) to disseminate information about culturally sensitive standards for voluntary referrals.

Goal 3: Increase the number of HIV-infected individuals who are receiving appropriate care and treatment for their HIV infection, opportunistic infections, and other related infections (other STDs, TB)

As recently as 1997, one-third of people in care for HIV infection did not receive appropriate care as defined by U.S. Public Health Service Guidelines for primary HIV treatment, and prophylaxis and treatment of opportunistic infections. Objectives for Goal Three are intended to increase the number of HIV-infected individuals who receive this standard of care for HIV infection, as well as for OIs and other related infections. Research activities include assessments of health care providers' use of the accepted prevention and treatment guidelines, and identification of populations not receiving adequate care. Action items include increasing availability of antiretroviral therapy (ART), continuing to publicize treatment guidelines and educate providers, and integrating treatment of HIV disease with other diseases.

Lead agency: HRSA/CDC **Collaborators:** NIH, HCFA, SAMHSA, AHCPR, IHS
Non-federal partners: community-based organizations, provider organizations, managed care organizations, pharmaceutical companies, national minority organizations, medical schools, nursing schools, state medical societies, insurers

Objectives and Action Items

1. Assess implementation of HIV prevention and treatment guidelines, and identify barriers to implementation.

- Survey public and private sector health care providers to determine the extent of their awareness, knowledge and implementation of accepted HIV prevention and treatment guidelines.
- Working collaboratively (CDC, HRSA, HCFA, state programs, insurers), use data obtained from population-based surveillance to determine the number of HIV-infected individuals who are receiving appropriate OI prophylaxis and treatment, and to identify populations not receiving these services.
- Assess effectiveness of strategies to reduce morbidity and mortality from HIV infection in underserved populations by measuring incidence and prevalence of preventable OIs and determining links to specific treatment intervention services.
- Conduct research to identify trends in the distribution of provider practices with HIV-infected clients by provider demographics, client demographics, and organizational setting.
- Conduct research to determine the impact of reimbursement policies on provider practices with HIV-infected clients.

2. Support efforts of public and private health care sectors and other sectors to increase availability of antiretroviral therapy (ART).

- Establish and enhance Federal and local public/private partnerships (including community-based organizations) to advocate continued support for and increase in the

availability of ART, and reduce disparities in care for underserved populations (e.g., expand AIDS Drug Assistance Programs).

- Lower cost barriers to implementing accepted prevention and treatment guidelines. Develop collaborations to project the costs of treating HIV-infected populations including underserved populations. Develop to ensure that agencies that provide payment for drugs have accurate data on populations in need.
- Expand current collaborations of government agencies with pharmaceutical companies to include information sharing about client and provider concerns about drug costs, acceptability and feasibility of regimens, and side effects.
- Develop a coalition of national minority organizations to promote awareness of importance of prevention and treatment.

3. Support efforts of public and private health care sectors to provide education and training that increases knowledge and implementation of accepted treatment guidelines.

- Provide training and support through the HRSA AETCs to maximize the number of providers who are aware of and comply with accepted prevention and treatment guidelines. Target and redirect provider training as needed, using information gained from provider surveys.
- Educate providers, government agencies, and insurers on the cost-benefit ratio of outpatient treatment vs. inpatient hospitalization.
- Educate providers, government agencies, and insurers on the cost-benefit ratio of comprehensive prevention services including primary prevention of HIV infection as well as secondary prevention (defined as preventing opportunistic infections and progression of HIV disease).

4. Support treatment of HIV in conjunction with treatment of related infections.

- Train providers to correctly diagnose and treat related infections (e.g., STDs) among HIV-infected individuals.
- Develop collaborations to support the implementation of quality assurance measures to monitor physician practice patterns for HIV-infected individuals related to STD care and treatment of TB and OIs.
- Develop comprehensive, integrated standards for screening and treating HIV in the context of co-morbidities such as STDs and TB. Develop HIV prevention and treatment guidelines for specific populations that integrate their care with services for other social or medical problems. For example, develop guidelines for substance abusers that focus on co-managing HIV disease and substance abuse, and integrate screening for TB.
- Use pilot studies and/or demonstration projects to assess whether an integrated guidelines approach enhances the delivery of integrated services.

Dissemination

- Continue to broadly disseminate accepted treatment guidelines by working collaboratively (CDC, HRSA, NIH, HCFA, SAMHSA, medical and other professional organizations such as National Medical Association, American Medical Association, American Psychological Association, Association of State and

Goal 4: Increase the number of HIV-infected individuals on appropriate therapy who are adhering to their prescribed therapy regimen.

Poor adherence to antiretroviral therapies (ART) can cause drug resistance, higher levels of viral load, disease progression, and potential transmission of drug-resistant virus. The objectives for Goal Four are designed to improve patients' ability to adhere to complicated drug therapy regimes and to learn more about the development of drug resistance. Research activities include development of a conceptual framework for adherence, identification of barriers to adherence, and studies of the role of adherence in development of drug resistance. Action items include development and widespread dissemination of effective methods and models to improve adherence.

