Evaluating High-Impact Prevention
Where have we been and where are we going?

Prevention Planning Group Meeting
Tampa, FL
May 12, 2015
High-Impact Prevention (HIP)

Required Components and Activities
- HIV Testing
- Prevention for Positives
- Condom Distribution
- Policy
- Prevention Planning
- Capacity Building and Technical Assistance
- Monitoring/Evaluation and Quality Improvement

Recommended Components
- Prevention for high-risk negatives
- Social marketing, media and mobilization
- PrEP/nPEP
HIP Funding Overview

- Prevention Program receives approximately $34 million (Category A- PRV and B- ETI)
- Funds directed towards areas most heavily impacted: Miami-Dade had 115% increase and Broward 114% since 2011
- Sequestration cuts in 2013 reduced budget by almost $2 million
- Funding expected to increase through 2016 (primarily in Miami-Dade and Broward counties)
HIP Contracts Overview

- Total funding in contracts*: $12.7 million
- Total number of contracts: 82
- Of these contracts, 81 (99%) target racial/ethnic minorities in their service areas; and 67 (82%) target gay, bisexual and other MSM, as well as transgender individuals

* Prevention contracts providing direct client services (HIV testing, linkage, interventions, mobilization, condom distribution, outreach, etc.); Includes HIP, MSM/Trans, ETI, DOC Peer Education, MAI-ARTAS and TOPWA contracts.
Number and Percentage of HIV-Diagnosed Persons Engaged in Selected Stages of The Continuum of HIV Care — Florida (incl. DOC), 2013

(1) Number of cases known to be alive and living in Florida through 2013, regardless where diagnosed, as of 06/30/2014 (used for unmet need calculations).
(2) Ever in Care = 86% of those cases were linked to care, based on persons living with HIV disease in Florida (regardless of where diagnosed) who ever had a CD4 or Viral load (VL) test in the electronic HIV/AIDS Reporting System (eHARS). (2010 National estimates are 79%*).
(3) 55% of cases were in care this year, based on HRSA unmet need definition, for persons living with HIV in Florida (regardless of where diagnosed) and having at least 1 HIV-related care service involving either a VL or CD4 test or a refill of HIV-related RX. (2010 National estimates for in care are 56%*).
(4) Estimated 90.6% of in care and on ART this year in Florida per 2011 MMP data (2010 National estimates are 80%*).
(5) Estimated 78.0% on ART & the viral load is <200 this year in Florida per 2011 MMP data (2010 National estimates are 70%*).
For additional information please refer to the Florida Continuum of Care slide set accessible at http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html
Of all tests performed in 2014, 70% were rapid, 25% blood and 5% oral fluid.
Statewide Condom Distribution Totals*, 2012-2014

* Condoms purchased at headquarters (Tallahassee) and drop-shipped to local health departments, for further distribution to community partners.
From 2012 to 2014, the total number of individuals reached through interventions delivered by CBOs decreased, however there was an increase in the proportion of HIV-positive, MSM and transgender individuals enrolled, leading to better alignment with **high-impact prevention**.
Future Funding Announcements

• HIP contract cycle (DOH FA#12-006) ends December 2016
• CDC 5-year cooperative agreement ends December 2016
• Factors affecting funding announcements
  - CDC initiatives/funding
  - Community needs assessments
  - State HIV/AIDS data/trends
  - CBO services, coverage areas, strengths, partnerships, collaborations
Evaluating the Shift to HIP

• How do we evaluate HIP?
• Common themes? Retention in care, medication adherence, comprehensive prevention models, patient-centered medical homes, lab-based 4th generation HIV testing, routine HIV testing, activities to support PrEP/nPEP, etc.
Was HIP fully implemented in your agency?

• Did agency/staff fully shift to HIP? Embrace HIP?
• What were/are some barriers to full implementation?
How was full implementation achieved?

• How did the agency adapt to the shift to HIP?
• What processes did you put in place to make the shift to HIP?
• What resources were helpful?
What is working well with HIP?

• What were some of your successes in shifting to HIP?
• Best practices achieved along the way?
What isn’t working well with HIP?

• What activities are challenging?
• What solutions have you identified to address challenges?
• What can we do better?
• What do we need to see more of to make a difference?
Community Feedback

- Flexibility for providers to modify or customize programs to meet needs of local communities
- Support a more comprehensive approach to include wellness models that start with emphasizing overall health, the need for regular screenings and access to healthcare
- Redesign contracts to be more flexible (e.g., allow modified EBIs, include more CTL, PrEP-related activities)
- Include more overall wellness programs and more self-esteem building activities; also include more peer-based models
- Create a system to track and identify the main barriers reported by people recently linked to care, which ultimately cause them to not return for care over time
Community Feedback (cont.)

- Increase resources for social media tools and templates of how and why to use them; more electronic resources
- Address the lack of cultural sensitivity among certain clinical providers
- Retention in care is a major problem
- Mental health and substance abuse issues account for the majority of reasons people don’t stay in care/on treatment
- More clinicians need additional education around guidelines for HIV care and treatment
- Evaluate the agencies by performance when awarding contracts and don’t rely on who writes the best grants
- Increase partnerships and collaborations in the future; well-defined roles are important
Community Feedback (cont.)

- Need for consistency when interpreting guidelines across county lines
- In areas with many providers, sometimes segregation can occur—existing providers can be of assistance to new providers; can DOH facilitate collaborations?
- Need to do a better job of collaborating with local agencies, forming partnerships and working together; play to each others’ strengths; as resources dwindle, it’s important to share those resources effectively
- For some non-clinical sites, once the client is linked to care they sometimes lose track of the client. They try to stay in touch but it is difficult
Contact Information

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