CDC’s Approach to High-Impact HIV Prevention in the Era of Expanding Prevention Options

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Atlanta, GA

23rd Annual Illinois State HIV/STD Conference
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DISCLOSURE STATEMENTS

I have never had any relevant personal financial relationships with any manufacturers of products or services that will be discussed in my presentation.

The findings and conclusions in this report are those of the presenter and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Overview

• Brief HIV epidemiology
• Context for HIV prevention
• High Impact Prevention (HIP)
  • HIV prevention programs
  • Monitoring progress of prevention activities
  • Resource allocation modeling
  • Behavioral interventions
  • Communications campaigns
  • PrEP
BRIEF HIV EPIDEMIOLOGY
Number of people living with HIV (prevalence) has grown because incidence is relatively stable and survival has increased.

Estimated HIV Transmission Rate

Number

Year

No. living with diagnosed HIV infection
Transmission rate

Rate, per 100

Two-thirds of new HIV infections occur among MSM
Health Inequities

- African Americans are 8 times and Latinos 3 times more likely to have HIV than whites

- HIV prevalence is associated with population density, region of residence, poverty, education, employment, and homelessness

- MSM >40 times HIV prevalence compared to other men and women given 2% estimated population prevalence

CONTEXT FOR PREVENTION
The National HIV/AIDS Strategy (NHAS) Announced in July 2010

The goals of NHAS:

1. Decrease incidence of HIV
2. Increase access to care and improving health outcomes for people with HIV
3. Reduce HIV-related health disparities
4. Achieve a more coordinated national response
Executive Order -- HIV Care Continuum Initiative

Accelerating Improvements in HIV Prevention and Care in the United States through the HIV Care Continuum Initiative
Monday, July 15, 2013

“We’ve got to keep pushing. We’ve got to make access to health care more available and affordable for folks living with HIV.”
— President Obama, June 13, 2013
Recent Events Affecting HIV Prevention

  – Increased focus on the care continuum (case finding, linkage to care, retention in care, and ART adherence)

• Scientific breakthroughs:
  – ART dramatically reduces transmission of HIV
  – Efficacy of pre-exposure prophylaxis (PrEP)
  – HIV testing advances allowing for earlier detection

• Introduction of an approved over-the-counter oral HIV test

• Affordable Care Act expanding coverage to tens of thousands with HIV and millions at risk for HIV
Challenging Times for HIV Prevention

- Federal deficit ~ from 500M to $1.1 trillion for FY 2012-FY14
- 3-year freeze on federal discretionary spending
- Several years of reductions in public health services
  - Loss of 46,000 state and local positions
  - Staff furloughs, hiring freezes, pay cuts
- Many community organizations closed, merging, or struggling

Kaiser Family Foundation; NASTAD; Center on Budget and Policy Priorities; National Coalition of STD Directors
The Continuum of HIV Care

Of the 1.1 million Americans living with HIV, only 25% are virally suppressed.

Given the Epi & Context, How Can We Reach our Prevention Goals?
HIGH IMPACT PREVENTION (HIP)
Prevention with Positives

- HIV testing, linkage to care and prevention services
- Antiretroviral therapy
- Retention in care and adherence
- Partner services
- Risk reduction interventions and condoms
- STD screening and treatment
- Perinatal transmission interventions

Prevention with Negatives

- Condom distribution
- Behavioral risk reduction interventions and condoms
- Pre-exposure prophylaxis (PrEP)
- Microbicides
- Syringe services
- Male circumcision
- STD screening and treatment
- Post-exposure prophylaxis (PEP)

Not focused on HIV status

- Social mobilization
- Condom availability
- Substance use, mental health, and social support
High-Impact Prevention (HIP)
Applying the science of implementation to maximize impact

- Primary goal is to prevent the largest possible number of new HIV infections and reduce disparities

- Framework for using data to maximize impact of available resources and technologies

- Directs effort and resources to the right places, populations, and strategies

www.cdc.gov/hiv/policies/hip.html
How CDC-DHAP is Working to Achieve HIP and NHAS Vision?