Lead agency: HRSA **Collaborators:** CDC, NIH, SAMHSA, IHS

Non-federal partners: provider organizations including nursing organizations, community-based organizations, pharmaceutical companies, Forum for Collaborative Research

Objectives and Action Items

1. **Develop standardized methods of measuring adherence that are simple and inexpensive.**
2. **Conduct research to determine the factors that motivate individuals who engage in high risk behaviors to adhere to prescribed therapy regimens and identify barriers to their adherence.**
 - Conduct studies to determine why patients discontinue ART after sustained use.
 - Conduct behavioral studies to identify how attitudes and beliefs about ART enhance or impede adherence.
 - Conduct controlled studies of programs that offer patient education and social services as a standard of care to determine the impact of patient characteristics (e.g., socioeconomic, ethnocultural, insurance, income, substance abuse, knowledge and education factors) on adherence.
 - Conduct studies to assess the impact of provider-patient relationship characteristics (e.g., rapport with the HIV care team, and overall patient satisfaction) on adherence.
 - Conduct studies to assess the impact of various health care provider characteristics on adherence. Consider the following provider practice characteristics: number of HIV patients, the number of HIV specialist physicians, and the number and type of services offered such as substance abuse counseling, nutrition, outreach, child care.

3. Address barriers to patient adherence.

- Work with community groups and provider organizations to develop a conceptual framework for adherence. Incorporate knowledge gained from DOT in TB treatment.
- Identify effective adherence programs and methods (e.g., strategies for helping patients cope with side effects, peer-led self-management training).
- Educate family members of patients on the importance of adherence.
- Conduct research to develop software to assist providers in keeping abreast of drug side effects and interactions.
- Increase capacity of pharmacists to provide counseling on adherence.

4. Distinguish the relative role of non-adherence in the development of drug resistance from other factors contributing to resistance; evaluate the role of other factors in contributing to resistance. Determine whether drug resistance develops in individuals who adhere to drug therapy. Conduct research to determine what degree of non-adherence promotes drug resistance.

- Include drug resistance monitoring in research studies. Increase the number of HMOs and private clinics involved in monitoring transmission of resistant strains.
- Include viral load monitoring in all program evaluation studies and all clinical health care settings. In collaboration with HCFA, encourage State Medicaid offices to adopt purchasing recommendations that include CD4 and viral load determination in contracts for Medicaid Managed Care Services.
- Combine studies of adherence with surveillance studies which determine the incidence of genotypic and/or phenotypic ART resistance among individuals who are beginning ART, have limited experience with ART, and have more extensive experience with ART.
- Continue surveillance studies of the transmission of ART-resistant HIV in key populations such as patients of STD clinics, pregnant women, recently infected individuals, prenatally infected infants, and patients with needle stick injuries. Expand surveillance systems to include special studies aimed to determine the prevalence of drug resistance in recently infected individuals and the factors associated with transmission of drug resistant strains.
- Conduct research studies of the correlation between genotypic resistance patterns and drug susceptibility assays in patients for which this correlation is not already well established, i.e., multi-drug regimens.

- Conduct basic science studies to determine the most reproducible and cost-effective method for sequencing relevant parts of the HIV genome.

Dissemination

- Disseminate information about effective methods and models for improving adherence via the Internet, journal articles, patient guides and other handouts in providers' offices, and adherence workshops and distance learning mechanisms that deal with specific issues such as nutrition problems, memory aids.

Goal 5: Increase the number of HIV-infected individuals who initiate and sustain HIV/STD risk reduction behavior.

Changing the behaviors that put people at risk for contracting HIV continues to be critical to controlling the epidemic. Goal Five objectives focus on increasing risk reduction behaviors by heightening awareness of the benefits of prevention, strengthening the capacity of prevention service providers, and reducing the barriers to accessing these services. Research activities include identifying motivations and barriers to sustaining risk reduction behaviors. Action items include communicating the benefits of prevention and strengthening local prevention services.

Lead agency: CDC **Collaborators:** NIH, HRSA, HCFA, SAMHSA, IHS

Non-federal partners: provider organizations, community-based organizations, Community Prevention partners

Objectives and Action Items

1. Conduct research to determine the factors that motivate individuals who engage in high risk behaviors to sustain risk reduction behavior and identify barriers to sustaining this behavior.

- Review the scientific literature on initiating and sustaining risk reduction behavior among HIV-infected individuals. Study psychological, social, gender, ethnocultural, legal, logistical, disease progression and treatment factors. Survey the literature for information, gained from work done in other chronic disease areas, on sustaining protective health behaviors over extended periods of time, and to identify successful risk reduction models that could be adapted for use with HIV-infected individuals.
- Assess the need to develop theoretical models to describe the motivations both for personal protection and for protecting others from HIV transmission.
- Prioritize and conduct research to answer outstanding questions about patterns and determinants of risk behavior, and about the effectiveness (including cost effectiveness) of current, enhanced, and alternative intervention models.
- Examine the role of social groups, organizations and policy-making bodies in creating a social context that encourages risk reduction.
- Determine the unintended behavioral consequences when risk reduction services are inadvertently provided at an inadequate level to an HIV-infected client.
- Determine what HIV-infected clients in public and private systems of care know about risks associated with HIV and the availability of prevention services. Identify their perceptions of these services and the barriers they face in accessing services.

