



2015 National HIV Prevention Conference

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Atlanta GA

Abstract Book

Accelerating Progress:

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MONDAY, DECEMBER 7 | ROUNDTABLE SESSIONS | 7:30 AM – 8:15 AM

Track B

Session BR01 - Accelerating PrEP Uptake and Engaging More People in Care: Breaking Down the Evidence and the Arguments for Scale-up of ARV-based Prevention

Room: Courtland (Hyatt Regency Atlanta)

Abstract 2260 - Accelerating PrEP Uptake and Engaging More People in Care: Breaking down the evidence and the arguments for scale-up of ARV-based Prevention

Author(s): *Cindra Feuer, Deirdre Grant*

Issue: PrEP and treatment as prevention are new strategies for HIV prevention but these tools will have limited impact on helping to end the epidemic without active community engagement and uptake. Targeting PrEP to those at highest risk—young gay/MSM and women of color and transgender people—reduces incidence and saves money. Testing, HIV care, treatment and viral suppression save lives and reduce onward HIV transmission. PrEP and HIV treatment/viral suppression are two key components of high impact prevention, also known as combination prevention. Since the FDA approval of Truvada as PrEP in 2012 and US treatment guidelines recommending treatment initiation for all those testing HIV positive, uptake of these pillars of prevention has been slow. The CDC estimates approximately 500,000 people in the US may benefit from PrEP but fewer than 10,000 are currently using it. As for treatment, out of all those in the US living with HIV, only 30 percent are virally suppressed and only about half of MSM diagnosed with HIV are engaged in regular care.

Key Points: This Roundtable will address the evidence, myths, and arguments for and against ARV-based prevention (PrEP and treatment) as pathways to ending the epidemic. Evidence shows that daily oral PrEP can reduce risk of HIV by more than 90 percent and viral load suppression can reduce risk of HIV transmission by almost 100 percent. To substantiate this, data from the PrEP trials—iPrEx, Partners PrEP, TDF2 and the more recent PROUD and IPERGAY—will be discussed. Likewise, data from the treatment as prevention trials HPTN 052 and Partners study will be discussed.

Common myths around PrEP and treatment will be explored and debunked. For PrEP these include: high costs; side effects; drug resistance; increased sexual risk behaviors; drug company conspiracy; and condoms and behavior change are enough. For treatment, conversation will revolve around health benefits vs. risk of early treatment—what we know and don't know and what the US guidelines recommend. The session will highlight the new CDC study showing 9 in 10 infections come from those not receiving care. Prevention of new infections depends on reaching people who are HIV positive with testing, treatment and care.

Issues of access will be addressed—how, where, etc. and a landscape of PrEP demonstration projects and their findings highlighted. Additionally, concerns about the medicalization of prevention, drawing money away from behavioral interventions will be addressed.

Implications: Science tells us that increasing PrEP access and engaging more HIV-positive people in care and treatment could prevent tens of thousands of new HIV infections. This Roundtable aims to build community understanding and support for ARV-based prevention so that these strategies do not remain underused. By understanding the research data and debunking misperceptions, participants will be able to cite the evidence and engage in cogent dialogue in support of uptake in their respective communities, nationwide.

Session BR02 - Fostering New HIV Prevention Researchers: NIH Grant Mechanisms

Room: Kennesaw (Hyatt Regency Atlanta)

Abstract 2286 - Fostering New HIV Prevention Researchers: NIH grant mechanisms

Author(s): *Cynthia Grossman, Susannah Allison*

Issue: It is critical to maintain a pipeline of new HIV researchers in order to reach the goal of an AIDS-free generation. Tight budgets combined with significant scientific advances in HIV research present a unique challenge to newer investigators as they enter into a competitive funding environment and try to identify and fill the most critical research gaps.

Key Points: The panel will include program officers from NIMH's Division of AIDS Research (DAR) and investigators who have NIH funding through career development mechanisms, both newly awarded and those who have successfully transitioned to secure additional funding. Program officers will moderate the session, discuss research priorities, and provide an overview of selected grant mechanisms most appropriate for new investigators with an emphasis on mentored career opportunities (K awards). The goal of the roundtable is to demystify the NIH grant application process, provide a point of contact with DAR for new investigators and connect funded investigators with those seeking funding.

Implications: Engaging the next generation of HIV researchers is critical to achieving the goal of an AIDS-free generation. While the scientific priorities for NIMH are published through funding opportunity announcements, this roundtable will provide a forum to answer questions in real-time with program officials responsible for portfolios of research across the spectrum of HIV prevention, care and treatment.

Track C

Session CR02 - Getting Clear on CLEAR! Implementation Tips and Techniques for CBO Staff

Room: University (Hyatt Regency Atlanta)

Abstract 1615 - Getting Clear on CLEAR! Implementation Tips and Techniques for CBO Staff

Author(s): *Benjamin Ignalino Jr., Melissa Margolis, Alexander Demopoulos*

Issue: Choosing Life! Empowerment! Action! Results! (CLEAR) is an evidence-based High Impact HIV prevention intervention developed for people living with HIV/AIDS. It is a client-centered program delivered one-on-one with clients who are having difficulty initiating or sustaining behaviors that

prevent HIV acquisition, transmission and/or reinfection. The intervention itself has been proven effective in different communities and sub-cultures. CBO staff have faced on-going challenges with adapting and implementing the intervention to not only fit their target populations and community but CBO as well.

Key Points: From February 2013 to March 2015, there have been 269 CLEAR training's with a total of 619 attendees. While CBO staff have been eager to take on the intervention, they have acknowledged that once they are back in the field, the implementation process can be difficult. In this workshop, we will pick up where the CLEAR training ends, and address some of these challenges. We will 1) highlight the benefits of CLEAR from CLEAR implementation programs across the country, 2) present early implementation findings of CLEAR programs, 3) provide best practices for organizations to adapt CLEAR into existing HIV Prevention and Care and Treatment services, and 4) discuss successes and lessons learned from CBOs currently implementing the CLEAR intervention. Additionally, attendees will be provided tips and techniques for CLEAR counselors that will reduce the number of challenges met during the implementation process, including around evaluation and recruitment and retention.

Implications: This workshop on CLEAR will delve into core elements of the intervention, challenges that new CLEAR counselors face, and strategies to successfully implement the intervention in a community-based setting. The round-table is set up so that participants can share their challenges and successes implementing the intervention. By the end of the workshop session attendees will be able to; 1. Discuss how to adapt the CLEAR intervention to fit an organization's current programming for HIV-Positive and High-Risk Negative individuals, 2. Describe one challenge they have and a potential solution for that challenge, and 3. List 3 action steps or techniques to support their own implementation of CLEAR.

Session CR03 - Healing through FAITHH: Developing an HIV Stigma Reduction Intervention

Room: Piedmont (Hyatt Regency Atlanta)

Abstract 1414 - Healing through FAITHH: Developing an HIV Stigma Reduction Intervention

Author(s): *Tiffany Aholou, Pamela Payne-Foster, Eric Cooks, Madeline Sutton, Susan Gaskins*

Issue: HIV-related stigma is a barrier to HIV prevention, especially in some faith-based settings. Stigma creates barriers across the HIV continuum of care, from refusing an HIV test to resistance to linkage and retention in care, which decreases the likelihood of viral suppression. HIV related stigma is most pronounced in the Deep South region of the United States (US) which has the largest percentage of African Americans (AA) and is disproportionately burdened by HIV. It is also the region with the highest percentage of Black Churches in the US. The Black Church is a cornerstone in the AA community with religion playing an important role in the lives of many AA and people living with HIV (PLWH); yet, higher religiosity is also associated with HIV stigma. Although HIV stigma reduction is a public health priority, there are few anti-stigma interventions for rural faith-based settings.

Key Points: An interactive, culturally-relevant, anti-stigma intervention curriculum was developed from several existing products and tailored for use [pilot-testing] in faith-based settings in rural Alabama. The curriculum was designed to equip participants with accurate HIV knowledge and skills and to challenge their sensibilities regarding HIV and PLWH. Resources used to inform the development of the

intervention included international (e.g., Ghana), national (e.g., Faith in Philly, NAACP and ACT Against AIDS) and local (e.g., Alabama Health Department) sources. There are eight modules included in the intervention (parentheses include an example objective for each module): 1) HIV Facts, Stats and Social Context (e.g., examine HIV statistics and social issues that impact HIV); 2) Naming the Problem (e.g., personalize stigma); 3) More Understanding, Less Fear (e.g., educate about fears and stigma towards PLWH); 4) Impact of HIV Infection on Families (e.g., discuss living and caring for PLWH); 5) Sex, Morality, Shame and Blame (e.g., understand the power of words and actions); 6) Stigma and Religion (e.g., explore religion as a source of stigma and support towards PLWH); 7) Coping with Stigma (e.g., help PLWH cope with stigma); and 8) Using Advocacy to Challenge Stigma and Promote Social Justice (e.g., identify ways to get involved with advocacy). The modules include evidence-based strategies to reduce stigma such as education, indirect contact with PLWH, skill-building and advocacy. The facilitators will discuss and describe the intervention activities and share lessons learned from the pilot study conducted with four Black Churches, including four church pastors and 80 church members in rural Alabama.

Implications: Partnerships between public health professionals and the faith community are vital for reducing HIV-related stigma and the burden of HIV among African Americans. Interventions that help equip faith communities with tools (i.e., a culturally-relevant, evidence-based curriculum) to effectively combat HIV-related stigma and increase awareness are important components as we work toward goals to reduce HIV-related health disparities.

Session CR06 - Addressing Obstacles to Data Quality and Timeliness for Uploads to EvaluationWeb®

Room: Fairlie (Hyatt Regency Atlanta)

Abstract 1296 - Addressing Obstacles to Data Quality and Timeliness for Uploads to EvaluationWeb®

Author(s): *Marc Wiehn, Daniel Dougan, Michele Rorie, Argelia Figueroa, Thuy-An (Annie) Vu*

Issue: All CDC-funded HIV testing, HIV risk reduction activities (RRA), and HIV partner services (PS) data must be submitted to CDC semiannually through EvaluationWeb (a web-based software-as-a-service database developed and supported by Luther Consulting, LLC funded by a contract with CDC) per grant requirements for jurisdiction-level health departments and directly funded community-based organizations.

Representatives from CDC have noted during data quality calls with grantees that the quality of data that is key entered into EvaluationWeb is significantly higher than similar data that is submitted by uploading XML or Microsoft Excel® files into the system. Subsequently, CDC has encouraged more direct data entry (DDE); however this is not always feasible. The jurisdictions most likely to upload data in lieu of DDE tend to be the jurisdictions with the highest volumes of data. Also, EvaluationWeb does not have a DDE interface for PS data, so this data must always be uploaded from external systems.

As a result of contacts to the Luther Consulting, LLC help desk from users throughout the data quality chain, we identified case studies that illustrate obstacles faced by grantees and by CDC that interfere with optimum data quality and timeliness.

Key Points: Many requirements from the CDC's Data Variable Set (DVS) were not enforced in the systems that preceded EvaluationWeb, which resulted in CDC receiving data of low or inconsistent quality. In order to improve data quality, EvaluationWeb enforces the DVS requirements in both the DDE and upload process, although the DDE process is more stringent. Even with the relaxed requirements for uploads, data managers may be faced with challenges when their data entry in the field does not align with CDC's requirements. When users upload data files into EvaluationWeb, it is typically because they initially collected the data in an external software system, which might not enforce validation rules from the DVS. These challenges and inconsistencies are often discovered when users attempt to upload the files extracted from their external systems into EvaluationWeb, which may be months removed from when data was initially collected.

Implications: In many cases, the technical issues that users experience when uploading files to EvaluationWeb are symptoms of larger disconnects related to programmatic implementation and field data collection. For example, as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, many healthcare systems are entering HIV testing data in electronic medical records (EMR) systems and extracting data from those systems into files to be uploaded into EvaluationWeb. The Stage 1 and Stage 2 guidelines, for meaningful use do not include validation of business rules from the DVS, so the data files extracted from these systems may be of inconsistent quality. This session is designed to facilitate meaningful dialogue between CDC, grantees, and Luther Consulting, LLC in order to close these gaps.

Session CR18 - Culturally Responsive Strategies for Reaching the Latino Community about HIV/AIDS Prevention and Linkage to Care

Room: Greenbriar (Hyatt Regency Atlanta)

Abstract 2283 - Culturally Responsive Strategies for Reaching the Latino Community about HIV/AIDS Prevention and Linkage to Care

Author(s): *Hilda Crespo, Maria Eugenia Lane, Carlos Ugarte*

Issue: Conducting culturally responsive outreach to the Latino Community.

Key Points: According to CDC (2013), HIV infection is a serious threat to the health of the Latino community. In 2010, Hispanics/Latinos accounted for over one-fifth (21% or 9,800) of all new HIV infections in the United States and 6 dependent areas despite representing about 16% of the total US population.

The objective of this session is to explore culturally responsive approaches for reaching the Latino population about HIV Prevention and to linking to care. The Latino partners of AAALI propose to share their innovative strategies for reaching this population group. Since 2009, ASPIRA and Farmworker Justice and the Hispanic Council on Aging have worked together as partners of the CDC's Act Against AIDS Leadership Initiative (AAALI). Together they have demonstrated strong leadership and commitment to the fight against HIV/AIDS during this partnership.

Among the strategies discussed are the use of social media to engage youth, intergenerational chats among youth and older Latino adults and dialogues with farmworkers, to name a few. This will be an interactive session with the opportunity for sharing information and learning about best practices in working with the Latino Community.

Implications: Effective outreach to the Latino community needs to take into consideration culture, language, vocation, religion, age, gender, etc.

Track D

Session DR01 - Building Capacity and Fostering Resilience among Young, Black Gay and Bisexual Men: A Case Study of the YBGLI Policy & Advocacy Summit

Room: Techwood (Hyatt Regency Atlanta)

Abstract 2543 - Building Capacity and Fostering Resilience among Young, Black Gay and Bisexual Men: A Case Study of the YBGLI Policy & Advocacy Summit

Author(s): *DaShawn Usher, Blake Rowley, Marvell Terry, Noel Gordon, Leo Moore, Barry Sapp*

Issue: Birthed out of the alarming rates of HIV among BMSM, particularly, YBMSM, a community driven initiative for young gay men of color was formed. The Young Black Gay Men's Leadership Initiative (YBGLI) is a national collaborative of committed young Black gay, bi, same gender loving (SGL) and other MSM between the ages of 18 - 29 that work towards addressing the HIV epidemic in the US. YBGLI is the only national initiative that is peer-led by MSM of color with an innovative approach of curbing the HIV epidemic amongst their peers by focusing on community mobilization, research, advocacy, and leadership development.