• Supporting state, local, community HIV prevention programs with funding and technical assistance

• Tracking epidemic and success of service provision through HIV surveillance and program monitoring

• Identifying new prevention interventions and improving operational implementation of existing strategies

• Epidemic and economic modeling to improve decision-making

• National campaigns and prevention efforts
HIV PREVENTION PROGRAMS
Health Department FOA (2012-2016): Better Aligning Resources

- $336M/year to 61 state and city HDs
- Money allocated by HIV prevalence (diagnoses) not cumulative AIDS cases

Matching Prevention Funds to the Epidemic

When CDC’s new approach is fully implemented, HIV prevention resources will closely match the geographic burden of HIV.

Proportion of Americans Living with an HIV Diagnosis (2008)

Proportion of CDC Core HIV Prevention Funding—FY2016
Proportion of CDC Core HIV Prevention Funding—FY2016

Maps do not include U.S. territories receiving CDC HIV prevention funding.

New funding allocation methodology will be fully implemented by FY2016; this breakdown assumes level overall funding.
Health Department FOA: Focusing on High Impact Interventions

- HDs must focus on interventions that will have the greatest impact on the epidemic
- Four required components for 75% of resources:
  - HIV testing
  - Prevention for people living with HIV
  - Condom distribution
  - Structural/policy barriers
- Increase use of surveillance data to inform program activities
- Allows flexibility based on local epidemic
HHS HD Demonstration Projects to Examine Models of HIP

- **ECHPP (2010-13)** → Chicago
  - Demonstration project of principles in NHAS in 12 cities with most cases of HIV, (44% of the epidemic)
  - Planning across funding streams and 24 interventions

- **CAPUS (2012-15)** – 8 states (Illinois)
  - Identify HIV-positive persons, and link, retain, and re-engage them in care by enhancing the surveillance-program feedback loop
  - Address social determinants of health affecting the continuum of care

- **P4C (2014-17)** – 4 states
  - HDs will work with HRSA-BPHC funded HCs to increase routine testing and enhance COC for PLWH
May 22, 2013

Dear Ryan White HIV/AIDS Program and CDC HIV Prevention Colleagues:

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) are pleased to support integrated HIV prevention and care planning activities.

HIV prevention planning groups supported by CDC review existing resources, current activities, and impacted populations for HIV prevention services and jurisdictional HIV prevention plans that guide HIV prevention activities. The Ryan White HIV/AIDS Program planning groups supported by HRSA are required to assess and recommend the allocation of resources to address the HIV services needs of PLWH. Implementing a comprehensive HIV prevention, care, and treatment plan provides an opportunity for integration, synergy, and efficiency in response to jurisdictional needs and federal requirements, and have been successful in local health departments.

Good planning is imperative for effective local and state decision making to integrate prevention and care that are responsive to the needs of persons at risk for HIV and PLWH. Activities to collaborate and/or develop a joint planning body are supported by HRSA. Community involvement is an essential component for planning effective HIV prevention and care programs in this country. Integrated planning approaches include but are not limited to: needs assessment activities, information sharing, cross-representation on prevention and care planning bodies, coordinated planning meetings, and merged planning bodies. Planning groups are encouraged to develop and sustain these approaches to HIV planning in a manner that increases access to and effectiveness of prevention, care, and treatment services within the jurisdictions.

We look forward to our continued work with all our partners and stakeholders in prevention and care and treatment planning and our continued work to accomplish these goals in the National HIV/AIDS Strategy.

Sincerely,

Jonathan H. Mermin, M.D., M.P.H. /s/ 
Director
Division of HIV/AIDS Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Laura W. Cheever, M.D., ScM. /s/ 
Associate Administrator and Chief Medical Officer
HIV/AIDS Bureau
Health Resources and Services Administration

Laura W. Cheever, M.D., ScM. /s/ 
Acting Associate Administrator for HIV/AIDS
HRSA

February 24, 2014

Dear Ryan White HIV/AIDS Program and CDC HIV Prevention Colleagues:

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and the Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention (DHAP) are pleased to support integrated HIV prevention and care planning groups and activities. Integrated planning, reports, and activities will help advance progress in achieving the goals of the National HIV/AIDS Strategy and improving outcomes on the HIV Continuum of Care.

HRSA and CDC have determined that the Ryan White HIV/AIDS Program (RWHP) Parts A and B Comprehensive Plans and the CDC Jurisdictional HIV Prevention Plan will be due in September 2016. Also due at that time will be the RWHP Part B Statewide Coordinated Statement of Need (SCSN). HRSA and CDC are working to align the guidance(s) for the RWHP Comprehensive Plans/SCSN and the Jurisdictional HIV Prevention Plan to enable the submission of an integrated HIV Plan that is responsive to the requirements of both HRSA and CDC.