2. Address barriers to initiating and sustaining HIV/STD risk reduction behavior.

- Increase HIV-infected individuals' awareness of the benefits of prevention and of options for risk reduction and prevention services. Include information about other HIV-associated risks such as OIs, hepatitis, and other STDs.
- Increase providers' awareness of prevention services benefits and options.
- Establish and enhance federal and local public/private partnerships to reduce organizational and environmental barriers to prevention services (e.g., lack of access to condoms and/or clean injection equipment, lack of organizational capacity for tracking referrals, lack of knowledge among providers of Prevention Case Management [PCM]).

3. Increase the number of HIV-infected individuals in prevention services including counseling and PCM.

- Continue to provide available interventions (e.g., counseling and testing, peer group support, PCM, long-term individualized psychotherapy, drug treatment) through public and private care systems to individuals who engage in high risk behaviors.
- Track the availability of counseling and testing and other services available to HIV-infected individuals, especially in areas of high seroprevalence.
- Determine the array of medical, psychological and social services needed to warrant devoting staff to the linkage activities specified in the PCM Guidelines (1997).
- Develop guidelines for service providers working in areas without the minimum array of services needed to make PCM linkage activities worthwhile.
- Provide technical assistance in adapting model programs to local needs and conducting ongoing monitoring of program quality. Develop mechanisms to enable staff of well developed programs to contribute to the improvement of weaker programs.
- Work with other agencies to fill in the gaps in the system of medical/psychological/social support services required by many HIV-infected individuals.
- Strengthen PCM. Improve existing procedures for screening HIV-infected individuals into PCM and improve the assessment of PCM client needs. Strengthen the connection between PCM client assessment results and PCM counselor action. Ensure that PCM programs are guided by local needs assessments, consistent with local HIV Prevention Plans, and coordinated with Ryan White Case Management Services, probation case management, and other local programs.

Dissemination

- Disseminate information on risk reduction and prevention services to HIV- infected individuals using their preferred communication channels. Disseminate information about prevention services, benefits and options to key health care providers. Translate research, program information and evaluation results into language useful to service providers and HIV-infected individuals.



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333
November 9, 1999

Todd Summers
White House Office of National AIDS Policy
736 Jackson Place NW
Washington DC, 20503

Dear Colleagues:

Attached is a revised draft version of the Implementing Maximum Prevention, Awareness, Treatment, and Care for HIV positive persons in the United States (IMPACT) Plan for your review. This is the version that came out of the meeting we held jointly on October 18th in Atlanta. As you will recall, we only had time to cover the first two goals on that day, so this version only reflects comments and suggestions regarding:

- I Increase number of infected individuals who know their HIV status as early after infection as possible
- II Increase number of HIV-infected individuals who utilize health care and prevention services

However, written comments that were received prior to the meeting for the rest of the goals have already been incorporated into the text. I have also enclosed a "working" memo from our contractor, summarizing the changes made.

We look forward to continuing our discussion of the additional 3 goals as soon as possible. Staff from Melissa Shepherd's office are attempting to arrange a meeting for later in November. It is my hope that our efforts will generate a comprehensive plan that will provide knowledge, services and treatment to individuals at increased risk for HIV infection and will facilitate the coordination between the different federal agencies involved. Please feel free to call me at (404) 639-8890 if you have any questions or concerns.

Sincerely,

Ronald O. Valdiserri, M.D., M.P.H.

Deputy Director

National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention

Enclosures

cc:

Dr. Helene Gayle

Dr. Joe O'Neill

MEMO

To: IMPACT Planning Group
From: Aspen International
Subj: Revised IMPACT plan
Date: November 1, 1999

This memo will describe the types of changes we made and how we went about making them. It also outlines some ideas for presentation of the plan that we did not incorporate into this set of revisions, and includes suggestions for next steps for the plan.

We made a variety of textual and structural changes in the plan, while maintaining much of the original language. We think that these changes address the other agencies' comments, make it easier to follow the document's flow, and eliminate redundancies and some uses of scientific jargon. We view this effort as creating a new "draft" document for your consideration; if you like the direction in which we have taken this document, we can make additional changes (some of which we discuss below) to further improve it.