Setting: Young BMSM (YBMSM) represent the only population in the US to experience a statistically significant increase in new HIV infections from 2006 through 2009, increasing 48% during that period. Despite billions of dollars in federal funding for HIV prevention and decades of HIV-related interventions and research, the disparity, particularly for YBMSM, only seems to be getting worse.

Project: This workshop will utilize a case study approach to explore how YBMSM are responding to the HIV epidemic in their local communities through leadership development. Presenters will provide examples of ways in which the YBGLI Policy & Advocacy Summit is building capacity and fostering resilience among this key population. First launched in 2012, the YBGLI Policy and Advocacy Summit brings together young Black gay, bisexual, and same gender loving men from various parts of the United States in order to help them become better advocates and leaders within their communities. Specifically, the summit provides those selected with the knowledge and skills needed to address the HIV epidemic through community mobilization, policy and legislative advocacy, and research. In addition, participants have sessions dealing with self-care and community building.

Results: Since 2012, three YBGLI Policy and Advocacy Summits have occurred across the country, bringing emerging YBMSM leaders together for a three-day personal development and community building intensive summit. Continuing to build the capacity and leadership of YBMSM, the summit

challenges participants to improve community mobilization efforts of YBMSM in order to more effectively disseminate and improve HIV prevention, care and treatment efforts in their communities. Applications were requested from young Black MSM (under 30) across the United States. Participants were selected based on their individualized leadership skills, and shown efforts to address community mobilization of YBMSM communities.

Lessons Learned: More than 180 Young Black, gay, bisexual, and same gender loving men have been part of the Policy and Advocacy Summit since its inception, with over 480 applications received. Preliminary findings from pre/post conference evaluations suggest the Policy and Advocacy Summit raises participants' knowledge of HIV and AIDS, their skill level at advocating for themselves and their communities, and strengthens their resolve to end the HIV epidemic among their peers. Final conclusions and analyses will be presented at the conference. In addition, regional issues and solutions developed by the 70 participants from the 2015 YBGLI Summit will be presented.

Session DR02 - Confronting Stigma in Provider Interactions with Gay Men/MSM of Color Using Mindful Communication Strategies

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 2525 - Confronting Stigma in Provider Interactions with Gay Men/MSM of Color Using Mindful Communication Strategies

Author(s): *Edwin Corbin-Gutierrez, Meico Whitlock, Olivia Ford, Michelle Samplin-Salgado, Jennie Anderson*

Issue: The lives of African American and Latino gay and bisexual men matter. Every new infection of HIV and STDs is one too many, and this population depends on competent health care providers. Stigma and HIV have long been intertwined, and using effective communication techniques to uncouple the two is challenging. Lambda Legal reports that two thirds of people living with HIV (PLWH) report experiencing one of the following forms of discrimination from health care providers: Refused to touch the patient or used excessive precautions; blamed the patient for their health status; used harsh or abusive language; or was physically rough or abusive.

Clinical providers have a critical role to play in improving the health outcomes of African American and Latino gay and bisexual men.

Gay patients are likely to assume that medical providers see them through a lens of bias until trust is established and maintained. Some of this mistrust is rooted in hearsay and myth. However, the mistrust itself has a real and lasting impact. It is central to the quality of the provider-patient relationship.

Addressing the patient's unsaid concerns can help a medical provider build trust. Trust can increase the patient's adhere to their treatment recommendations and, ultimately, that individual's health outcomes.

Key Points: This roundtable session outlines mindful communication decision-making principles aimed at guiding the development of an effective anti-stigma communications approach. It focuses on understanding how HIV-related stigma operates in patient-provider relationships, the role that communication plays in eliminating it, and tools to foster mindful communication.

In particular, the discussion strategizes pragmatic steps that providers can take in their everyday roles and interaction with patients to build trust with men who identify as gay or bisexual. In particular, the guided conversation addresses: (1) issues of language for improved patient interactions with African American and Latino gay and bisexual men; (2) clinical process recommendations to foster “safe spaces” and de-stigmatizing environments; (3) standard of care updates for this population and the role that stigma plays in their dissemination and recommended implementation; and (4) resources to proven approaches that address the challenges outlined in the discussion.

Implications: To successfully address HIV, professionals in the field need approaches for addressing HIV-related stigma that include more mindful communication regarding people living with and impacted by HIV. The language that providers use defines how we work with clients. For better or worse, how we communicate about HIV impacts how policy is shaped, how programs are developed and implemented, and how individual behavior plays out at the community level. Through this session, participants will gain experiential understanding on how to be a mindful communicator, and will provide concrete examples to examine how stigmatizing language such as “at-risk” or “hard-to-reach” operates in the context of vulnerable communities, to help us understand their unintended “othering” consequences. This framework of communication principles can also be applied at every level of communication processes, from social marketing design, cultural competency and program delivery curricula, to modeling everyday communication with peers and clients.

Session DR03 - Do Long Term Survivors Have a Role in HIV Prevention?

Room: Edgewood (Hyatt Regency Atlanta)

Abstract 1313 - Do Long Term Survivors Have a Role in HIV Prevention?

Author(s): *Mark King, Craig Washington, Nina Martinez, Linda Felix*

Issue: A panel of four HIV prevention professionals who are also long term survivors, with a combined survival span of over 100 years, host this candid discussion about the role they believe they can play in our prevention efforts and where they believe they have been left behind. Long term survivors of HIV infection are among the most well-informed and dedicated members of the HIV arena, and have become one of the most marginalized when it comes to HIV prevention. What value might they bring to our prevention efforts, both from a primary and secondary perspective?

Key Points: How does the fact many people are living long and healthy lives with HIV help or hurt our prevention messages? How do we reconcile conflicting messages about living with HIV ("you can lead a healthy life" vs. "don't get HIV or you'll die"). How do we value, or dismiss, the legacy of long term survivors when crafting prevention messages? How do we remain credible with our audience, and honor those who have survived? Are long term survivors seen as cautionary tales or success stories?

Implications: Long term survivors can be an enormous resource for our prevention efforts and for those we are trying to reach. By utilizing long term survivors, we are also helping to address the isolation and lack of meaning that is widespread among those who have lived with HIV for decades. Long term survivors have a unique viewpoint about prevention messages that often do not speak to their lived experience with HIV.

Session DR04 - Examining CBO Sustainability through Multiple Lenses Got Sustainability: Surviving and Thriving in a Changing World

Room: Marietta (Hyatt Regency Atlanta)

Abstract 1933 - Examining CBO Sustainability through Multiple Lenses

Author(s): Paola Barahona, Monique Tula, Erin Nortrup, Ronald Johnson

Issue: The purpose of this roundtable is to deconstruct the concept of sustainability by sharing multiple strategies for improving AIDS service organizations' (ASOs) and HIV-serving community based organizations' (CBOs) ability to survive amidst an increasingly dynamic fiscal and political landscape.

This roundtable will be informed by the collaborative expertise of AIDS United staff and partners who represent the agency's policy and program portfolios. Presenters will provide an overview of the political context in which all HIV-serving CBOs are currently operating; share tools that can assess current and long-term sustainability; and discuss technical assistance and funding opportunities that support organizational transformation.

Key Points: The first segment of this roundtable will be a panel discussion which examines external factors that influence HIV funding for CBOs; including the Affordable Care Act, Medicaid expansion, and the future of Ryan White funding. Audience members will be exposed to the benefits of participating in advocacy initiatives to influence funding and policy decisions made at the state and federal levels.

The second segment will focus on best practices and innovative ways CBOs have approached long-term sustainability when faced with dwindling funding streams. Participants will learn about tools that assess an organization's capacity to keep programs alive beyond the end of a funding source.

The third segment will highlight examples of technical assistance AIDS United has provided to help decision-makers choose a path of sustainability that is right for their organization.

The final segment will offer audience members an opportunity to raise questions and discuss concrete strategies to navigate the relatively untraversed territory of healthcare reform.

Implications: This roundtable will feature presenters and panelists who will discuss the importance of proactive engagement in sustainability efforts amidst the evolving healthcare landscape. The session will first focus on how policy interfaces with CBO programs and how organizations can leverage their access to on the ground information to mobilize stakeholder involvement. The session will then move into how decision-makers can build into sustainability readiness for their organizations. During this segment, participants will be exposed to examples of how CBOs have successfully integrated approaches that resulted in the strength and expansion of vital services supported by stronger infrastructures. Finally, AIDS United will share tools to help decision-makers determine the right path for their organizations.

Session DR06 - Reaching for the Stars: Risk Taking to Grow, Meet the Needs of Consumers and Stay on Mission

Room: Lenox (Hyatt Regency Atlanta)

Abstract 2394 - Reaching for the Stars: Risk Taking to Grow, Meet the Needs of Consumers and Stay on Mission

Author(s): *Dedra Spears Johnson, Anne Wiseman*

Issue: Heart to Hand (HTH) is a suburban program situated between two urban areas (Washington, DC & Baltimore, MD) and the only community-based ASO in our county. Over the past 17 years, we have fought the misnomer in our community that HIV is solely an urban problem. It has affected our ability to grow as fast as our urban counterparts and particularly our ability to support our growing HIV+ population (our county is number one in our state for new HIV infection). The purpose of this roundtable is to share lessons learned as we have expanded our scope of services with more non-traditional partners such as local pharmacies through the 340B program, and local health institutions through the Maryland Health Connections Program and Prince Georges County DSS.

Key Points: In light of limited resources, HTH's leadership has fearlessly pursued more non-traditional ways to expand our services. We will discuss how we have engaged in new partnerships with pharmacies, ventured into health care reform, and actively participated in community partnerships in order to effectively support our growing population. Highlights include:

- Heart to Hand is the only community-based ASO in our county participating the 340B pharmacy program, which ultimately results in increased financial support for HTH and increase access to medication for our consumers;
- This past year, we became a connector entity for the Maryland Health Connections—the state's ACA Insurance Marketplace. HTH Health Navigators were staffed at local hospitals and health clinics to connect residents to insurance. This resulted in new and re-newed partnerships with local hospitals, FQHC's and community health departments;
- We are actively engaged in several community partnerships and planning councils to ensure our county's needs are not overlooked.

Implications: ASO's must remain diligent about finding new sources of support and expanding our services in light of increasingly limited resources. This must all be done within the mission and vision driving the organization. Continuing contributions to best practices and lessons learned can only strengthen our ability to serve our communities in a sustainable manner. For suburban programs that are often out of the "limelight", collaboration, sharing, support and guidance is critical to our success.

Session DR07 - HIV Prevention and Women: Delivering What Works and Preparing for What's Next in the Pipeline

Room: Baker (Hyatt Regency Atlanta)

Abstract 2340 - HIV Prevention and Women: Delivering what works and preparing for what's next in the pipeline

Author(s): *Deirdre Grant, Manju Chatani, Anna Forbes, Dazon Dixon Diallo*

Issue: In the United States, women still account for nearly a quarter of new HIV diagnoses. In addition to treatment and care those with HIV, there is a great need for access to proven and emerging HIV prevention options, especially women-controlled options.

Daily oral Truvada as PrEP was approved by the US FDA in July 2012 for women (and men). In the time since approval there has been some research conducted (both qualitative and clinical) to investigate how best to get this very effective prevention method to women who need and desire to use it, but it has been insufficient.

While advocates push for increased awareness of and access to PrEP (currently the only woman-controlled HIV prevention method that can be used independent of sex), there is also a need to prepare for and understand the potential results of upcoming trials - such as ARV-based vaginal rings and long-acting injectable antiretrovirals for HIV prevention - and the longer-term outlook for women's prevention.

Key Points: The experience from recent PrEP implementation shows that it is critical to engage a range of stakeholders, and especially communities, in advance of the release of data from large-scale trials of new HIV prevention strategies. This helps to accelerate access – such as moving forward with implementation, identifying appropriate follow-up activities, and bringing information to communities that most need these new HIV prevention options.

This roundtable will include: introductory presentations on (1) international HIV prevention research including PrEP demonstration projects, efficacy trials of the vaginal dapivirine ring, long-acting injectable PrEP and (2) status of women's access to PrEP in the US and where PrEP fits into the current package of prevention tools.

A moderated group discussion will aim to identify information needs on the ongoing research, as well as reflect on lessons learned from the last three years since oral PrEP has been an FDA-approved HIV prevention option for women.

An interactive scenario planning exercise will elicit feedback from participants on what may/could happen in future scenarios and introduce ways to influence steps in the process to get from research results to product implementation.

Implications: Having an informed and engaged group of stakeholders aware of the status of PrEP rollout for women and how they can advocate for expanded access could accelerate the rate of implementation. Informed advocates prepared for an HIV prevention trial result can increase the chance that – if the results are positive - local, state and national-level stakeholders will identify and implement next steps relevant for its context. In fact, we have seen that this is critical to help avoid unnecessary delays to access and scale-up of new options.

Session attendees will leave the roundtable with: an update on current HIV prevention research timeline; an update on women's access to PrEP in the US – and how they can affect implementation, community advocacy and access; skills to influence key decision-points on the road from a research

result to approval and scale-up; and information on how to connect to other advocates working in this space.

Track E

Session ER02 - Policy is Treatment & Prevention: Engaging YMSM of Color

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 2349 - Policy is Treatment & Prevention: Engaging YMSM of Color

Author(s): *Jason Cianciotto, Demetrius Thomas*

Issue: While HIV incidence among other racial and ethnic groups is declining, new infections among communities of color are increasing, particularly in young men who have sex with men (YMSM). This is occurring despite research indicating that YMSM of color do not engage in riskier sexual behaviors. They do, however, experience greater healthcare disparities, increased socio-economic disadvantages, and heightened and systemic stigma and discrimination. HIV/AIDS service providers struggle to identify, engage, and retain YMSM of color in services and programs. Even when they are able to achieve a modicum of outreach success, biomedical interventions tend to be the sole focus, but they are not the sole need. Service providers must address both the biomedical needs and structural drivers specific to YMSM of color through effective public policy at all levels of government.