HRSA and CDC encourage RWHP and HIV prevention programs at the local and state level to integrate planning activities. These encompass comprehensive needs assessment, information and data sharing, cross-representation on prevention and care planning bodies, coordinated planning projects, combined meetings, and merged planning bodies. Planning groups are encouraged to streamline their approaches to HIV planning so that it increases access to and effectiveness of prevention, care, and treatment services within the jurisdictions.

Good planning is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV infection and people living with HIV. Activities to collaborate and/or develop a joint planning body are supported by both HRSA and CDC. Community involvement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States.

We look forward to continued work with all our partners and stakeholders involved in HIV prevention and care and treatment planning to accomplish the goals of the National HIV/AIDS Strategy and the HIV Continuum of Care Initiative.

Sincerely,

/Laura W. Cheever/ 
Laura W. Cheever, M.D., ScM. /s/ 
Associate Administrator and Chief Medical Officer 
HIV/AIDS Bureau 
Health Resources and Services Administration

/Kenneth C. Castro/ 
RADM Kenneth G. Castro, M.D. 
Assistant Surgeon General, U.S. Public Health Service Commanding Flag Officer, 
CDC/ATSDR Commissioned Corps Acting Director, Division of HIV/AIDS Prevention 
National Center for HIV/AIDS, Viral Hepatitis,
CDC’s CBO FOAs

- CDC’s Flagship CBO FOA (2010 – 2015)
  - 131 directly funded CBOs → testing and EBIs
  - $41 million/year
  - CBOs were redirected in year 5 to focus on HIP/COC

- Young MSM and Transgender of Color FOA (2011– 2016)
  - 34 CBOs (30 for MSM; 6 focused on transgender persons) implementing:
    - HIV testing with Personalized Cognitive Counseling (PCC)
    - Behavioral interventions and support services
  - $11 million per year/ $55M total funding
  - Approximately 90,000 tests with minimum 4% positivity rate

- CDC new flagship CBO FOA embraces HIP
  - Applications due November 14, 2014
New Capacity-Building Assistance (CBA)

- $23 million/year over a 5-year project cycle (2014 – 2018)

- 21 organizations awarded funds to provide capacity building to CBOs, HDs and health care settings
  - 8 CBA providers funded for capacity building with HDs
  - 11 CBA providers funded for capacity building with CBOs
  - 3 CBA providers funded for health care organizations

- Focus is on High-Impact HIV Prevention (HIP) and supportive activities
Public health strategy to use HIV surveillance data to identify persons not in care and offer care facilitation services

- Goals to increase the number of:
  - HIV-diagnosed persons who are engaged in care
  - HIV-diagnosed persons with an undetectable viral load

- Implementation
  - Most health departments' Data to Care programs fall into one of three overarching models for linkage and re-engagement
    - Health department-initiated outreach
    - Healthcare provider-initiated outreach
    - A combination of both approaches

D2C products are available under “Public Health Strategies” on www.effectiveinterventions.org
MONITORING PROGRESS OF PREVENTION PROGRAMS
Nationally and locally
National HIV Prevention Progress Report

- Released December 2013
- Synthesizes data from three CDC surveillance systems to describe progress on key DHAP indicators
- First report represents baseline and available results for 2011

Available at: www.cdc.gov/hiv/policies/npr
State HIV Prevention Progress Report (SPR), 2014

- State-level data on 6 key indicators
- Complements the CDC National HIV Prevention Progress Report
- Aligned with NHAS goals
- Progress for the nation depends on the progress within each state
HIV Testing (ever)

- National 2015 Goal 44.2%
- National Average 42.5%
- Illinois 36.6%
Linkage to HIV medical care

- National 2015 Goal: 85.0%
- National Average: 79.8%
- Illinois: 73.8%
CDC Rapid Feedback Reports (RFRs)

- Brief, regular RFRs for programmatic FOAs
  - Health department prevention
  - Young MSM and transgender persons of color

- A few easily understood indicators
- Feedback on progress towards goals and comparison to other grantees
- Provided to grantees only
Category A – Young Men of Color Who Have Sex with Men, by Agency (Agencies depicted by rows. Data from Year 1 Annual Progress Reports)