1. Revising the plan

The major changes we made to the document are summarized below:

- **Incorporated agency comments, including written comments and comments delivered during the October 18th meeting.**
- **Imposed a uniform structure on the document, and made other structural changes to improve the flow.** As directed, we eliminated the plan's division of objectives into "Implement/Evaluate" objectives and "Research" objectives. We then rearranged objectives, grouping objectives relating to research at the start of each goal, followed by objectives related to the implementation of activities. The logic behind this was to first present the research activities that would identify specific problems, thus, providing the data upon which implementation activities could be based. When appropriate, we added dissemination steps highlighted by a box to emphasize the importance of disseminating information learned in research and through program operation to the field. We also removed redundancies, grouped similar items together, and deleted explanatory information.
- **Simplified the language and terminology.** Keeping in mind that an eventual audience for the plan will be partners who may not have a technical background, and in response to the HRSA written comment that the document has an "overly scientific structure and tone," we reduced technical jargon, simplified sentence structure, and eliminated references to some internal programs and acronyms.

- **Indicated activities that were ongoing.** In response to agency comments, we highlighted activities that were already underway by indicating the responsible agency in italics. See section 3, below, for a discussion of the difficulties we encountered in carrying out this step.

2. Specific changes

Specific changes we made to the document include the following:

- Added a brief introductory paragraph to each goal explaining its context and purpose and highlighting the objectives.
- Incorporated written comments from HRSA, NIH (2 sets of comments), and IHS
- Incorporated comments from participants at the October 18th meeting
- Modified selected terminology:
 - ♦ Changed “routinize HIV testing” to “promote voluntary HIV testing and counseling on a routine basis” (in response to comments from HRSA and Dr. Eisenberg);
 - ♦ Changed “mobilize” to “support” or “establish partnerships;”
 - ♦ Changed “high risk individuals” to “individuals who engage in high risk behaviors” (in response to comments about “population profiling”);
 - ♦ Changed “remove barriers” to “reduce,” “lower,” or “counter” barriers.
- Throughout the document, more than one term was used to express the same concept. In an effort to make the language consistent, we made the following word choices:
 - ♦ “ART” instead of “HAART;”
 - ♦ “accepted treatment guidelines” instead of “practice guidelines,” or “standard of care;”
 - ♦ “special populations” and “underserved populations” instead of “vulnerable populations;”
 - ♦ “HIV status” instead of “serostatus;”
 - ♦ “substance abusers” instead of “IDUs;”
 - ♦ “implementation of treatment guidelines” instead of “application of guidelines.”
- Deleted references to “funding” in the document under the assumption that the IMPACT plan is a blueprint outlining what needs to be done, not how to get funding to do it. Frequent use of the word “funding” could distract readers of the plan from focusing on the substance.

3. Issues requiring further attention

- **Clarify the meaning of the terms “primary prevention” and “secondary prevention”** in light of confusion expressed about these terms in agency comments.
- **Identifying ongoing activities.** The only way that we could identify if an activity was actually in progress was through the agencies’ written and verbal comments. We integrated these comments as best as we could given the fact that some of the comments were vague and did not refer to specific programs. Identifying all of the ongoing activities would require more extensive research than we could do in the time frame we had to revise the plan.
- **Addition of hepatitis.** Should hepatitis be added each time infections related to HIV are listed, e.g., STDs, TB?

IMPACTusa

Goal 1: Increase the number of infected individuals who know their HIV status as early after infection as possible.

CDC has estimated that there are approximately 250,000 HIV-infected people in the U.S. who do not know they are infected. The objectives for Goal One are designed to heighten public awareness about the benefits of knowing one's HIV status and to increase access to and use of testing and counseling services. Research activities include surveillance to refine relevant epidemiological data, and behavioral studies and knowledge assessments of HIV- infected individuals and health care providers to help determine barriers to testing. Action items include broad-based communication campaigns, and structural and behavioral interventions that promote the implementation of testing and counseling services on a routine basis.

Lead agency: CDC **Collaborators:** HRSA, NIH, SAMHSA, HCFA, IHS, DOJ
Non-federal partners: state health agencies, provider organizations, managed care organizations, businesses, unions, faith communities, legislators, community-based organizations, national minority organizations, media

Objectives and Action Items

1. Establish baseline number of people who are infected but who do not know their HIV status and update the baseline regularly.
2. Refine epidemiological information about the HIV-infected population, including newly infected individuals.
 - Use innovative techniques such as the "detuned" assay to determine whether there is an increase in the number of newly infected individuals among those who are diagnosed as HIV-infected.
 - Revise EPI profiles to include characteristics of newly infected individuals for community planning group jurisdictions.
 - Collaborate with HRSA on data recording systems to profile populations, including populations that are not in care systems.
 - Support state partners in development and implementation of epidemiological information from new cases surveillance program.
 - Reexamine who is considered to be at high risk for HIV infection.

3. Conduct research to identify the factors that influence people who engage in high risk behaviors to seek testing, including factors that act as barriers.

- Determine the characteristics of individuals who engage in high risk behaviors who do not seek HIV testing.
- Determine the characteristics of individuals who get tested late after infection.
- Identify the motivating factors related to testing that are relevant for different groups of individuals who engage in high risk behaviors.
- Identify characteristics of individuals who do not carry out a decision to be tested and determine why they do not follow through.
- Explore the validity of the theory that individuals who engage in high risk behaviors will be more likely to be tested if they perceive a benefit to testing, such as post-exposure prophylaxis (PEP).
- Identify community level barriers to testing (e.g., use results of HRSA survey of community health centers to determine the availability of HIV testing in these locations).
- Determine barriers to testing that are the result of discrimination.