Key Points: As early as 1996, the CDC reported that communities of color represented the highest proportion of persons living with HIV/AIDS (PLWHA) of all racial and ethnic groups, with YMSM of color shouldering the biggest burden. More recently, the HIV Care Continuum Initiative has emerged as an important framework that helps identify gaps in care. However, providers have not been able to translate findings of the Care Continuum into action, and policy recommendations continue to be outdated and ineffective.

Policy is Treatment and Prevention is a new framework designed by Gay Men's Health Crisis's (GMHC) that identifies prevention and treatment programming needs and also supports a more comprehensive and targeted HIV/AIDS policy agenda. It identifies both biomedical interventions and structural drivers of the epidemic within the context of two primary goals: (1) to prevent at-risk negatives from entering the Continuum, and (2) to address the factors that prevent PLWHA from achieving viral suppression. This framework has helped GMHC identify specific structural drivers that create the context of high risk for YMSM of color. As a result, GMHC has been able to better reach YMSM with improved comprehensive services that connect them to evidence-based prevention interventions.

Facilitators will summarize current research on HIV disparities in YMSM of color, describe how the framework identifies structural drivers of the epidemic, and through sharing specific examples of GMHC programs, show how changing the HIV/AIDS care landscape for YMSM of color is possible. Facilitators will also discuss GMHC's comprehensive policy, advocacy and public education agendas that directly address structural drivers of the epidemic.

Implications: If current HIV incidence trends continue, more than half of the population of YMSM of color could seroconvert in the next decade. While this disproportionate impact is not new, it is critical that the CDC and service providers address the complex drivers of the epidemic among this population. We must design and utilize novel and creative frameworks that drive cutting edge, culturally competent, and effective prevention and treatment programs for YMSM of color. GMHC's Policy is Treatment and Prevention framework can support these efforts among service providers nationwide.

Session ER03 - Leveraging NASTAD's Center for Engaging Black MSM Across the Care Continuum (CEBACC) - Creating a Policy Agenda for Black gay Men; Increasing Access to Care

Room: Spring (Hyatt Regency Atlanta)

Abstract 2168 - Leveraging NASTAD's Center for Engaging Black MSM Across the Care Continuum (CEBACC) - Creating a Policy Agenda for Black gay Men; Increasing Access to Care

Author(s): *Justin Rush, Emily McCloskey, Blake Rowley*

Issue: Currently, the CDC estimates that 10,600 new HIV infections occurred among Black gay men/Men who have sex with men (MSM), in comparison to their White counterparts in the same year, consisting of an estimated 11,200 new HIV infections. In addition to Black gay men/MSM bearing a disproportionate rate of infection, young Black gay men/MSM between the ages of 13 – 29 have been identified as being the most at-risk population for infection, accounting for roughly 4,800 of new infections, more than half that of their young White or Latino counterparts. Currently, young Black gay men/MSM represent the only population in the United States to experience a statistically significant increase in new HIV infections from 2006 through 2009, increasing 48% during the period. When analyzed by race, the HIV continuum demonstrates that the highest disparity is among Blacks, with 79% having not achieved viral suppression. This workshop will focus on the development of a policy agenda to address these disparities, while examining how to leverage the National Alliance of State & Territorial AIDS Directors (NASTAD)'s Center for Engaging Black MSM Across the Care Continuum (CEBACC) to ensure that Black gay men/MSM have access to and are engaged in care.

Key Points: Keeping the research in mind, it is important that health department staff, public health professionals and LGBT advocates create and implement innovative support policies that leads to equitable outcomes, such as increased access to AIDS Drug Assistance Programs (ADAPs) and better navigation of the HIV Care Continuums among Black gay men/MSM. If we are to successfully move the needle on HIV, significant public health interventions supported by grassroots community mobilization, legislative advocacy and engagement need to be created and tailored to the myriad and unique needs of Black gay men/MSM. In order to do this, there must be a "meeting of the minds," a consensus as to determine the most pertinent issues are affecting Black gay men/MSM are and craft recommendations to alleviate existing disparities.

Implications: The round table is a unique opportunity to provide additional support for health departments and other healthcare delivery professionals to laser-focus their work concerning Black gay men/MSM and construct comprehensive strategies for engaging Black gay men/MSM. Ultimately, the development of such strategies will lead to increased engagement in care systems as well as successful

navigation across the care continuum. Attendees will leave with practical advice and tools for their own and collaborative advocacy efforts.

Session ER06 - Breaking Point: Syringe Access Policy Opportunities in Light of the Opioid/Heroin Epidemic and Health Care Reform

Room: Inman (Hyatt Regency Atlanta)

Abstract 2380 - Breaking Point: Syringe Access Policy Opportunities in Light of the Opioid/Heroin Epidemic and Health Care Reform

Author(s): *Daniel Raymond*

Issue: The Indiana HIV outbreak, with 130 infections linked to injection of the prescription opioid Opana identified by late April 2015, cast a spotlight on the importance of syringe access programs in HIV prevention. The recent resurgence of injection drug use (primarily prescription opioids and heroin) has posed new public health challenges, particularly in rural and suburban lacking syringe access capacity. At the same time, the Affordable Care Act has created new incentives for improving health care access for people who inject drugs, opening up opportunities for integrating syringe access and harm reduction into the broader health care system.

Key Points: Although HIV incidence associated with injection drug use had steadily declined over the last 25 years across the country, injection of prescription opioids and heroin has driven a 75% increase in new hepatitis C infections between 2010 and 2012. Existing syringe access programs report a growing demand for services, particularly among a younger generation of newer injectors. However, syringe access coverage is limited in the majority of the country, and concerns persist about syringe access gaps in rural and suburban areas. In response, syringe access legislation was passed in Kentucky, and has been introduced in Florida, Indiana, and Texas. New programs have been launched or are in planning stages in Kentucky, Ohio and West Virginia.

Both new programs and existing programs struggle with resource constraints, including the lack of access to federal funds. In response, programs in California, the District of Columbia, New York, and Washington State are pioneering innovative approaches to leverage health care reform to sustain their work and facilitate improved access and retention in health care for people who inject drugs. Syringe access programs are also taking leadership roles on the frontlines of preventing opioid and heroin overdose deaths, and navigating new relationships with law enforcement.

This roundtable will review these policy developments and facilitate a discussion of how the opioid epidemic and health care reform are transforming the policy landscape for syringe access programs.

Implications: Syringe access policy has moved from the margins of HIV prevention to the center of the prescription opioid and heroin epidemic. New opportunities to advance syringe access policy are emerging in previously unlikely areas of the country, while syringe access programs are gaining greater recognition for their expertise in engaging people who inject drugs. These successes come with new challenges, as syringe access programs and advocates navigate new relationships with law enforcement and the health care system, and struggle with resources and sustainability. However, the lessons from Indiana, Kentucky, and other states are laying the groundwork to inform and shape the next decade of state and federal syringe access policy.

MONDAY, DECEMBER 7 | ORAL SESSIONS | 10:30 AM – 12:00 PM

Track A

Session A01 - Young Men Who Have Sex with Men: Findings from the NHBS-YMSM Pilot Project

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1846 - Young Men Who Have Sex with Men and HIV Behavioral Surveillance: Ethical Considerations and Parental Permission for Minors

Author(s): *Michael Newcomb, Brian Mustanski, Antonia Clifford, Nikhil Prachand*

Background: Young men who have sex with men (YMSM) are substantially impacted by HIV in the United States, but very little is known about HIV incidence, prevalence and associated risk behaviors among YMSM under the age of 18. Wide-scale efforts to engage this age group have rarely been undertaken, in part due to ethical issues surrounding enrollment of minors into research, and there is lack of clarity in many Institutional Review Boards about the legality and ethics of waiving parental permission for research participation. In order to inform protocol development for the NHBS-YMSM Supplement, the aims of this study were to: 1) examine the feasibility of recruiting YMSM minors into research while requiring parental permission; and 2) understand parents' perspectives about their children's involvement in research and waivers of parental permission.

Methods: Aim 1: we conducted the Parent-Adolescent Health Pilot Study to understand how to recruit LGBT youth-parent dyads into research. The LGBT youth was required to be 14-18 years old, enroll with one or both of their parents, and live with their participating parent. All participants were recruited online. Aim 2: we conducted 35 in-depth interviews with parents of LGBT youth. Parents were asked to discuss their thoughts on parental permission for research participation after being presented with a vignette describing a study analogous to the NHBS-YMSM protocol.

Results: Aim 1: we screened 1,752 minor adolescents for the Parent-Adolescent Health Study. Of these, 1475 (84.2%) were ineligible, the vast majority (87.4%) because they were unwilling or unable to talk to their parent about being involved in the study. Of the 463 eligible adolescents, only 63 attempted to receive parental permission, and only 20 dyads completed the study (1.1%). Aim 2: Less than 10% of parent believed that parental permission should definitely be required for the study, and approximately three quarters believed that it definitely should not be required. Parents who believed permission should not be required provided reasons that fell into 2 general categories: 1) the need to protect the child (i.e., requiring permission may "out" the child and place them in danger); and 2) the need to address public health (i.e., requiring permission would decrease representativeness of the sample and bias data). Several parents responded that "maybe" permission should be required. Of these, the vast majority stated that requiring permission depended on the age of the child, and overwhelmingly parents stated that permission should no longer be required at age 15 or 16.

Conclusions/Implications: Data from these studies indicate that requiring parental permission for HIV surveillance with YMSM renders such studies unfeasible and potentially unsafe for some participants.

We will discuss these findings in the context of federal and state law, and we propose that waivers of parental permission should be granted for HIV surveillance of YMSM for youth ages 16-17, at a minimum, but are allowable and preferable for youth ages 13-17. These waivers are critical in recruiting a large a representative enough sample to obtain accurate and much-needed data on HIV among adolescent YMSM.

Abstract 1937 - HIV Behavioral Surveillance among Young Men Who Have Sex With Men 13-17 Years Of Age in New York City

Author(s): *Kathleen Reilly, Alan Neaigus, Lila Starbuck, Kerri O'Meally*

Background: In the United States, between 2008 and 2011, young men who have sex with men (YMSM) aged 13-24 had the greatest increase in number of new HIV infections relative to other age groups of MSM. NYC continues to have the greatest number of HIV diagnoses compared with other U.S. cities. There is presently no surveillance system to monitor risk behaviors among MSM under 18 years of age and existing surveillance systems that focus on youth do not specifically target YMSM. The objectives of the National HIV Behavioral Surveillance (NHBS)-YMSM pilot study are to determine the most effective sampling method to reach this population, ascertain the feasibility of conducting such a study, and evaluate the need to conduct ongoing HIV surveillance among this population.

Methods: In NYC, participants are recruited either through 1) respondent driven sampling (RDS) (n=300) where initial participants (“seeds”) are chosen through ethnographic and formative research by study staff and subsequent participants are recruited through previous participants or 2) venue-based sampling (VBS) (n=300) where participants are recruited from venues where YMSM congregate. Young men are eligible to participate if they are 13-17 years of age; live in the NYC metropolitan statistical area (MSA); were born male and are currently living as a male; ever had any sexual contact with another male OR self-identify as gay or bisexual OR report same-sex sexual attraction; and are able to complete the survey in English. Eligible YMSM who provide informed consent are given an anonymous structured interview administered in private by trained interviewers and a voluntary HIV test. Data collection started in November 2014 and will continue until sample size is reached or December 2015.

Results: As of April 2015, 46 participants completed the study interview. There have been 32 VBS participants and 14 RDS participants (9 seeds and 5 recruits). Most participants were black (n=20, 43.4%) or Latino (n=19, 41.3%); 16-17 years of age (n=40, 87.0%), reported gay (n=35, 77.8%) or bisexual (n=10, 22.2%) identity; and reported ever having oral (n=38, 82.6%) or anal sex (n=34, 73.9%) with a male. In the past 12 months, 30 (65.2%) had more than one sex partner, 22 (47.8%) had anal sex without a condom, and 22 (48.9%) reported meeting a sex partner through websites or apps. More than half reported that their high school has a gay-straight alliance (n=29, 65.9%) and 25 (54.3%) reported getting the emotional support they need from their family. However, 9 (19.6%) reported having been “kicked out” of their house or run away because someone knew they were attracted to males. Of those that provided a specimen for HIV testing (n=35, 76.1%), two (5.7%) participants were HIV positive (one self-reported positive status and one unaware).

Conclusions/Implications: The NHBS-YMSM pilot study shows promise for conducting behavioral surveillance among YMSM and identifying potential risk factors and HIV infections in this population.

Identifying successes and challenges in recruiting YMSM could aid in the development of an HIV behavioral surveillance system to monitor this vulnerable population.

Abstract 2006 - The National HIV Behavioral Surveillance System for Young Men who have Sex with Men (NHBS-YMSM): Designing and Implementing HIV Surveillance for the Next Generation

Author(s): *Justin Smith, Alexandra Balaji, Cyprian Wejnert, Gabriela Paz-Bailey*

Background: From 2008–2011, YMSM aged 13–24 years had the greatest percentage increase (26%) in diagnosed HIV infection. The ongoing risk for HIV infection among YMSM underscores the need for effective HIV prevention messages and services, and yet the knowledge base for guiding these interventions is limited. The National HIV Behavioral Surveillance (NHBS) system provides valuable behavioral information that is used to guide HIV prevention interventions among adult MSM. Establishing a similar data collection system focused on adolescent MSM presents several distinct challenges, including 1) population definition issues (the target population may or may not have come to terms with or disclosed their sexual identity, behavior, or attraction), 2) sampling constraints (youth who are members of a marginalized or stigmatized group are not easily found or enumerated), and 3) balancing ethical obligations regarding consent for participation and protection of privacy for respondents still dependent on their parents.

Methods: In February 2011, CDC convened an expert panel comprised of 16 individuals with experience in research with YMSM. The goal of the panel was to solicit guidance for the development of behavioral surveillance among YMSM. During a facilitated discussion, the panel was asked to provide recommendations on eligibility criteria for a future YMSM bio-behavioral surveillance system and sampling and recruiting methods, considerations for providing HIV testing, and to suggest questionnaire domains for the behavioral assessment. The information gathered during the consultation was then incorporated into a protocol and supplemental funding announcement to conduct a pilot surveillance project in conjunction with NHBS.