Figure 1a. Number of Clients Tested for HIV

Figure 1b. Percent of Clients with a New Confirmed Positive Result

Figure 1c. Percent of New Positives Linked to HIV Medical Care

Agencies that met or exceeded the target are depicted in black, agencies that did not meet the target are indicated in light red. The vertical line represents the minimum targets for: tests conducted (600); % of tests with a new confirmed positive result (4%); and % of new positive clients linked to HIV medical care (70%).
RESOURCE ALLOCATION
Mathematical Modeling

• Increased emphasis on determining how best to spend scarce resources
  – National models suggest significant resources to gay and bisexual men and PLWH
  – Faster implementation of HIP saves lives and $

• Developed resource allocation model in ECHPP with Philadelphia

• Worked with HHS on RAMP to pilot the ECHPP model with 3 other sites (including Chicago)
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All values less than $253,000 and up to $402,000 are cost saving to the health care system (depending on time of diagnosis).
Compendium

• Original Compendium (1999)
  ➢ 24 interventions
  ➢ Literature between 1988-1996

• Compendium Update (2002)
  ➢ 8 interventions
  ➢ Literature up to 2000

• Represented the first attempt to organize the behavioral intervention literature for CDC grantees – focus on efficacy of interventions to reduce sexual and injection risk
The Updated Compendium (2014)

- **Risk Reduction Chapter:**
  - 84 EBIs

- **Adherence Chapter:**
  - 10 EBIs
  - All ILI or GLI

- **NEW LRC Chapter:**
  - 4 EBIs
    - “Evidence based”
  - 5 Els
    - “Evidence informed”

---

**Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention**

- **NEW Linkage to, Retention in, and Re-engagement in HIV Care (LRC) Chapter**
- **Medication Adherence (MA) Chapter**
- **Risk Reduction (RR) Chapter**

The Evidence-Based Interventions (EBIs) and Best Practices in the Compendium are identified by the CDC’s Prevention Research Synthesis (PRS) Project through a series of ongoing systematic reviews. Each eligible intervention is evaluated against explicit criteria (LRC criteria; MA criteria; RR criteria) and has shown sufficient evidence that the intervention works. The PRS project will regularly update this Compendium as new EBIs and Best Practices are identified.

The Compendium comprises three chapters. A complete listing of each chapter can be accessed below.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>EBIs/Elis</th>
<th>Publication Date</th>
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<tr>
<td><strong>NEW Linkage to, Retention in, and Re-engagement in HIV Care (LRC) Chapter</strong> of the Compendium includes 9 best practices (4 EBIs; 5 evidence-Informed Interventions, Els). (Updated on August 1, 2014)</td>
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[www.cdc.gov/hiv/prevention/research/compendium](http://www.cdc.gov/hiv/prevention/research/compendium)
**Diffusion of Effective Behavioral Interventions (DEBI) Project has disseminated 27 interventions for sex and drug risk reduction**

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<td>Mpowerment</td>
<td>SEPA</td>
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<td>Nia</td>
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<td>POL</td>
<td>Sister to Sister</td>
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<td>Partnership for Health</td>
<td>START</td>
</tr>
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<td>Personalized Cognitive Counseling</td>
<td>Street Smart</td>
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<td>WILLOW</td>
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Quantifying the Prevention Benefits of EBIs: Prevention Benefit Index (PBI)

- In 2013, CDC estimated a PBI for our 23 primary prevention sex/drug EBIs (e.g., those targeted to HIV-negative persons) considering:
  - Real-world intervention delivery costs per person served
  - Incidence of the target population
  - Intervention effect size

\[
\text{(Cost-per-client-served) x 100,000} \\
\text{(HIV incidence rate of target population}^a\text{) x (1-Effect Size)}
\]

\(^a\text{Incidence rate per 100,000}\)
Prevention Benefit Index (PBI)

- PBI compared to lifetime costs of HIV ($402,000)

- EBIs supported by CDC for HIV-negative persons were reduced from 23 to 12 with PBIs less than 402k

- All populations with an EBI retained at least one EBI

- Our behavioral intervention portfolio now focuses on those EBIs with the greatest likelihood of reducing sexual and drug risk of HIV-negative persons at the lowest costs

Farnham, et al., JAIDS, 2013
CDC Supported EBIs by population

- **PLWH**
  - CLEAR
  - Healthy Relationships
  - Partnership for Health
  - WILLOW