4. Survey providers and managed care organizations to determine knowledge, attitudes, practices, risk assessment activities, barriers and facilitators related to HIV testing and counseling.

- Explore whether reimbursement for HIV risk assessment/counseling for individuals who engage in high risk behaviors would increase the use of these practices by providers and managed care organizations.
- Conduct cost-effectiveness studies to clarify the cost benefit ratio of different testing options.

5. Conduct multimedia communications campaign to encourage people to learn their HIV status as early as possible after infection.

- Conduct formative and evaluative research to determine effective communication campaign activities and messages.
- Define the components/sources of stigma associated with HIV infection.
- Determine effective methods for enlisting the private sector in the campaign.
- Design campaign activities and messages using audience segmentation strategies and incorporating the results of formative and evaluative research.
- Craft campaign messages that increase knowledge about the connection between possible high risk exposures and symptoms of acute retroviral syndrome.
- Craft campaign messages to facilitate risk assessments and promote HIV testing by individuals who engage in high risk behaviors. Deliver these messages via interpersonal and multimedia communications channels.
- Establish public/private partnerships to support campaign objectives and activities.

- Develop targeted mass media campaigns to counter the stigma associated with HIV testing and treatment among individuals who engage in high risk behaviors.
 - Develop targeted small media materials that address community perceptions (e.g., lack of adequate confidentiality in publicly funded testing sites).
- 6. Promote the availability of voluntary HIV testing (requiring informed consent) and counseling on a routine basis.**
- Work with providers, managed care organizations under contract to care for Medicaid-eligible individuals, to promote the acceptance and increase the availability of risk assessment and HIV testing and counseling as a routine part of medical care. Explore with HCFA the provision of financial incentives in the Medicaid fee-for-service system and managed care contracts to promote HIV risk assessment, testing and counseling. Increase availability of testing and counseling in primary care clinics, community health centers and other HRSA medical care systems.
 - Increase the availability of HIV testing in emergency rooms in large urban hospitals, STD clinics and drug treatment services.
 - In collaboration with the Department of Justice, Bureau of Prisons, develop guidelines and implement programs for HIV testing and counseling in prisons and jails on a routine basis.
 - Increase the capacity of state/local health departments and community-based organizations to provide testing within high-risk communities through the use of mobile vans and storefront clinics.
 - Facilitate the licensing of additional rapid tests that can be used to improve screening and speed knowledge of HIV status.
 - Facilitate access to existing and future HIV testing technologies.
 - In collaboration with HRSA, provide training for physicians in the use of rapid tests through the AIDS Education and Training Center (AETC) network.
- 7. Implement targeted, community-level interventions to encourage HIV testing among individuals who engage in high risk behaviors.**
- Establish and enhance public/private partnerships to foster interventions targeting individuals who engage in high risk behaviors.
 - Enlist the support of minority faith communities to influence community norms about HIV testing through teaching about the importance of early HIV diagnosis.
 - Educate state legislators and policymakers on the benefits of maintaining anonymous testing options to reach populations who engage in high risk behaviors.
 - Promote the removal of structural barriers to testing related to hours of operation, location of testing sites, and availability of transportation. Lessen the need to return for results by encouraging the use of rapid tests and provide incentives for returning for results if rapid tests are not available or preferred.
 - In collaboration with community-based organizations, implement culturally competent HIV testing and counseling services.

8. Develop and implement methods for more effective use of the partner notification system to target the partners of newly infected individuals.

Dissemination

- Disseminate campaign messages and materials via print and broadcast media, the Internet, and other venues that will reach individuals that engage in high risk behaviors.
- Provide widespread dissemination of the revised *Counseling and Testing Guidelines* through a variety of channels (e.g., Internet, mail, fax, satellite broadcast, distance learning).
- Use the Internet to disseminate information about confidential/anonymous HIV testing sites. Disseminate information about effective targeted, community interventions to promote testing and counseling through a variety of media (e.g. Internet, mail, fax, distance learning.)

Goal 2: Increase the number of HIV-infected individuals who utilize health care and prevention services.

Despite knowledge of their HIV status, many HIV-infected individuals are not currently receiving health care and prevention services. The objectives for Goal Two are aimed at improving the linkages between prevention and care services, and promoting easy access to integrated care services. Research activities include assessing the effectiveness of referral services and identifying barriers to entry into prevention and care systems. Action items include developing models to address these barriers and enhancing organizational capacity to provide effective referrals and care services.

Lead agency: HRSA **Collaborators:** CDC, NIH, SAMHSA, HUD, IHS

Non-federal partners: community-based organizations, provider organizations, managed care organizations, national minority organizations

Objectives and Action Items

1. Assess effectiveness of referrals to care and prevention services.

- Identify effective methods and models of linking HIV-infected individuals to care and preventive services; identify models in existing grantee mechanisms.
- Assess effectiveness of current linkages and referrals to preventive and care services, focusing on referrals by community-based organizations, public facilities, and providers in the private sector.
- Measure time between counseling (peer or provider) and use of services.