Results: The expert panel provided several key recommendations to CDC. First, the target population should be defined broadly, in terms of sexual behavior, identity, and attraction. Second, a pilot study should be conducted to test multiple sampling and recruitment methods, including methods involving mobile- and internet-based social networking applications. Third, the panel emphasized the need for participants who test positive for HIV to be actively linked to appropriate medical care and HIV case management services at the time they receive their test results. Finally, the panel proposed questions about mental health and suicide, social support, bullying, and sex education be included in the behavioral assessment. CDC is currently conducting an HIV behavioral surveillance pilot project, NHBS-YMSM, in three cities: Chicago, New York City (NYC), and Philadelphia. In addition to being male and 13–17 years old, eligibility criteria for NHBS-YMSM include ever having had sexual contact with another male, self-identifying as gay or bisexual, or reporting same-sex sexual attraction. Each of the three project sites is implementing two sampling methods simultaneously, with the goal of completing interviews with 600 eligible males (300 per method). Chicago and Philadelphia are implementing respondent-driven sampling (RDS), and Facebook sampling (FBS). NYC is implementing RDS and venue-based sampling (VBS). Regardless of the sampling method, all eligible participants complete a behavioral assessment and optional HIV testing.

Conclusions/Implications: The consultation on bio-behavioral surveillance for YMSM identified important considerations for the design of future data collection efforts, including knowledge gaps that are being addressed through the ongoing NHBS-YMSM pilot study.

Abstract 2013 - Understanding the Social Networks of Young Men Who have Sex with Men: Formative Ethnographic Findings from the NHBS-YMSM Pilot Project

Author(s): *Justin Sitron, Linda Hawkins, Anna Schlupp, Josh Franklin, Carmen Johnson, Kathleen Brady*

Background: Young men who have sex with men (YMSM) ages 13-29 continue to be one of the highest sub-groups to be infected with HIV (CDC, 2012). Existing models of health behavior, risk factors, and intervention approaches have not been sufficient in capturing the experience of YMSM nor reducing their risk of HIV infection. The specific nuances about the context in which YMSM meet one another, negotiate sexual interactions, and make sexual decisions are still unknown. This study sought to better understand the social networks of YMSM and their interest in participating in sexuality-related research, in an effort to improve recruitment for a pilot National HIV Behavioral Surveillance System for YMSM (NHBS-YMSM).

Methods: This qualitative study took place in Philadelphia, PA, using a combination of 10 key informant (KI) interviews and four focus groups with YMSM. The KIs ranged in age from 21 to 50, and represented a range of roles in their interactions with YMSM. There were a total of 28 focus group participants, ranging in age from 16 to 21, of diverse racial/ethnic backgrounds, the largest represented being Black/African American. Notes taken during the KI interviews and focus groups were analyzed using an inductive axial coding approach. Responses were summarized using the conceptual framework used to construct the interview and focus group guides. This study primarily aimed to garner information about YMSM social networking behaviors and appropriate recruitment strategies for NHBS-YMSM.

Results: Two prominent themes emerged; first, Garnering Community Support, which included data explaining the role community agencies and leaders play in the recruitment of YMSM. The second, Specific Methodological Considerations, included data that described barriers and recommendations with regards to: in-person recruitment, online recruitment, incentives for participation, recruitment communications, study process and duration, social networks & peer connections, HIV testing, and racial/ethnic community dynamics.

Conclusions/Implications: While cultural mores are shifting to be more accepting of same-sex relationships, YMSM still experience stigma, social isolation, and racial/ethnic segregation in which same-sex communities largely are separate from their heterosexual peers. YMSM continue to encounter barriers such as cultural climates of homonegativity, outing, and challenges with financial and social resources. However, YMSM are utilizing the internet, social networking websites, and smart phone applications, in addition to physical locations, to connect with each other and overcome barriers. YMSM described the nuanced ways in which they use social networks- namely geo-social applications, Facebook, and text messaging, as well as physical locations to gather, meet new people, set up dates, and “hang out”. While social networks and physical locations may be appropriate for participant recruitment, YMSM see these as private social spaces in which, recruitment may be seen as an intrusion.

Long-standing approaches to recruitment may continue to be appropriate to recruit YMSM, however the framing and messaging of those recruitment strategies should be considered in the context in which it is delivered- namely via Internet-based social networks and in-person.

Session A08 - Let's Talk About Substance Use, Mental Health, and HIV

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1321 - Alcohol and Drug Use Prevalence and its Association With High-Risk Sex among HIV-infected MSM Receiving Medical Care

Author(s): *Christine Mattson, Xia Lin, Mark Freedman, Linda Beer, Jacek Skarbinski*

Background: Alcohol and drug use (“substance use”) are common among persons living with HIV. Substance use can have a detrimental effect on the health of HIV-infected persons by interfering with receipt of routine care and reducing adherence to antiretroviral therapy. Substance use can also increase HIV transmission directly through sharing drug injection equipment or by impairing judgment, which can result in high-risk sexual behaviors. Men who have sex with men (MSM) are disproportionately affected by HIV and recent estimates of HIV incidence among MSM have increased. In this analysis we describe the prevalence of substance use among HIV-infected MSM and assess its association with high-risk sex.

Methods: The Medical Monitoring Project conducts clinical and behavioral surveillance among a representative sample of HIV-infected adults receiving medical care in the United States. Data were collected from patient interview and medical record abstraction 6/2009 through 5/2013. Durable viral suppression was defined as an HIV viral load undetectable or <200 copies/mL at every measurement in the past 12 months. “High-risk sex” was defined as anal intercourse without a condom with a partner of negative or unknown HIV status in the past 12 months among those who were not durably virally suppressed. We assessed the weighted percentages of persons who, in the past 12 months, binge drank alcohol (5 or more drinks in a sitting), drank alcohol before or during sex, used non-injection or injection drugs, or used drugs before or during sex, and assessed whether the behaviors were associated with high-risk sex in bivariate analyses. We also evaluated the independent association between stimulant use (methamphetamines, amphetamines, cocaine, crack) and high-risk sex using multivariable logistic regression.

Results: Among MSM diagnosed with HIV for at least 12 months, 66% (95% confidence interval (CI) 64–67) were durably virally suppressed, 17% (CI 16–19) had high-risk sex, 21% (CI 20–22) binge drank, 44% (CI 43–46) drank before or during sex, 38% (CI 35–40) used drugs, 32% (CI 29–35) used drugs before or during sex, and 15% (CI 13–16) used stimulants. In bivariate analyses among sexually active MSM, we identified statistically significant ($p < 0.05$) associations between high-risk sex and drinking alcohol before or during sex (1.27 (1.01–1.59)), non-injection drug use (PR = 1.51, CI 1.23–1.85), and injection drug use (PR = 2.01, CI 1.44–2.79). There was no association between binge drinking and high-risk sex. In the multivariable model, stimulant use was independently associated with high-risk sex (adjusted prevalence ratio = 1.8 (CI, 1.4–2.2)) after adjusting for number of sex partners, which was the only confounding factor we identified.

Conclusions/Implications: Substance use was common and associated with high-risk sex among HIV-infected MSM receiving medical care in the United States. Given the detrimental effect substance use can have on health, this analysis supports previous recommendations to provide substance abuse treatment and counseling to HIV-infected MSM in need. In addition, because stimulant use was independently associated with high-risk sex, reducing stimulant use may also help decrease risk of HIV transmission among MSM in care.

Abstract 1330 - Substance Use Prevalence and Its Association with Risky Sexual Behavior among HIV-Infected Heterosexual Men Receiving Medical Care — United States, 2009–2012

Author(s): Xia Lin, Jacek Skarbinski, Mark Freedman, Linda Beer, Christine Mattson

Background: Substance use is common among persons living with HIV. Substance abuse can interfere with HIV-infected persons' ability to remain engaged in care and adherent to antiretroviral therapy (ART), which can lead to poor health outcomes. In addition, substance use can increase the probability of HIV transmission through sharing injection equipment or engaging in risky sexual behavior. In 2012, 85% of diagnosed HIV infections among adult and adolescent females were attributed to heterosexual contact. Information on HIV-infected heterosexual men's risk behavior can be used to improve their health and also has HIV prevention implications for their female partners. The objective of this analysis is to describe the prevalence of substance use among HIV-infected heterosexual men and to assess the association between substance use and sero-discordant condomless sex (SDCS).

Methods: The Medical Monitoring Project is a surveillance system designed to produce representative estimates of clinical outcomes and behaviors of HIV-infected adults receiving medical care in the United States. Data were collected from patient interviews and medical records 6/2009 through 5/2013. The analysis was limited to heterosexual men who reported sex with women only and were diagnosed with HIV for at least 12 months. Durable viral suppression was defined as an HIV viral load undetectable or <200 copies/mL at every measurement in the past 12 months. SDCS was defined as vaginal or anal condomless intercourse with a partner of negative or unknown HIV status in the past 12 months. We evaluated the prevalence of any drug use (including injection and non-injection drugs) and SDCS among all heterosexual men. Among sexually active (in the past 12 months) heterosexual men who were virally unsuppressed, we assessed the associations between SDCS and any drug use, non-injection drug use, and any drug use before or during sex. Additionally, we used multivariable logistic regression to assess the independent association between any drug use and SDCS.

Results: Among all heterosexual men, 60% (95% confidence interval (CI) 57–63) were durably virally suppressed, 15% (CI 13–17) had SDCS, and 28% (CI 25–31) used drugs. In bivariate analyses among those sexually active and virally unsuppressed, we identified statistically significant ($p < 0.05$) associations between SDCS and any drug use (prevalence ratio (PR) = 1.7, CI 1.1–2.6), and non-injection drug use (PR = 1.6, CI 1.1–2.3). Using drugs before or during sex was also associated with SDCS (PR = 1.8, CI 1.2–2.8). Multivariable analysis on the association between any drug use and SDCS did not identify any confounding factors or effect modifiers.

Conclusions/Implications: Among HIV-infected heterosexual men who were not virally suppressed and in medical care, men who used drug were more likely to engage in SDCS, which could facilitate HIV

transmission to female sex partners. Previous research demonstrates that persons living with HIV who have undergone substance abuse treatment and counseling are more likely to remain in HIV medical care, adhere to ART, and adopt safer behaviors. Our analysis suggests that reducing drug use among HIV-infected heterosexual men may also decrease HIV transmission to female partners.

Abstract 2179 - The Association of Major Depression, Substance Use, and ART Adherence among HIV-positive Adults Receiving Medical Care in Georgia, 2009-2012

Author(s): *Rachel Culbreth, David Maggio, Shanta Dube*

Background: Currently, there are approximately 1.2 million people in the United States living with HIV and it is estimated that 25.6% of HIV-positive adults suffer from depression. Depression has been associated with substance use and smoking in the general population and in HIV-positive adults. Antiretroviral (ART) medication non-adherence has been associated with major depression among HIV-positive adults; however, the findings have been inconsistent. Major depression is defined by the DSM-IV criteria as experiencing five or more depressive symptoms for 7 or more days during a 14 day period. The Eight-Item Patient Health Questionnaire (PHQ-8) is one measure that is used to screen for major depression and has demonstrated consistent validity and reliability. The objective of this study is to explore the association between major depression and substance use, including current cigarette smoking, and ART medication non-adherence among HIV-positive adult Georgians receiving medical care for HIV during 2009-2012.

Methods: Data from a three-stage, probability sample of 608 HIV-positive adults who took part in the 2009-2012 Georgia Medical Monitoring Project (MMP) were analyzed. Eligible facilities are sampled every 2 years. Facilities are eligible to participate in MMP if they prescribe antiretroviral medications or order CD4 or HIV viral load tests, and once facilities agree to participate, a total patient list of 400 eligible patients across all facilities is randomly generated. Patients must be at least 18 years old, diagnosed with HIV, and receiving care. Descriptive analysis and multivariate logistic regression models were conducted to assess relationships between depression and current cigarette smoking, injection drug use, other non-injection drug use (excluding alcohol use), and ART medication non-adherence adjusting for sociodemographic covariates (age, gender, race, and education). All analyses accounted for non-response and complex sampling design and were performed using SAS 9.2 (Cary, NC).

Results: Among HIV-positive adults in Georgia, approximately 9.2% met the criteria for major depression; 15.2% of women and 6.9% of men had major depression. Heterosexual adults also had a higher percentage of major depression (11.9%) than adults who identified as bisexual (8.3%) or homosexual (6.1%). Major depression was also highest among young adults (17.1%) and adults with a high school diploma or GED (13.0%). Major depression was associated with a greater odds of current cigarette smoking (3.04; 95% CI: 1.48, 6.23); injection drug use (5.62; 95% CI: 0.96, 32.81), and other non-injection drug use (2.17; 95% CI: 1.10, 4.25), after adjusting for sociodemographic variables. Major depression was also associated with a greater odds of ART medication non-adherence, 2.52 (95% CI: 1.20, 5.28).

Conclusions/Implications: Consistent with patterns in the literature, we found positive associations between depression, smoking, ART medication non-adherence and other non-injection drug use among

HIV-positive adults. Abstaining from substance use and tobacco use behaviors have been shown to prolong life for HIV-positive adults. The presence of depression and multiple behaviors, such as smoking, substance use, and medication non-adherence, should be noted by clinicians, and interventions that address multiple adverse behaviors should be utilized.

Abstract 2210 - Homonegativity and Depression among Men Who Have Sex With Men

Author(s): *Paige Padgett, Jan Risser, Salma Khuwaja, Zaida Lopez, Catherine Troisi*

Background: Homonegativity (HN) and depression influence HIV risk behaviors among men who have sex with men (MSM). Homonegativity describes the extent that men accept negative social attitudes about same-sex relationships. Depression mediates HIV risk behaviors. It is unclear if these influences vary by race. We describe the contributions of HN and depression on risky behaviors, comparing Black, White, and Hispanic MSM.