- **Adapted for PLWH**
  - CONNECT
  - START

- **IDU**
  - PROMISE

- **Women**
  - PROMISE
  - Sister to Sister

- **MSM**
  - d-up!
  - Mpowerment
  - 3MV
  - POL
  - PCC
  - PROMISE
  - VOICES/VOCES

- **General**
  - Safe in the City
  - RESPECT

- **High-risk youth**
  - PROMISE

- **Transgender persons**
  - Can adapt select interventions

www.effectiveinterventions.org
Current EBIs are Being Updated to Include New Prevention Information

- Nearly all EBIs were designed and tested before the prevention advances of the past 5 years

- CDC is currently updating EBIs to include information about:
  - The importance of treatment for HIV-positive persons
  - The prevention benefits of treatment
  - The prevention benefits of PrEP and PEP
COMMUNICATION CAMPAIGNS
Raising Awareness

- Campaign Materials
- Awareness Day Materials
- Websites/Fact Sheets
- CDC Info
- Weekly Electronic Publications
- Conference Exhibiting

DHAP INsider

UPDATE
Division of HIV/AIDS Prevention

June 21, 2015

CDC Division of HIV/AIDS Prevention

Vision: A future FREE of HIV

Mission: To promote health and quality of life by preventing HIV infection and reducing HIV-related illness and death in the United States
Act Against AIDS
Campaign Portfolio

- Supports the National HIV/AIDS Strategy (NHAS) and the Division of HIV/AIDS Prevention Strategic Plan through communication and education campaigns for multiple audiences including:
  - General public
  - Populations most affected by HIV
  - Health care providers
HIV Treatment Works

Campaign launched September 2014

Target Audience:
People living with HIV (PLWH)

Goals:
- Increase engagement and retention in care and adherence to antiretroviral treatment for PLWH.
- Increase information seeking about HIV care and treatment among PLWH.
- Support informed treatment and care decision making for PLWH
“Hear this, HIV: I'm going to take care of me so I can take care of those I love.”

Angie - Loganville, GA
Living with HIV since 1995.

I break into dance whenever the mood and music move me. I won't let my HIV rob me of anything in life. I know that staying in care and on treatment helps me to be the best mother, wife and HIV peer-educator I can be. I tell other HIV-positive women: All the fear that you have can be overcome. Every day I wash down my pills with a prayer. I'll continue to do so until my dying day – and HIV will not be the cause of it.

cdc.gov/ActAgainstAIDS/HIVTreatmentWorks
"Think you can slow me down, HIV? Not in this lifetime."
Yuri - Miami, FL
Living with HIV since 1986.

"HIV: This is not the end...
Just the start of a new way of life."
Janet - Anchorage, AK
Living with HIV since 1993.

cdc.gov/ActingOut2013/HIVTreatmentWorks

"HIV treatment works."
When I heard I had HIV the doctor told me I had six weeks to live. As a transgender woman, it was hard to find a doctor who understood my needs. So I read books and talked to counselors. When my insurance didn’t cover the drug I needed, a pharmacist who is HIV positive also took the drug. She gave me the medicine and let me know she was there for me. My life is now about being healthy and living. HIV treatment works.

cdc.gov/ActingOut2013/HIVTreatmentWorks

"The best is yet to be.
I’m here. I’m living. I’m happy. So take that, HIV."
Cedric - Street, AR
Living with HIV since 2003.

cdc.gov/ActingOut2013/HIVTreatmentWorks
Start **Talking. Stop HIV.**

A new phase of the AAA initiative targeting one of the hardest-hit populations: gay and bisexual men

- A national HIV prevention communication campaign **created by and for gay and bisexual men**

- Seeks to reduce new HIV infections among gay and bisexual men by promoting open communication about a range of HIV prevention strategies for sexual partners
Target Audience:

- Openly gay and bisexual men
- Ages 18-64, with an emphasis on those 18-29
Campaign Goals

- Increase HIV-related communication
- Increase knowledge about HIV prevention strategies (e.g., Condoms, ART, PrEP, PEP) for intimate partners
- Increase HIV-related information-seeking behaviors
- Increase positive norms about HIV-related communication

Start Talking. Stop HIV.
Protect yourself and your partner. Talk about testing, your status, condoms, and new options like medicines that prevent and treat HIV. Get the facts, and tips on how to start the conversation, at cdc.gov/ActAgainstAIDS/StartTalking.
PrEP
PrEP Clinical Practice Guidelines: Key Recommendations