2. Conduct research to identify barriers to providing and accessing HIV-related health care and prevention services.

- Identify structural, cultural, logistical, financial, and legal barriers to care services.
- Continue to assess provider knowledge of appropriate referrals and care services.
- Continue to collect survey data from providers and clients to identify available care services, to determine utility and accessibility of services, and to identify unmet needs.
- Continue to collect survey data from providers, clients, and HIV-infected individuals not using care services, to identify barriers to entering and remaining in care. Study the following potential barriers: denial, substance abuse, confidentiality concerns, health insurance limitations, family obligations, lack of transportation, perception that treatment doesn't work, mental health limitations, and physician fees and productivity and service requirements.
- Determine individual and system factors that motivate special populations (e.g., youth, substance abusers, pregnant women, homeless persons, Native Americans and other minority groups) to enter and remain in care systems.

- Assess whether care services offered to special populations are sensitive to ethnocultural, language, and age differences.

3. Address barriers to providing and accessing care.

- Continue to provide training to providers to improve knowledge and quality of services, lower barriers, and promote the inclusion of prevention services in the practice environment.
- Working with community-based organizations, continue to provide peer counseling and education to clients to improve knowledge of services and lower barriers.
- In collaboration with SAMHSA and HUD, promote the provision of comprehensive, integrated care including systems of supportive care and services (e.g., pharmacy, physical therapy, transportation assistance, housing assistance, substance abuse treatment). Develop and test models to integrate HIV prevention, diagnostic, and treatment services with related medical, social, and mental health services.
- Refocus program guidance and activities on needs of special populations identified by surveillance and other population-based surveys.

4. Increase capacity of public and private health care sectors to link HIV-infected individuals to care and preventive services.

- Establish and enhance Federal and local public/private partnerships (including community-based organizations) to strengthen linkages between prevention and care services.
- Increase public health infrastructure capacity to serve populations with limited access to care.
- Develop standards and protocols for making culturally sensitive referrals and assisting access to services, using practices acceptable to communities and providers.

Dissemination

- Provide widespread dissemination of information about effective models that link HIV infected individuals to care and preventive services, and models that integrate HIV prevention, diagnostic, and treatment services with related medical, social and mental health services. Use a variety of media including the Internet, mail, fax, and conferences as well as existing networks (HRSA and CDC grantees).
- Use established networks (HRSA and CDC grantees) to disseminate information about culturally sensitive standards for voluntary referrals.

Goal 3: Increase the number of HIV-infected individuals who are receiving appropriate care and treatment for their HIV infection, opportunistic infections, and other related infections (other STDs, TB)

As recently as 1997, one-third of people in care for HIV infection did not receive appropriate care as defined by U.S. Public Health Service Guidelines for primary HIV treatment, and prophylaxis and treatment of opportunistic infections. Objectives for Goal Three are intended to increase the number of HIV-infected individuals who receive this standard of care for HIV infection, as well as for OIs and other related infections. Research activities include assessments of health care providers' use of the accepted prevention and treatment guidelines, and identification of populations not receiving adequate care. Action items include increasing availability of antiretroviral therapy (ART), continuing to publicize treatment guidelines and educate providers, and integrating treatment of HIV disease with other diseases.

Lead agency: HRSA/CDC **Collaborators:** NIH, HCFA, SAMHSA, AHCPR, IHS
Non-federal partners: community-based organizations, provider organizations, managed care organizations, pharmaceutical companies, national minority organizations, medical schools, nursing schools, state medical societies, insurers

Objectives and Action Items

1. Assess implementation of HIV prevention and treatment guidelines, and identify barriers to implementation.

- Survey public and private sector health care providers to determine the extent of their awareness, knowledge and implementation of accepted HIV prevention and treatment guidelines.
- Working collaboratively (CDC, HRSA, HCFA, state programs, insurers), use data obtained from population-based surveillance to determine the number of HIV-infected individuals who are receiving appropriate OI prophylaxis and treatment, and to identify populations not receiving these services.
- Assess effectiveness of strategies to reduce morbidity and mortality from HIV infection in underserved populations by measuring incidence and prevalence of preventable OIs and determining links to specific treatment intervention services.
- Conduct research to identify trends in the distribution of provider practices with HIV-infected clients by provider demographics, client demographics, and organizational setting.
- Conduct research to determine the impact of reimbursement policies on provider practices with HIV-infected clients.

2. Support efforts of public and private health care sectors and other sectors to increase availability of antiretroviral therapy (ART).

- Establish and enhance Federal and local public/private partnerships (including community-based organizations) to advocate continued support for and increase in the

availability of ART, and reduce disparities in care for underserved populations (e.g., expand AIDS Drug Assistance Programs).