Methods: Data were from the 4th MSM cycle of National HIV Behavioral Surveillance project (Houston site). We recruited participants by venue-based time-space sampling. We used the Ross and Rosser HN scale and the CESD-10 depression scale, higher scores indicating higher HN and higher depression symptoms. We defined risky behavior as sharing needles and/or drug preparation equipment and/or having unprotected anal intercourse in the last 12 months. Stratified by race, we examined differences in HIV status, HN, depression, and age, by risk status, with ANOVA, and with multivariable logistic regression.

Results: Our sample of 539 men was 40% Black, 39% White, and 21% Hispanic. High-risk behaviors were reported among 24% Blacks, 37% Whites, and 38% Hispanics ($p=0.01$). More Blacks (40%) than Whites (17%) and Hispanics (18%) tested positive for HIV ($p=0.01$). Whites were older (39 years) than Blacks (32 years) and Hispanics (33 years) ($p=0.01$). HN scores were higher among Blacks (27) than Whites (21) and Hispanics (23) ($p=0.01$). CESD-10 indicating clinical depression (>15) was found in 40% of Blacks, 40% of Whites, and 20% of Hispanics ($p=0.33$). High- and low-risk Blacks had similar mean age (31 vs. 32 years, $p=0.44$), mean HN scores (24 vs. 27, $p=0.16$), and mean depression scores (17 vs. 17, $p=0.84$). 52% of high-risk Blacks tested HIV positive compared to 36% of low-risk Blacks ($p=0.05$).

High-risk Whites were younger (mean age 37 years) than low-risk (mean age 41 years, $p=0.03$), had similar HN scores (19 vs. 22, $p=0.11$), similar depression scores (18 vs. 18 $p=0.73$), and similar rates of HIV positivity (13% vs. 18%, $p=0.28$). High-risk Hispanics, were younger (mean age 31 years) than low-risk (34 years, $p=0.09$), had similar HN scores (25 vs 22, $p=0.21$), similar depression scores (18 vs. 18, $p=0.78$), and similar rates of HIV positivity (11% vs 22%, $p=.015$). In the multivariable logistic regression, age, depression, HN and HIV were not statistically significantly associated with high-risk behavior among any race group.

Conclusions/Implications: These findings provide some context and direction for interventions that target high risk behaviors to prevent infections. We found differences by race in high-risk behaviors, age, HN scores, and HIV positivity at testing. 60% of our sample had CESD-10 scores indicating clinical depression. HN and depression were not associated with high-risk behavior by race. Some suggest that high HN is associated with unprotected anal intercourse but also with fewer partners resulting in a null impact on high-risk behavior. Others found depression to be associated with high-risk behavior,

although we did not. We will need to explore further analytic techniques to explain associations between higher HIV positivity, higher HN, and high depression scores among Blacks in this sample of MSM.

Track B

Session B01 - From the Aware to the Willing: Understanding the Knowledge and Attitudes for PrEP among Clinicians and Consumers

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 1420 - Knowledge, Information-Seeking, Communication, and Use of PrEP and PEP among Gay and Bisexual men

Author(s): *JoEllen Stryker, Vanessa Boudewyns, Euna August, Nickolas DeLuca*

Background: Pre-exposure prophylaxis, or PrEP, and post-exposure prophylaxis (PEP) represent promising prevention strategies to reduce HIV incidence. However, the uptake of PrEP/PEP is bound by limited awareness and understanding. The purpose of this analysis was to assess factors associated with the current levels of knowledge, information-seeking, partner communication, and use of PrEP/PEP among MSM.

Methods: A web-based survey was conducted among sexually active gay and bisexually identified men from December 2014-March 2015 (N=3,104, but results reported here are from provisional dataset N=2194). Participants were recruited from an online LGBT consumer panel. The survey oversampled younger (18-39), African American/black, and Hispanic-Latino (H-L) men. Cross-tabulations and chi-square tests were used to examine bivariate relationships. Binary hierarchical logistic regression procedures were used to examine predictors of PrEP/PEP knowledge, communication, information seeking and use, including demographics [age, race, income, education, status (where applicable)] and risk factors [number of casual partners, condom use, and partner status (where applicable)].

Results: Overall, knowledge of PrEP and PEP was high: 73.6% and 60.4% of the sample had heard about PrEP and PEP respectively. Only 41.7% and 43.7% of men talked to main or casual partners about PrEP respectively, and only 28.4% and 30.9% talked to main or casual partners about PEP. Information-seeking about PrEP was more common than information seeking about PEP (65.2% versus 52.0%). Only 7.4% of men reported ever taking PrEP, and 3.6% reported ever taking PEP. At the bivariate level, black respondents were significantly more likely than white respondents to search for information and talk to sex partners about both PrEP and PEP. Compared to men who were HIV-negative, men who were HIV-positive were significantly more likely to know about, talk about, and look for information about both PrEP and PEP. At the bivariate level, men were more likely to use PrEP if they had higher levels of education and income; were in a serodiscordant relationship; had higher numbers of casual partners; and knew about, talked to partners about, and looked for information about PrEP. In a multivariate model, predictors of ever having taken PrEP included: having more casual sexual partners, knowledge about PrEP, and communicating with sex partners about PrEP. Bivariate predictors of PEP include being black (versus white); being in a serodiscordant relationship; having more casual sexual partners;

knowing, talking to partners, and looking for information about PEP. Multivariate predictors of ever having taken PEP include: income, communicating with main sex partners about PEP, and information-seeking about PEP.

Conclusions/Implications: In general, knowledge, partner communication, and information-seeking are significant predictors of PrEP and/or PEP use. There may be structural barriers to accessing PrEP among black MSM, who in this sample were more likely to know about, talk about and look for information about PrEP, but were not significantly more likely to use it. HIV-positive men can play an important role in increasing HIV-negative men's awareness of PrEP and PEP. Finally, structural interventions, including education efforts and campaigns, designed to encourage partner communication about HIV and PrEP/PEP may aid in increased awareness and subsequent use.

Abstract 1686 - PrEP Awareness and Attitudes in a Nationally Representative Survey of Primary Care Clinicians in the United States, 2009-2013

Author(s): Dawn Smith, Maria Mendoza, Charles Rose

Background: As trials were assessing the safety and efficacy of daily oral antiretroviral preexposure prophylaxis (PrEP) for the prevention of HIV infection, it was clear that there was a need to understand the evolution of knowledge of and attitudes toward PrEP among primary care clinicians, many of whom provide care to uninfected persons at risk for HIV acquisition.

Methods: 1500-1507 physicians and nurse practitioners were surveyed in 2009, 2010, 2012, and 2013, to assess their awareness of PrEP, willingness to prescribe PrEP, and whether they support use of public funds to pay for PrEP. Descriptive statistics were computed for physician demographics and PrEP-related questions.

Results: Awareness of PrEP was low among clinicians (2009: 24%, 2010: 29%) but increased after trials reported effectiveness (2012: 49%, 2013: 51%). After the awareness question, a description of PrEP with an estimated effectiveness of 75% was provided. Across the 4 study years 92% of clinicians indicated a willingness to prescribe PrEP to at least one group at high risk of HIV acquisition. A smaller majority of clinicians indicated support for public funding of PrEP: 59% in 2009, 53% in 2010, and 63% in 2013. In 2009-2012, 1% of clinicians reported prescribing PrEP. In 2013, 4% reported prescribing PrEP, and of these clinicians, 67% had prescribed it for men who have sex with men (MSM), 25% for persons who inject drugs, and 45% for men or women in an HIV-discordant couple during conception attempts. In 2012 and 2013, clinicians demonstrated limited knowledge about recommended practices for providing PrEP. Of the 11 questions asked, the most common response was "don't know" on four questions (64-73%), incorrect response rates were greater than correct responses for three questions, and correct response rates were greater than incorrect response rates for four questions. The most commonly requested education topics were identifying indications for PrEP (73%), managing side effects and toxicities (59%), brief risk reduction counseling (57%), brief medication adherence counseling (53%), taking a brief sexual history (49%), and billing for PrEP-related care (48%). Routine HIV screening for all patients ages 13-64 years was reported by 20% of clinicians, for all pregnant women by 54%, for all MSM by 52% and for patients being treated for an STI by 74%.

Conclusions/Implications: In surveys conducted before and after the release of PrEP trial results demonstrating efficacy for multiple transmission risk groups, primary care clinicians were initially largely unaware of PrEP. They indicated high levels of willingness to prescribe it for patients at high risk of HIV acquisition and expressed interest in education on specific topics about how to deliver this new clinical HIV prevention method. Data for 2014 are forthcoming and will be incorporated into the current analysis to monitor continuing trends in clinician knowledge, attitudes, and practices as the use of PrEP increases in the US.

Abstract 2151 - Knowledge, Attitudes, and Acceptability of Pre-Exposure Prophylaxis in an Urban HIV Clinic

Author(s): *Erika Aaron, Jenani Jayakumaran, Zsofia Szep, Ed Gracely, Emily Schriver*

Background: Pre-exposure prophylaxis (PrEP) is an effective tool to reduce HIV transmission. The primary objective of this study was to assess HIV positive (HIV+) persons' awareness of PrEP and acceptance of its use for their HIV negative (HIV-) partners.

Methods: A cross sectional survey was conducted among HIV+ subjects who received care at an urban HIV clinic between January 2013 and June 2013. The survey examined knowledge, attitudes, and acceptability of PrEP, and perception of transmission risk of HIV. Chi-Square test and Fisher's exact test were used to compare proportions.

Results: Among 206 HIV+ subjects the median age was 46, 57% were male and 77% were African American. Only 15.3% (32) were aware of PrEP; gay/bisexual participants ($p=0.014$) and men ($p=0.013$) were more likely to have heard of PrEP. Once educated about PrEP those who believed PrEP would reduce their partner's risk for HIV were more likely to recommend PrEP to their partner ($p<0.001$). 92% said they would be "extremely likely" or "likely" to discuss PrEP use with their provider. Of 159 subjects whose main partner was HIV-, gay/bisexual ($p=0.007$), male participants ($p=0.044$), and those who were consistently taking meds ($p=0.049$) were more likely to have heard of PrEP. Those who perceived they were at risk of transmitting HIV ($p<0.001$) and those who were consistently taking meds (0.049) were more likely to agree that PrEP could reduce the risk of HIV to their partners.

Conclusions/Implications: Although clinical trials have illustrated that PrEP is a highly effective HIV prevention tool, the acceptability of PrEP will ultimately determine the success of this drug. This study illustrates the willingness of a cohort of HIV+ individuals to recommend PrEP to their partners. While knowledge was limited about the utilization of PrEP, once educated, HIV+ individuals were interested in learning how to protect their partners from acquisition of HIV. Communication by providers with their HIV + patients is recommended as this population is an underutilized link to HIV- partners. It is important that health care providers are educated about PrEP and inform their patients about its benefits.

Abstract 2154 - Potential Missed Opportunities: Willingness and Knowledge of PrEP in High Risk YBMSM Accessing Sexual Health Care

Author(s): *Renata Arrington-Sanders, Anthony Morgan, Jessica Oidtman, Jason Farley, Susan Sherman*

Background: Almost a year after the Centers for Disease Control and Prevention released clinical practice guidelines for pre-exposure prophylaxis (PrEP), studies suggest uptake of PrEP among high risk groups such as young Black men who have sex with men (YBMSM) is low. YBMSM continue to experience new HIV infections at a rate of 3 times that of their white counterparts. We sought to assess knowledge, attitudes and willingness to take PrEP among YBMSM.

Methods: 199 gay, bisexual, or questioning YBMSM ages 15-24 completed a confidential cross-sectional Internet survey querying current sexual risk behaviors, knowledge & willingness to use PrEP and frequency of health care visits and sexual orientation disclosure. Multivariate logistic regression analysis was used to assess factors associated with both knowledge of and willingness to use PrEP among the 147 participants who reported being HIV-negative.

Results: HIV prevalence in the sample was 26%. Of HIV negative respondents (n=147), 8% described being on PrEP currently and 74% reported being sexually active in the prior 3 months, with 66% of these respondents reporting any condomless receptive anal sex in the past 3 months. More than half (54%) of HIV-negative YBMSM reported visiting a doctor in the past 6 months. 14% of HIV-negative YBMSM reported visiting a doctor for symptoms of an STI and the majority (62%) reported having disclosed their sexual orientation to their providers. However, only 39% had any knowledge of PrEP, yet 62% reported a willingness to take PrEP. In multivariate models, increasing age (AOR=1.24, p=0.022) and disclosure of sexual orientation to a doctor (AOR=2.19, p=0.043) were significantly associated with knowledge of PrEP, adjusting for frequency of doctor's visits and perceived HIV risk. Additionally, only perceived HIV risk (AOR=1.32, p=0.035) was associated with willingness to take PrEP, controlling for condom use frequency and sexual orientation. HIV risk behavior was not associated with either knowledge of or willingness to take PrEP.

Conclusions/Implications: Providers are missing key opportunities to educate high risk YBMSM regularly accessing sexual health care services about biomedical advancements in HIV prevention such as PrEP. Given the high willingness of the sample to take PrEP if available, providers might consider routinizing information about PrEP and questions assessing eligibility and willingness to take PrEP into care visits with their YBMSM patients.

Session B03 - After Diagnosis: Innovative Strategies for Linking PLWH to Care

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1292 - From Incarceration to Linkage to Care: Adapting Project START for PLWH

Author(s): *Barry Zack, Katie Kramer*

Issue: An estimated 14-25% of persons with HIV in the United States were in a prison or jail the previous year. Most (known) individuals living with HIV receive care and HIV medications while incarcerated, however, many fail to adhere to HIV treatment and care after being released from prison or jail. This gap is often due to the lack of transitional planning with these individuals as they prepare to return to the community. Working with individuals prior to release and continuing with them in the community after release is essential to helping facilitate a seamless transition into the community.

Setting: Multiple federal, state and local government agencies have funded community based and health service organizations to facilitate Project START Plus (+) in various correctional facilities including state prisons, local jails and community correctional facilities. These facilities are located in both urban and rural settings throughout the US.

Project: Project START (PS) is the only CDC EBI that was developed specifically for the incarcerated population. It was translated from research to community practice for the CDC 2009 directly funded CBO initiative. PS has recently been adapted for PLWH to Project START Plus (PS+) with an emphasis on strengthening linkages to HIV care in the community after release from prison or jail.