- **Daily, oral PrEP with Truvada®:**
  - Is recommended as one prevention option for:
    - Sexually-active MSM
    - Heterosexually active men and women
    - Injection drug users (persons who inject drugs)

- Should be discussed with HIV discordant couples for use during conception and pregnancy

- Use should be weighed carefully for adolescent minors and transgender persons due lack of data


Truvada® is a fixed-dose combination tablet containing emtricitabine 200mg and tenofovir 300mg. The use of trade names is for identification purposes, and does not constitute endorsement by the USPHS/HHS
## Daily Oral PrEP Efficacy by Adherence

<table>
<thead>
<tr>
<th>Intervention</th>
<th>mITT</th>
<th>Drug detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM (iPrEx, TDF/FTC)</td>
<td>44%</td>
<td>92%</td>
</tr>
<tr>
<td>Heterosexuals (Partners PrEP, TDF/FTC)</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td>IDU (Bangkok Tenofovir Study, TDF)</td>
<td>49%</td>
<td>70%</td>
</tr>
</tbody>
</table>


Other Findings from PrEP Trials

- **No evidence of:**
  - Serious clinical risk
  - Increase in risk behaviors (risk compensation)

- **Adherence matters:**
  - Daily PrEP medication can provide high levels of prevention effectiveness but only if taken consistently
  - PrEP medication has some “forgiveness” if occasional doses are missed
  - There is no evidence that PrEP medication is effective when taken sporadically or intermittently
Potential PrEP Providers

- STD care providers
- HIV care providers
- Primary care providers
- Drug Treatment Providers

HIV uninfected at substantial risk
Why is PrEP Alone Not Enough?

• PrEP medication does not reduce the risk of other adverse health outcomes
  – STIs
  – Unwanted pregnancies
  – Health consequences of injection drug use

• For HIV prevention
  – Combining methods improves protection
    • When medication doses are missed
    • When medication alone doesn’t completely block HIV transmission
What CDC-DHAP is Doing Next

– PrEPline; warmline and website for clinical consultation about PrEP started Oct 2014
  • 855-448-7737 (855-HIV-PrEP) [11am-6pm M-F]

– SHIPP and Context Matters Studies
  • Evaluating PrEP delivery in four community health centers
  • Chicago, Newark, Houston, Philadelphia
  • All persons with indications for PrEP (MSM, HET, IDU)

– Measuring PrEP knowledge, issues, and practices among health care providers, public health practitioners, and potential users

– Monitoring PrEP uptake with national electronic databases of commercially insured and Medicaid patients
Some Illinois PrEP Activities

• SHIPP/Context Matters site in Chicago
• Chicago HD has established a multi-sectoral PrEP Working Group
• Chicago HD STD program is beginning a PrEP pilot study in collaboration with one STD clinic and Howard Brown Health Center
Conclusions

- High impact prevention directs our efforts and resources to the right places, populations, and strategies

- There are a number of new prevention options
  - We have many types of interventions that work
  - Combining at a systems-level is an emerging science
  - For individuals, they work better when combined together
  - Increasing awareness and achieving broader uptake among stakeholders are key public health challenges

- A high-impact lens is crucial for developing a prevention strategy that will make a difference at the national, local, and individual level
Thank you

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Division of HIV Prevention
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MS D-21
Affordable Care Act

HHS Guidelines for Treatment Services:
- ART recommended regardless of CD4 lymphocytes
  - Incorporates clinical and prevention benefits
  - Aiming for synergy in prevention & care

Three Example Activities:
- Care and Prevention in the U.S. (CAPUS)
- FY2014 Billing Redirection: Increase capacity for reimbursement of services such as HIV and STD testing
- Persons Living with HIV (PLWH): Draft comprehensive set of prevention and care recommendations for persons with HIV
Affordable Care Act
Major HIV Prevention Opportunities

Preventive Services

- Services rated A or B by USPSTF are covered with no co-pay by Medicaid expansion plans and most private plans:
  - HIV screening for people aged 15-64 years and testing of persons at increased risk (USPSTF A Rating)
  - Behavioral counseling for STI/HIV prevention

- Medicaid Final Rule includes preventive services “recommended” by licensed practitioners
  - Potential flexibility for reimbursement