- Lower cost barriers to implementing accepted prevention and treatment guidelines. Develop collaborations to project the costs of treating HIV-infected populations including underserved populations. Develop to ensure that agencies that provide payment for drugs have accurate data on populations in need.
- Expand current collaborations of government agencies with pharmaceutical companies to include information sharing about client and provider concerns about drug costs, acceptability and feasibility of regimens, and side effects.
- Develop a coalition of national minority organizations to promote awareness of importance of prevention and treatment.

3. Support efforts of public and private health care sectors to provide education and training that increases knowledge and implementation of accepted treatment guidelines.

- Provide training and support through the HRSA AETCs to maximize the number of providers who are aware of and comply with accepted prevention and treatment guidelines. Target and redirect provider training as needed, using information gained from provider surveys.
- Educate providers, government agencies, and insurers on the cost-benefit ratio of outpatient treatment vs. inpatient hospitalization.
- Educate providers, government agencies, and insurers on the cost-benefit ratio of comprehensive prevention services including primary prevention of HIV infection as well as secondary prevention (defined as preventing opportunistic infections and progression of HIV disease).

4. Support treatment of HIV in conjunction with treatment of related infections.

- Train providers to correctly diagnose and treat related infections (e.g., STDs) among HIV-infected individuals.
- Develop collaborations to support the implementation of quality assurance measures to monitor physician practice patterns for HIV-infected individuals related to STD care and treatment of TB and OIs.
- Develop comprehensive, integrated standards for screening and treating HIV in the context of co-morbidities such as STDs and TB. Develop HIV prevention and treatment guidelines for specific populations that integrate their care with services for other social or medical problems. For example, develop guidelines for substance abusers that focus on co-managing HIV disease and substance abuse, and integrate screening for TB.
- Use pilot studies and/or demonstration projects to assess whether an integrated guidelines approach enhances the delivery of integrated services.

Dissemination

- Continue to broadly disseminate accepted treatment guidelines by working collaboratively (CDC, HRSA, NIH, HCFA, SAMHSA, medical and other professional organizations such as National Medical Association, American Medical Association, American Psychological Association, Association of State and

Goal 4: Increase the number of HIV-infected individuals on appropriate therapy who are adhering to their prescribed therapy regimen.

Poor adherence to antiretroviral therapies (ART) can cause drug resistance, higher levels of viral load, disease progression, and potential transmission of drug-resistant virus. The objectives for Goal Four are designed to improve patients' ability to adhere to complicated drug therapy regimes and to learn more about the development of drug resistance. Research activities include development of a conceptual framework for adherence, identification of barriers to adherence, and studies of the role of adherence in development of drug resistance. Action items include development and widespread dissemination of effective methods and models to improve adherence.

Lead agency: HRSA **Collaborators:** CDC, NIH, SAMHSA, IHS

Non-federal partners: provider organizations including nursing organizations, community-based organizations, pharmaceutical companies, Forum for Collaborative Research

Objectives and Action Items

1. Develop standardized methods of measuring adherence that are simple and inexpensive.
2. Conduct research to determine the factors that motivate individuals who engage in high risk behaviors to adhere to prescribed therapy regimens and identify barriers to their adherence.
 - Conduct studies to determine why patients discontinue ART after sustained use.
 - Conduct behavioral studies to identify how attitudes and beliefs about ART enhance or impede adherence.
 - Conduct controlled studies of programs that offer patient education and social services as a standard of care to determine the impact of patient characteristics (e.g., socioeconomic, ethnocultural, insurance, income, substance abuse, knowledge and education factors) on adherence.
 - Conduct studies to assess the impact of provider-patient relationship characteristics (e.g., rapport with the HIV care team, and overall patient satisfaction) on adherence.
 - Conduct studies to assess the impact of various health care provider characteristics on adherence. Consider the following provider practice characteristics: number of HIV patients, the number of HIV specialist physicians, and the number and type of services offered such as substance abuse counseling, nutrition, outreach, child care.

3. **Address barriers to patient adherence.**

- Work with community groups and provider organizations to develop a conceptual framework for adherence. Incorporate knowledge gained from DOT in TB treatment.
- Identify effective adherence programs and methods (e.g., strategies for helping patients cope with side effects, peer-led self-management training).
- Educate family members of patients on the importance of adherence.
- Conduct research to develop software to assist providers in keeping abreast of drug side effects and interactions.
- Increase capacity of pharmacists to provide counseling on adherence.

4. **Distinguish the relative role of non-adherence in the development of drug resistance from other factors contributing to resistance; evaluate the role of other factors in contributing to resistance. Determine whether drug resistance develops in individuals who adhere to drug therapy. Conduct research to determine what degree of non-adherence promotes drug resistance.**

- Include drug resistance monitoring in research studies. Increase the number of HMOs and private clinics involved in monitoring transmission of resistant strains.
- Include viral load monitoring in all program evaluation studies and all clinical health care settings. In collaboration with HCFA, encourage State Medicaid offices to adopt purchasing recommendations that include CD4 and viral load determination in contracts for Medicaid Managed Care Services.
- Combine studies of adherence with surveillance studies which determine the incidence of genotypic and/or phenotypic ART resistance among individuals who are beginning ART, have limited experience with ART, and have more extensive experience with ART.
- Continue surveillance studies of the transmission of ART-resistant HIV in key populations such as patients of STD clinics, pregnant women, recently infected individuals, prenatally infected infants, and patients with needle stick injuries. Expand surveillance systems to include special studies aimed to determine the prevalence of drug resistance in recently infected individuals and the factors associated with transmission of drug resistant strains.
- Conduct research studies of the correlation between genotypic resistance patterns and drug susceptibility assays in patients for which this correlation is not already well established, i.e., multi-drug regimens.