The adaptation of PS+ involved tailoring the tools to make them relevant to those who are HIV positive. Input was received from current directly funded CDC grantees, and was reviewed by the California PTC, and the CDC PS+ Dissemination Team Lead. The PS+ intervention adaptation was piloted at two sites, one based in a jail (Exponents at Rikers Island, NYC) and the 2nd, in a State prison (AIDS Arms, Texas).

A one-day adaptation site visit was conducted to review current programs and provide adaption training. Post training support was provided through monthly follow-up calls for 5 months. We conducted both process and outcome evaluations.

Results: Of the 28 PS+ participants at the two pilot sites, 100% received their supply of medications upon release from custody, 75% received a prescription for their medication, 93% filled their prescriptions in the community, and 96% were linked to HIV care in the community after release. At one site, 100% were re-enrolled (or reinstated) into ADAP, 58% enrolled in Medicaid and 53% enrolled in insurance.

Lessons Learned: Project START+ is an effective and feasible intervention to recruit, intervene and retain people with HIV into care and treatment after release from prison or jail. Key findings to success demonstrate that it is (still) critical to get “buy-in” from the correctional facility, staff/client relationships are key, medical appointments should be made a pre-release goal and pre-release incentives should be given at the first post release medical appointment. Also key and innovative is the practice of community medical clinics to create weekly “PS+” slots. Along with the risk & linkage to care assessments, the transitional assessment is equally critical for identifying other life priorities, such as housing, mental and substance use treatment and other social services.

Abstract 2011 - Adapting Linkage-To-Care Models: Utilizing Advances in Testing Algorithms to Meet and Exceed National Linkage-To-Care Goals

Author(s): *Joseph Olsen, Ashley King*

Issue: The CDC recommends that HIV testing programs offer services to link clients identified as living with HIV/AIDS to medical care and help them progress through the continuum of care. On July 13th 2010 the National HIV/AIDS Strategy set forth a goal of increasing national linkage to care rates from 65% to 85%. In a healthcare landscape where algorithms for rapid HIV diagnoses and linkage-to-care protocols change rapidly in order to keep up with advances in HIV testing technology; the need for an

effective and flexible linkage-to-care model that sets clients up for success in navigating the continuum-of-care is imperative.

Setting: NO/AIDS Task Force (NATF) a division of CrescentCare is a New Orleans Community Based Organization. NATF provides 5,500+ free HIV tests to the local community annually with an average positivity rate of 2%. The linkage-to-care program at NATF uses innovative strategies to increase the rates of clients who access care with the goal of keeping clients in care and achieving viral suppression. These strategies can vary based on the location where a client first tests HIV positive.

Project: NATF conducts HIV testing in many settings around New Orleans including: 3 walk-in clinics, French Quarter bars, the municipal courthouse, multiple Walgreens locations, the Mexican and Honduran Consulates, local youth centers, and community testing via a medical mobile unit. In 2012, 2013 and 2014 NATF conducted 3131 HIV tests, 4647 HIV tests, and 5710 HIV tests respectively. The positivity rate during these years ranged from 1.8% - 2.5%. During these years multiple linkage-to-care protocols were used to adapt to changes in testing technology and algorithms for HIV diagnosis. Diagnosis of HIV was first done by rapid oral HIV test followed by a Western Blot confirmatory test that took two weeks to process/notify the client. The second testing algorithm used for HIV diagnosis during this time is a rapid-rapid model where clients testing positive would, during that same session, test a second time using a blood sample on a rapid test kit made by a different manufacture; upon a second positive rapid positive result the client has the option to begin the process of linking-to-care right away, reducing time related barriers of entry to care.

Results: Prior to 2012 NATF had a linkage-to-care rate of 50%. The 2012 linkage-to-care rate was 73.1% By January 2014 the linkage to care rate within 90 days rose to 90% and the average overall linkage-to-care rate from September 1, 2012-September 30, 2014 was 91% (n=174 positive clients). The consistent increase in linkage-to-care rates during shifts in testing algorithms is attributed to the 2012 development of a flexible and client centered linkage model by a HRSA funded Patient Navigator.

Lessons Learned: The formation of clear linkage-to-care protocols and efficient testing models are crucial in achieving high linkage rates. Efficient linkage-to-care is a crucial part of HIV prevention and positive health outcomes for people living with HIV/AIDS. Transitioning to a rapid-rapid testing model significantly expedites the linkage-to-care process. It is possible to reach and exceed the goals set by the National HIV/AIDS Strategy.

Abstract 2386 - The Effects of Depression and Substance Abuse on Engagement in Treatment among Men Who Have Sex with Men Recently Diagnosed with HIV

Author(s): *Skye Ross, Patrick A Wilson, Nathan B Hansen*

Background: Men who have sex with men (MSM) remain the primary population affected by HIV and AIDS. Engagement in medical care within 3 months is associated with earlier initiation of antiretroviral therapy (ART), which is recommended for improvement in health status and reduction in HIV infectiousness. Depression and substance use negatively impact HIV health outcomes.

Methods: MSM recently diagnosed with HIV (within the past 3 months) were recruited to participate in a yearlong study, Promoting Action Towards Health (PATH). The analyses presented focus on the associations between depression, substance use, and treatment engagement at baseline. It was expected that baseline treatment engagement and ART initiation would be lower among those with depression, problems due to alcohol use, and/or problems due to drug use. A timeline follow back for alcohol and substance use for the three months prior to HIV diagnosis was administered in an interview format. The Center for Epidemiological Studies – Depression (CES-D), Alcohol Use Disorders Identification Test: Self-Report Version (AUDIT), Drug Abuse Screening Test 10-Item (DAST), and items related to ART initiation and engagement in medical care and other services were administered via computer assisted self-interview (CASI). Analyses were conducted to assess the prevalence of depression and substance use and their impacts on engagement in care.

Results: Of the 92 participants, 65.2% indicated depression. Ninety percent of participants used alcohol within three months of assessment and 77.2% reported using drugs within three months of assessment, most commonly marijuana, methamphetamine, and amyl nitrate (poppers). The severity of depression was marginally associated with initiation of ART (chi-square = 5.595, df = 2, p = .061). The severity of problems associated with drug use was associated with poor engagement in treatment (chi square = 8.297, df = 2, p = .016). The frequency of amyl nitrate use was significantly associated with the number of missed medical appointments (t = -2.49, df = 69.43, p = .015) and there were trends between the number of missed medical appointments and frequency of methamphetamine use (t = -1.95, df = 56.70, p = .056) and the total number of alcoholic beverages consumed during the 3 months prior to HIV diagnosis (t = -1.82, df = 33.23, p = .078).

Conclusions/Implications: Findings suggest that depression, problems associated with alcohol and substance use, amyl nitrate, methamphetamine, and alcohol use may impede engagement in care among MSM recently diagnosed with HIV. It is also known that substance use impairs judgment and increases the risk of HIV transmission. This study obviates the need for comprehensive mental health and substance use treatment to be made available for MSM at the time of being diagnosed with HIV. Future research may focus more on the biological impact of substance use and depression on acute infection, disease progression, and HIV transmission within communities.

Session B06 - We Are All Men: Exploring the Sexual Health and HIV Risks in Black Men

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1323 - Understanding Social Marginalization and Sexual Risk Behavior for HIV among HIV-Positive and Negative African American Men who have Sex with Men/Women: Applying Syndemic Theory

Author(s): *Jerris Raiford, Pilgrim Spikes, Anthony Johnson, Cleo Manago, Darrell Wheeler*

Background: African American men who have sex with men (MSM) in the US continue to bear disproportionately high rates of HIV despite similar behavioral risks when compared to other MSM groups. Non-behavioral factors may contribute to this phenomenon. Syndemics theory proposes that a set of two or more conditions interact synergistically to increase the burden of disease in a population. Employing syndemic theory as a model for understanding sexual risk behavior for HIV infection and

transmission, this study tested the likely impact of syndemic factors for increased HIV risk among HIV-positive and negative African American MSM and men who have sex with men and women (MSM/W).

Methods: Using baseline data from a sample of 534 African American MSM and MSM/W, 18-55 years old, recruited for a randomized HIV risk-reduction trial, this analysis examines whether a higher number of syndemic conditions was associated with: self-reported HIV infection, higher rates of HIV-related attitudes and risk behavior, access to health services, and a history of incarceration. Men reported whether they engaged in exchange sex, condomless anal intercourse by partner status (e.g., male, female, primary, casual, HIV status) and sexual positioning (insertive or receptive anal intercourse), the number of days since last HIV test, and the degree to which it is important to keep sex with men a secret. Syndemic conditions included unemployment, lack of money for basic necessities, homelessness or unstable housing, and discrimination and victimization due to sexual orientation or racial minority status.

Results: Logistic regression models controlling for age, detected significant, additive effects of an increasing number of syndemic conditions on self-reported HIV status, perceived importance of keeping sex with men a secret, condomless anal intercourse with male and female partners, a history of exchange sex, a lack of medical insurance and regular health provider, and previous incarceration. All HIV-positive men reported having a regular health provider and syndemic conditions were not significantly associated with insurance status for this group. However, those HIV-positive men reporting all four syndemic conditions were 17.1 times as likely to report selling sex for food, drugs, money or shelter when compared to men reporting one or none of these syndemic conditions (CI=2.00-146.64, $p=.01$). Among HIV-negative men, syndemic conditions were not associated with HIV testing as 77% reported having tested for HIV in the past 12 months.

Conclusions/Implications: Whereas previous research suggests that syndemic factors may negatively affect African American MSM's engagement in the HIV care continuum, in this study, all HIV-positive men reported access to health services, increasing experience with syndemic conditions were not associated with this access, and a majority of HIV-negative men reported HIV testing in the past 12 months. However, syndemic conditions were positively and additively associated with other HIV infection and transmission risk attitudes and behaviors. These findings support the need to continue developing interventions beyond individual-level prevention and control and to focus on reducing the impact of syndemic factors to reduce infection and transmission among this population.

Abstract 1873 - Is Sex with Older Male Partners Associated with Elevated Sexual Risk Behavior Among Young Black MSM?

Author(s): *Leandro Mena, Richard Crosby, Angelica Geter, DeMarc Hickson, Timothy Brown, Courtney Sims*

Background: Sexual networks characteristics of young black MSM may explain some of the disparities observed in the HIV risk experience by this group versus other MSM. The objective of this study is to determine whether generally, having sex with older male partners is associated with elevated sexual risk in a clinic-based sample of young Black MSM who reside in a southern city with high HIV seroprevalence.

Methods: A convenience sample of 400 Black MSM (ages 18 through 29) completed a computer-assisted self interview in a private area of a clinic dedicated to sexual health. The questionnaire included an item assessing whether male sex partners were generally at least 5 years older than the study respondent. Contingency table analyses were used to determine whether those having generally older sex partners also reported elevated sexual risks.

Results: Of 387 men providing valid data, 79 (20.4%) reported that their sex partners were generally at least 5 years older than themselves. These men did not differ from the remainder of the sample relative to having unprotected anal sex as a TOP in the past 90 days ($P=.65$) or as a Bottom ($P=.54$). They were, however, significantly more likely to have multiple partners as a BOTTOM ($P=.014$), but this was not true as a TOP ($P=.38$). Men with older partners were more likely to report having sex with someone they knew to be HIV-positive ($P=.036$) and they were marginally more likely to report sexual concurrency ($P=.058$). They were also more likely to report ever having been diagnosed with an STI ($P=.016$) and they were more likely to test positive for HIV at study enrollment -- 43.6% of those with older partners tested positive versus 24.5% of those not having older partners ($P<.001$). Despite this last finding, differences in testing positive for Chlamydia/gonorrhea at enrollment were not observed ($P=.93$).

Conclusions/Implications: In this clinic-based sample of young Black MSM, engaging in sex with predominately older males was associated with a substantial elevation in the odds of also having HIV. This may be attributable to past STIs, having multiple partners as a BOTTOM, having sex with persons known to have HIV, and (possibly) partner concurrency.

Abstract 1875 - Similarities and Differences in Sexual Risk Behaviors Between Young Black MSM Who do and do Not Have Sex with Females

Author(s): *Angelica Geter, Richard Crosby, Leandro Mena, Laura Beauchamps, DeMarc Hickson, Timothy Brown, Courtney Sims*

Background: To determine whether young Black MSM who also have sex with females report similar levels of sexual risk behaviors as their counterparts who do not have sex with females. This data is based on a clinic-based sample of young Black MSM who reside in a southern city with high HIV seroprevalence.

Methods: A clinic-based sample of 400 Black MSM (ages 16 through 29) was recruited in a southern city with high HIV seroprevalence. A computer-assisted questionnaire assessed a broad range of sexual risk behaviors (using the past 90 days as the recall period) and laboratory testing was performed to detect prevalent Chlamydia and gonorrhea infections as well as HIV. Contingency table analyses and t-tests were used to compare MSM also having sex with females to those having sex exclusively with males.

Results: Of 398 men providing valid data, 173 (43.0%) had recently engaged in penile-vaginal sex. These men were significantly less likely to report: 1) having concurrent sex partners (23.5% vs. 35.6%; $P=.01$), 2) having unprotected fellatio (74.5% vs. 83.3%; $P=.043$), 3) having multiple sex partners as a BOTTOM (33.1% vs. 44.6%; $P<.02$), 4) having any unprotected anal sex as a BOTTOM (26.7% vs. 40.9%; $P<.013$), and 5) having any anal sex (82.7% vs. 91.6%; $P = .007$). They were equally likely to report: 1) serosorting as an HIV prevention method (48.8% vs. 47.5%; $P=.80$), 2) having multiple male partners as a TOP (46.7%

vs. 40.1%; $P=.20$), 3) having any unprotected anal insertive sex with males (25.2% vs. 32.0%; $P=.15$), 4) frequency of sex with males as a TOP (mean = 4.15 times vs. 4.67 times, $P=.61$), 5) frequency of sex with males as a BOTTOM (mean = 6.28 times vs. 7.12 times, $P=.61$). A marginal difference was observed for not using condoms the last time sex first occurred with a new male partner (18.1% vs. 25.7%; $P=.076$). Of note, those having sex with females were less likely to test positive for HIV (22.4% vs. 32.1%; $P=.036$), but not less likely to test positive for Chlamydia/gonorrhea (33.9% vs. 38.8%; $P=.33$).

Conclusions/Implications: In this clinic-based sample of young Black MSM, those also having sex with females were less likely than their counterparts to engage in 5 of 11 assessed risk behaviors and they did not report any sexual risk behavior exceeding that of their counterparts. These MSM may be exercising greater caution due to “secrecy concerns.”

Abstract 2449 - The Bisexual Relationship Scale: Developing a Culturally Informed Measure of Relationships among Behaviorally Bisexual Black Men and their Female Partners

Author(s): *Sonja Mackenzie, Tazima Jenkins Barnes*

Background: The highest rates of HIV infection in the U.S. are currently found among urban Black men who have sex with men, including bisexually active men. Sexual risk behaviors are high between Black bisexually active men and their female partners, yet these relationships remain understudied.

Methods: Project WAMERU (Women and Men Expanding Relationship Understandings) is a five-year NIMH study of HIV risk and relationships among behaviorally bisexual Black men and their female partners. Drawing on formative qualitative interviews with men ($N=60$) and women partnered with bisexual Black men ($N=20$), we coded the data on disclosure, gender, relationship power, bisexual stigma, incarceration and religion using ATLAS.ti qualitative analysis software. We developed a culturally-appropriate quantitative measure of disclosure of bisexual activity among men and levels of knowledge among women of partner’s bisexual activity.

Results: We developed a 68-item draft scale to assess the presence of culturally-specific sexual relationship norms among behaviorally bisexual Black men and their female partners. Domains include: gender norms, religion, relationship power, bisexual stigma, incarceration, disclosure, and knowing as a reciprocal component of disclosure among women. Analysis of 80 qualitative interviews led to initial 90 item scale, and 20 cognitive interviews were conducted with women and men for comprehension and clarity. Results of the cognitive interviews indicated the need for intersectional constructs to capture the structural context of bisexual relationships and HIV risk behaviors. The development of the African American Bisexual Relationship Scale involved a community-engaged research process that ensured the cultural relevance of this relationship scale. This scale is being used in a cross sectional quantitative assessment of the effects of disclosure, levels of knowledge of bisexual activity, and gender ideologies on sexual risk behaviors among this population of men and their female partners.

Conclusions/Implications: The development of the Bisexual Relationship Scale among Black behaviorally bisexual men and their female partners is described as an example of a community-engaged research process to help inform structurally and culturally-informed HIV prevention understandings and prevention interventions.

Session B10 - The "T" is Not Silent: Addressing Disclosure and other Determinants in HIV Outcomes of Transgender Individuals

Room: Embassy E/F (Hyatt Regency Atlanta)

Abstract 1272 - What Protects Transgender and Gender Variant Youth from HIV and Other Negative Health Outcomes? Results of a Systematic Review

Author(s): *Oscar Beltran, Heather Armstrong, Michelle Johns, Lisa Barrios*

Background: Transgender and gender variant youth have been found to be at high risk for negative sexual and mental health outcomes including HIV, STIs, and depression. (Garofalo et al., 2006). Recently, research has begun to focus on factors which may serve to protect and improve the health and well-being of these youth. As this research is conducted across the health and social sciences, we conducted a systematic review to synthesize this work for a cohesive understanding of the research area.

The purpose of this systematic review was to inform clinicians and scholars of the state of research on protective factors among transgender/gender variant youth. In particular, protective factors associated with sexual and mental health outcomes were identified using an ecological framework. This study also aimed to address the importance of conducting research with this population, and the implications of this research for preventing poor sexual health outcomes, including HIV.

Methods: A systematic search for peer-reviewed articles published between 1999 and 2014 was conducted across 19 English-language databases (e.g., Medline, PsychInfo, Web of Science) and 13 Spanish-language databases (e.g., LILACS, Fuente Academica, PAHO). Eligibility criteria included: examination of at least one protective factor in relation to at least one sexual health or mental health outcome among a sample or subsample of transgender/gender variant adolescents; participants who ranged from 10 to 24 years of age; and studies conducted in Western industrialized countries or Latin America. Included articles were subsequently coded for study design, sample characteristics, protective factors, and outcomes.

Results: A total of 2,046 abstracts were screened. Of those, 66 were selected for full-text review, and 29 articles were included in the final sample. Of these 17 had a quantitative research design, 9 used qualitative methods, and 3 used mixed-methods. Articles included in our final sample identified self-esteem, HIV knowledge, partner communication, and family cohesion as protective factors that reduced HIV risk; and parental support, personal mastery (i.e., defined as a sense of control over important life outcomes), and peer relations were identified as mental health protective factors. When considered from an ecological perspective, research conducted to date has focused primarily on individual- and relationship-level factors (24 out of 29 articles).

Conclusions/Implications: Transgender/gender variant populations are a key risk group for HIV. The results of this systematic review provide a theoretically informed synthesis of the current research on protective factors among transgender and gender variant adolescents. The results highlight key factors that could be tested in HIV- and other risk-reduction programs to confirm their protective effects, and used to inform clinicians working with this population. The results also highlight areas in need of

additional research including research on sociocultural protective factors and research with gender variant youth who do not identify as transgender.

Funding source: This study was funded by an Arcus Foundation grant awarded to the CDC Foundation.

Abstract 1880 - The Association of Disclosure of HIV and Transgender Status with HIV Care Outcomes among HIV-positive Transgender Women of Color

Author(s): *Deepalika Chakravarty, Greg Rebchook, JoAnne Keatley, Luis Gutierrez-Mock, Jae Sevelius, Madeline Deutsch, Andres Maiorana, Starley Shade*

Background: Transgender women of color are at high risk of HIV infection, and efforts to fully engage HIV-positive transgender women of color in HIV care are urgently needed both to improve their health and to reduce the risk of HIV transmission to others. Multiple forms of stigma and oppression may create obstacles to care and also prevent some HIV-positive transgender women from disclosing their HIV status and gender identity to others. Unless these barriers to care are overcome, the goals of the National HIV/AIDS Strategy may not be realized for this highly impacted community. To address this serious problem, the Health Resources and Services Administration (HRSA) under the Special Programs of National Significance (SPNS) funded 9 demonstration sites nationwide to develop and implement model interventions to improve engagement in care among HIV-positive transgender women of color.

Methods: As part of the efforts to evaluate their interventions, the demonstration sites are conducting computerized surveys among their participants, and have recruited 400 HIV-positive transgender women of color between December, 2013 and March, 2015. Sample descriptive statistics were calculated and bivariate logistic regressions were conducted using SAS 9.4. The binary outcome variables (0=No, 1=Yes) were: receipt of HIV primary care (HIVPC) ever, receipt of HIVPC in the past 6 months, whether currently on ART, whether viral load (VL) was undetectable at last test. The explanatory variables were disclosure of one's HIV status and of one's transgender status to sex partners, transgender friends, non-transgender friends and family.

Results: The average age of the women was 38 years (SD=11) and 41% were Latina. While 76% had ever received HIVPC, 47% had done so in the past 6 months, and 27% were currently on ART. The majority of women had disclosed their HIV status and transgender status (64% and 68%). Compared to those who had not disclosed their HIV status to anyone, those who had disclosed it were significantly more likely to have ever received HIVPC (OR:2.29; 95% CI:1.22, 4.29), received HIVPC in past 6 months (OR:1.94; 95% CI:1.14, 3.31) and be on ART (OR:1.84; 95% CI:1.01, 3.37). Similarly, compared to those who had not disclosed their transgender status to anyone, those who had disclosed it were significantly more likely to have ever received HIVPC (OR:2.49; 95% CI:1.26, 4.92), received HIVPC in past 6 months (OR:2.83; 95% CI:1.51, 5.31), be on ART (OR:2.81; 95% CI:1.30, 6.07) and have an undetectable VL (OR:2.51; 95% CI:1.32, 4.78).

Conclusions/Implications: Findings demonstrate that disclosure of one's HIV-positive status and transgender status to sex partners, friends and family has a significant positive association with linkage to, and engagement in care among HIV-positive transgender women of color. Disclosure, in this respect, may be a proxy for the presence of a safety net of social connections for this population. Future

interventions should aim to on the one hand, equip transgender women with skills to disclose these statuses to their immediate social circle and on the other, educate the wider community in being supportive of HIV-positive transgender women.

Abstract 2099 - The Association of Healthcare Empowerment and Structural Factors with HIV Care Outcomes among HIV-positive Transgender Women of Color

Author(s): *Deepalika Chakravarty, Greg Rebchook, JoAnne Keatley, Luis Gutierrez-Mock, Jae Sevelius, Madeline Deutsch, Andres Maiorana, Starley Shade*

Background: Transgender women of color are at high risk of HIV infection, and efforts to fully engage HIV-positive transgender woman of color in HIV care are urgently needed both to improve their health and to reduce the risk of HIV transmission to others. Individual as well as structural factors present significant barriers to care and unless these barriers are overcome, the goals of the National HIV/AIDS Strategy may not be realized for this highly impacted community. To address this serious problem, the Health Resources and Services Administration (HRSA) under the Special Programs of National Significance (SPNS) funded 9 demonstration sites nationwide to develop and implement model interventions to improve engagement in care among HIV-positive transgender woman of color. We investigated the association of select structural constructs and healthcare empowerment with engagement in HIV care in this population.

Methods: As part of the efforts to evaluate their interventions, the demonstration sites are conducting computerized surveys among their participants, and have recruited 400 HIV-positive transgender women of color between December, 2013 and March, 2015. The broad-ranging survey includes questions on demographics, HIV care, structural barriers and healthcare empowerment. Sample descriptive statistics were calculated and bivariate logistic regressions were conducted using SAS 9.4. The binary outcome variables (0=No, 1=Yes) were: whether currently on ART, whether viral load (VL) was undetectable at last test and good adherence to ART. The explanatory variables were: transience (2 or more moves in 6 months), homelessness (at least 1 night in the past 6 months), missed doctor's appointment(s) due to lack of transportation (in the past year) and one's level of healthcare empowerment.

Results: The average age of the women was 38 years (SD=11) and 41% were Latina. More than half (56%) had at least a high school education while 77% had an annual income of less than \$15,000. Less than half (47%) had received primary care for HIV in the past 6 months, and 27% were currently on ART. Transient women were less likely to be on ART (OR:0.39; 95%CI:0.18, 0.84) and have an undetectable VL (OR:0.40; 95%CI:0.20, 0.82). Those lacking transportation were less likely to have good adherence (OR:0.22; 95%CI:0.09, 0.52) and less likely to have an undetectable VL (OR:0.50; 95%CI:0.30, 0.85). Those dealing with homelessness were also less likely to have good adherence (OR:0.38; 95%CI:0.18, 0.82). In contrast, higher levels of healthcare empowerment were associated with greater likelihood of being on ART (OR:1.41; 95%CI:1.11, 1.80) and having an undetectable VL (OR:1.37; 95%CI:1.10, 1.70).

Conclusions/Implications: Findings demonstrate that structural factors such as transience, homelessness and lack of transportation are impediments to ART adherence and VL suppression among HIV-positive transgender women of color. The silver lining however, is that greater healthcare

empowerment is associated with desirable HIV care outcomes. For greater and sustained effectiveness, future interventions should be designed to tap into the synergy of addressing structural barriers on the one hand while educating members of this population to attain greater healthcare empowerment.

Abstract 2540 - Project HEAL: A Treatment Plan for Transgender and Non-transgender Women with Substance Abuse and PTSD

Author(s): *Taryn Feuerberg, Jury Candelario, Terry Jay, Maria Roman, Colleen Eckels, Nancy Sekizawa*

Issue: According to the Los Angeles County Comprehensive HIV Plan for 2013-2017, Los Angeles County (LAC) is currently home to 77,886 cumulative cases of HIV. There are over 14,400 transgender persons estimated living in LAC, with transgender women experiencing HIV prevalence at a rate of 20 times higher than transgender men. This growing epidemic in LAC is a result of many compounding factors including a high percentage of individuals who experience risky sexual behavior, drug use, poor economic and environmental conditions, homophobia, transphobia, stigma, and shame. In HEAL, 95% of the transwomen enrolled experienced symptoms of PTSD as a result of their life experiences.

To take an expanded and contextual view of HIV infections among transwomen, HEAL focuses on substance abuse and co-occurring PTSD. Substance abuse (SA) increases the likelihood of risky sexual behavior (sex work, unprotected sex, etc), and risky drug/needle use. Additionally, substance abuse often occurs as a means of coping with traumatic events, or because of a traumatic incident the individual experienced as a result of their drug use.

Setting: Project HEAL (HEAL) is a group therapy program utilizing the evidence-based Seeking Safety program. HEAL is funded by the Substance Abuse and Mental Health Administration.

Project: Provide Seeking Safety protocols in either a 12-week or 6-week group therapy format to women who meet the specified eligibility requirements. Eligibility requirements: 1) identify as racial/ethnic minority female, 2) have a substance use issue in the last 24 months, and 3) had an experience that the client defines as “traumatic”. Clients are offered additional therapy if clinically relevant. Clients are screened at intake, discharge, and 6 months post-intake with SAMHSA CSAT Government Performance and Results Act (GPRA) tool, Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and PTSD Symptom Checklist (PSC). Clients are offered free HIV and Hepatitis tests. Clients are offered therapy for up to 3 months post-discharge.

Results: HEAL has been an active APAIT program since August 2013. We have enrolled 70 transwomen in the program since then, overall meeting 104% for our client enrollment goals in year one. As of Year 2, Quarter 2, we have met 92% of our client enrollment quota. The overall retention rate for the last 1.5 years has been 73% (N=50), from intake through discharge.

GPRA analysis demonstrated that at discharge, HEAL clients reported a 225.0% increase in substance abstinence in the last 30 days, as compared to intake. At discharge, HEAL clients reported an 80.0% increase in employment from intake, as well as a decrease in PTSD symptoms, anxiety, and depression (as reported by BDI, BAI, and PSC).

Lessons Learned: Counselors conducted outreach at sober livings, Alcoholics/Narcotics Anonymous (AA/NA) meetings, homeless shelters, drop-in centers, drug rehabilitation facilities, hospitals, community organizations, HIV support organizations, offering incentives for referrals, creating a safe environment for expressing gender identity, implementing groups in clients' native language, and having staff cross-trained in HIV/gender and sexuality diversity/cultural competence.