- Conduct basic science studies to determine the most reproducible and cost-effective method for sequencing relevant parts of the HIV genome.

Dissemination

- Disseminate information about effective methods and models for improving adherence via the Internet, journal articles, patient guides and other handouts in providers' offices, and adherence workshops and distance learning mechanisms that deal with specific issues such as nutrition problems, memory aids.

Goal 5: Increase the number of HIV-infected individuals who initiate and sustain HIV/STD risk reduction behavior.

Changing the behaviors that put people at risk for contracting HIV continues to be critical to controlling the epidemic. Goal Five objectives focus on increasing risk reduction behaviors by heightening awareness of the benefits of prevention, strengthening the capacity of prevention service providers, and reducing the barriers to accessing these services. Research activities include identifying motivations and barriers to sustaining risk reduction behaviors. Action items include communicating the benefits of prevention and strengthening local prevention services.

Lead agency: CDC **Collaborators:** NIH, HRSA, HCFA, SAMHSA, IHS

Non-federal partners: provider organizations, community-based organizations, Community Prevention partners

Objectives and Action Items

1. Conduct research to determine the factors that motivate individuals who engage in high risk behaviors to sustain risk reduction behavior and identify barriers to sustaining this behavior.

- Review the scientific literature on initiating and sustaining risk reduction behavior among HIV-infected individuals. Study psychological, social, gender, ethnocultural, legal, logistical, disease progression and treatment factors. Survey the literature for information, gained from work done in other chronic disease areas, on sustaining protective health behaviors over extended periods of time, and to identify successful risk reduction models that could be adapted for use with HIV-infected individuals.
- Assess the need to develop theoretical models to describe the motivations both for personal protection and for protecting others from HIV transmission.
- Prioritize and conduct research to answer outstanding questions about patterns and determinants of risk behavior, and about the effectiveness (including cost effectiveness) of current, enhanced, and alternative intervention models.
- Examine the role of social groups, organizations and policy-making bodies in creating a social context that encourages risk reduction.
- Determine the unintended behavioral consequences when risk reduction services are inadvertently provided at an inadequate level to an HIV-infected client.
- Determine what HIV-infected clients in public and private systems of care know about risks associated with HIV and the availability of prevention services. Identify their perceptions of these services and the barriers they face in accessing services.

2. Address barriers to initiating and sustaining HIV/STD risk reduction behavior.

- Increase HIV-infected individuals' awareness of the benefits of prevention and of options for risk reduction and prevention services. Include information about other HIV-associated risks such as OIs, hepatitis, and other STDs.
- Increase providers' awareness of prevention services benefits and options.
- Establish and enhance federal and local public/private partnerships to reduce organizational and environmental barriers to prevention services (e.g., lack of access to condoms and/or clean injection equipment, lack of organizational capacity for tracking referrals, lack of knowledge among providers of Prevention Case Management [PCM]).

3. Increase the number of HIV-infected individuals in prevention services including counseling and PCM.

- Continue to provide available interventions (e.g., counseling and testing, peer group support, PCM, long-term individualized psychotherapy, drug treatment) through public and private care systems to individuals who engage in high risk behaviors.
- Track the availability of counseling and testing and other services available to HIV-infected individuals, especially in areas of high seroprevalence.
- Determine the array of medical, psychological and social services needed to warrant devoting staff to the linkage activities specified in the PCM Guidelines (1997).
- Develop guidelines for service providers working in areas without the minimum array of services needed to make PCM linkage activities worthwhile.
- Provide technical assistance in adapting model programs to local needs and conducting ongoing monitoring of program quality. Develop mechanisms to enable staff of well developed programs to contribute to the improvement of weaker programs.
- Work with other agencies to fill in the gaps in the system of medical/psychological/social support services required by many HIV-infected individuals.
- Strengthen PCM. Improve existing procedures for screening HIV-infected individuals into PCM and improve the assessment of PCM client needs. Strengthen the connection between PCM client assessment results and PCM counselor action. Ensure that PCM programs are guided by local needs assessments, consistent with local HIV Prevention Plans, and coordinated with Ryan White Case Management Services, probation case management, and other local programs.

Dissemination

- Disseminate information on risk reduction and prevention services to HIV- infected individuals using their preferred communication channels. Disseminate information about prevention services, benefits and options to key health care providers. Translate research, program information and evaluation results into language useful to service providers and HIV-infected individuals.