Strategies for retention: hosting graduations celebrations, asking for client feedback, offering housing assistance, therapy, and providing access to a food pantry and medical clinic on-site.

Track C

Session C01 - Results from Health Departments Using HIV Surveillance Data for Linkage and Re-engagement to HIV Care

Room: A707 (Atlanta Marriott Marquis)

Abstract 1173 - Treatment as Prevention: Using HIV Surveillance Data to Link People to HIV Medical Care

Author(s): *Jessica Harvill, Melissa Boyette*

Issue: Ensuring that persons with human immunodeficiency virus (HIV) infection receive appropriate medical care is critical for preventing disease progression and transmission. In 2012, the Alaska HIV/STD Program began a Linkage to Care (L2C) demonstration project to increase the proportion of HIV-infected Alaskans who are accessing ongoing medical care.

Setting: L2C services were offered to all persons with a new diagnosis of HIV in Alaska and to all persons residing in Alaska with a previous diagnosis of HIV who did not meet the project definition of in HIV medical care.

Project: In Alaska, HIV and AIDS are reportable by both healthcare providers and laboratories. Reported laboratory results and case data are recorded in the enhanced HIV/AIDS reporting system (eHARS). Alaska's L2C Program utilized eHARS HIV surveillance data to identify individuals who were newly diagnosed as HIV-positive, or who were known to be HIV-positive and not accessing HIV medical care, to offer them short-term, intensive support in engaging with an HIV medical care provider and other supportive services.

Results: From January 1, 2012 through July 31, 2014, 78 persons were newly diagnosed as HIV-positive in Alaska. As of October 31, 2014, 71 (91%) of those had received L2C services. Of the 71 persons who received L2C services, 70 (99%) received a CD4 and viral load test and 52 (73%) were known to have achieved viral suppression. Of the 7 persons not offered L2C services, 5 moved from the state before linkage services could be offered, 1 died, and 1 was not locatable.

From January 1, 2012 through July 31, 2014, 390 previously reported HIV cases identified as out of care by the eHARS surveillance system underwent individual level review to determine their HIV care status. Of those 390 cases 219 (56%) were determined to have moved from the state; 94 (24%) were

determined to be residing in Alaska and out of HIV medical care; 29 (13%) were found to be deceased; 26 (7%) were ineligible for L2C services; and, 22 (6%) were not locatable. As of October 31, 2014, 85 (90%) of the 94 persons who were determined to be residing in Alaska and out of HIV medical care accepted L2C services. Of those who accepted L2C services 85 (100%) received a CD4 and viral load and 66 (78%) are known to have achieved viral suppression.

Lessons Learned: Successful implementation of linkage to care programs requires shifts in HIV surveillance and prevention systems and necessitates the development of infrastructure to provide services, including: 1) Mandating reporting for HIV laboratory results, including HIV-positive antibody/antigen tests, HIV viral loads, and CD4 values at all levels; 2) Ensuring timely entry of all HIV results into surveillance systems; 3) Establishing systems for data sharing between HIV prevention and surveillance programs; 4) Ensuring that linkage to care staff have access to databases which can provide current locating information; and 5) Establishing referrals systems with HIV testing providers, medical case management agencies, and health care providers to ensure seamless navigation for newly diagnosed and out of care HIV-positive individuals.

Abstract 1650 - Maryland's PS12-1201 Demonstration Project: Improving the Health of Marylanders Living with HIV through Enhanced Linkage-to-Care Systems and Activities

Author(s): *Hope Cassidy-Stewart, Marcia Pearl, Colin Flynn, Jacquelyn Malasky*

Issue: Among Marylanders newly-diagnosed with HIV during 2011, 30% did not have a reported CD4 or viral load test within 3 months of their HIV diagnosis, and among Maryland HIV cases alive on 12/31/2011, 57% did not have at least one reported CD4 test during the previous year. These data indicated that a significant number of persons living with HIV (PLWH) in Maryland were not successfully engaged in ongoing HIV care, highlighting the need to strengthen public health linkage-to-care (LTC) systems.

Setting: The Maryland Department of Health and Mental Hygiene (MDHMH) was awarded funds under CDC-RFA-12-1201 to implement a demonstration project to improve LTC outcomes in the four Maryland counties with the highest HIV prevalence (Anne Arundel, Baltimore, Montgomery, and Prince George's).

Project: Maryland's project sought to improve LTC outcomes through a review of LTC practices and systems at state and local levels, and utilization of HIV surveillance data to implement re-engagement outreach. To improve initial LTC, MDHMH partnered with local health departments (LHDs) in the target counties to create LTC process maps and identify/address gaps. State system improvements included quality assurance mechanisms to ensure adequate follow-up and documentation of LTC outcomes, and data system modifications to more effectively track LTC field activities and outcomes. To improve ongoing care engagement, MDHMH analyzed HIV surveillance data to identify PLWH in the target counties who had potentially dropped out of care (OOC). These data were shared with the LHDs, who conducted record searches, provider calls, and client outreach to assess current engagement in care for these OOC PLWH and offered re-engagement support, as needed.

Results: In June 2014, Maryland conducted analyses to assess changes in population-level LTC outcomes for newly-diagnosed PLWH in the target counties. All four counties showed increases in the percentage

of newly-diagnosed PLWH linked to HIV medical care within 90 days of HIV diagnosis, with an overall increase from 69% to 84%. In April 2015, Maryland analyzed re-engagement data for the 650 potentially OOC PLWH investigated by LHDs. These data show that 61% were engaged in HIV care at the time of follow-up, 3% were deceased, 29% had an unknown care status due to the client moving out of jurisdiction or being unable to locate, and 7% were not currently engaged in HIV medical care. Field outreach was initiated for those not currently engaged in HIV medical care, resulting in 20 PLWH who had fallen out of care being re-engaged.

Lessons Learned: Through a systematic review of LTC processes at the state and local level and expanded use of surveillance data to initiate and inform LTC activities, Maryland was able to significantly improve LTC outcomes in the four target counties. When utilizing HIV surveillance data to initiate and inform re-engagement activities, the majority of potentially OOC PLWH investigated by LHD teams were found to already be engaged in care. These findings are similar to the results experienced in other jurisdictions, and underscore the need to refine data-to-care protocols and determine the most efficient use of HIV surveillance data for care re-engagement work.

Abstract 1869 - Using HIV Surveillance Data for Enhanced HIV Partner Services

Author(s): *Michelle Wozniak, Ana Maria Visoiu-Knapp, Noel Tarver*

Issue: HIV Partner Services (PS) is a Centers for Disease Control and Prevention (CDC) recommended service in the United States as of 2008. PS increases program collaboration, service integration and cost effectiveness; and should be offered to everyone newly diagnosed with HIV. In Hawaii, over half of new HIV infections are diagnosed by private medical providers. Although HIV surveillance staff have access to reported infections, the data are not accessible to HIV Prevention program staff who perform PS. Thus, HIV diagnoses by private medical providers do not receive the benefits of PS including: partner notification, linkage to care and linkage to support services.

Setting: The goal of HIV PS is to reach all people diagnosed with HIV in Hawaii and their partners regardless of place of diagnosis.

Project: Successful applicant and recipient of Category C demonstration project funding for 2012-2015 from CDC for Enhanced HIV PS.

Establish and implement data sharing agreement between HIV surveillance and HIV prevention programs to use individual surveillance level data for PS.

Department of Health staff and Prevention With Positives staff from contracted AIDS Services Organizations attended PS skills training in November 2012.

Letter and brochure introducing the topic of HIV Surveillance data for Enhanced HIV PS were developed, approved and mailed to all providers who made diagnoses within the past five years.

HIV surveillance staff modified CDC SAS code to identify new cases from laboratory data set. New cases are matched with eHARS during a weekly data download. Newly identified cases are shared weekly with HIV prevention program staff.

The HIV prevention program confirms each new case with the physician and offers PS. PS staff interview new cases, links them to care and to case management, and confidentially notifies partners. Partners notified are offered HIV testing.

Results: From September 2012- December 2014, there were 90 newly identified HIV cases interviewed for PS. These 90 cases elicited 136 partners named, 12 of whom were previously positive. Of the 136 partners named, 85 were successfully contacted and tested for HIV. Of those 85 tested, 12 (14%) were identified as new positives.

When adjusted for those who do not live in Hawaii, of those who were interviewed for PS, 48/60 (80%) were linked to care, 46/60 (77%) were retained in care and 36/60 (60%) have achieved viral suppression.

Lessons Learned: The use of individual level HIV surveillance data for HIV prevention programming has created a culture shift, shifting focus from a broad screening of everyone to targeting efforts towards those who will most benefit.

This effort has evolved from HIV PS to re-engagement in care activities. The use of HIV surveillance data can benefit HIV prevention programming and enhance HIV surveillance with increased reporting and data accuracy.

The innovative use of individual level HIV surveillance data can be successful with proper and timely community buy-in from AIDS Service Organizations, Ryan White Providers, Community Health Centers, and Medical Providers. STD Disease Investigation Staff offer valuable lessons learned in interviewing cases, partner tracing and relationship building with medical providers.

Abstract 2046 - Using HIV Surveillance Data for Linkage and Re-engagement to HIV Care, the Washington State Experience

Author(s): *David Heal, Jason Carr, David Kern*

Issue: When Washington State began using the HIV continuum as a framework for program development and outcome evaluation in 2012, an accurate method of estimating proportions of the population at each stage of the continuum was lacking due to a large number of reported cases with unknown residence and care status. Also lacking were practical means to locate and contact out of care PLWH, determining their barriers to accessing care, and re-linking them to care.

Setting: State health department in a moderate prevalence state with a large majority of reported cases concentrated in one contiguous urban area, but with a significant proportion in smaller population centers and a large rural area with few cases.

Project: The Washington State Department of Health (DOH) received PS12-1201 Category C funding in 2012 for a four-year demonstration project to use HIV surveillance data for linkage and re-engagement to HIV medical care. Linkage efforts focused on all cases within Seattle King County that received HIV Partner Services, gay and bisexual men throughout the state, and men who received an HIV test via STD partner services. Surveillance data were used to investigate more than 3500 reported cases with unknown care status to determine their current residence and status, then facilitate re-engagement in care for those living in Washington and not receiving medical care. Re-engagement services were offered by HIV disease investigators (DIS) and via referral to a specialized intervention, the Care and ART Promotion Program (CAPP). In Seattle, public health staff completed disease investigations and provided CAPP. Outside of King County services provided through partnership with DOH Field Services staff and DIS in selected health jurisdictions. DOH funded community based organizations in these

jurisdictions to provide CAPP. A specialized data system, Locating Out of Care (LOOC) supported project activities.

Results: Accuracy of HIV surveillance data in Washington State improved because of project activities that filled gaps and expunged inaccurate or obsolete information. Approximately 10 percent of persons with unknown care status received re-engagement assistance. Washington enhanced its modelling of the state HIV continuum, and now uses this information to guide integrated statewide prevention and care services. Washington recognized an ongoing role for using surveillance data to guide and document linkage and re-engagement in HIV medical care for PLWH and plans to use the infrastructure created to assess PrEP uptake across the state. The LOOC functionality will be incorporated in a new department-wide data system now being developed, to ensure continuation of activities begun for the demonstration project.

Lessons Learned: Active surveillance and robust integration of HIV prevention and care services, STD services, and epidemiology is practical and necessary for state and metropolitan health departments to effectively manage resources to achieve maximum population impact on the HIV epidemic in their jurisdictions. Significant time, will, and money are needed to build this capability. Integrated data from multiple sources is indispensable and an adequate information system that supports fieldwork and population impact must be developed and maintained. Overcoming barriers to collaboration with internal and external partners is feasible, but requires focused attention by program developers.

Session C11 - The Care and Prevention in the US (CAPUS) Demonstration Project: CAPUS

Room: A708 (Atlanta Marriott Marquis)

Abstract 1462 - CAPUS Panel on Addressing Social and Structural Factors Affecting Racial and Ethnic Minorities' Testing, Linkage to, Retention in and Re-engagement with Care and Prevention

Author(s): *Samuel Burgess*

Issue: HIV disparities based on race, sexual orientation, and gender identity persist in Louisiana. In 2011, the HIV rate for African Americans in Louisiana was over seven times higher than among Whites, and the percentage of adult HIV diagnoses attributed to MSM peaked at 53% from a low of 40% in 2002. Transgender women that were tested for HIV in 2011 were 4 times more likely to have a positive result than males that were tested. By focusing on institutional racism, homophobia, and transphobia, the health department and partners are addressing these inequities and working towards building anti-racist and anti-heterosexist institutions. The Louisiana Office of Public Health-STD/HIV Program (SHP), with three community partners, have worked on a capacity building strategy to address these disparities for three years as a part of the CAPUS grant.

Setting: Staff from SHP and three CBOs in New Orleans and Baton Rouge participated in a process of workshops and strategic planning in an effort to reduce HIV inequities related to race, sexual orientation, and gender identity.

Project: The Louisiana STD/HIV Program has undertaken a Capacity Building Strategy over the past 2.5 years, which includes two series of workshops (Undoing Racism and Deconstructing Homophobia and Transphobia) that have been provided to staff at 4 agencies.

Results: From June 2013-September 2014, 200 people have attended 12 workshops related to structural racism, homophobia, and transphobia. Individual participant responses to pre and post workshop surveys from all Undoing Racism and Deconstructing Homophobia and Transphobia yielded overwhelmingly positive results. An increase was demonstrated in the following areas: knowledge of institutional racism, homophobia, and transphobia, self-efficacy to engage in improving institutional racism, homophobia, and transphobia, self-efficacy to explain racial and heterosexual privilege, and intentions to address bias related to racism, homophobia, and transphobia.

Lessons Learned: Leadership involvement and buy-in from organizations are crucial to the success of this type of process, and there were several instances in which those leading the strategy needed to pause and take stock of staff's reactions to the content. Understanding privilege was key to moving conversations forward. Working toward equity is a serious time commitment, and requires a slow, deliberate pace so that all staff understand the framework of structural oppression. In addition to focusing prevention efforts on individual behavior change and biomedical interventions, we learned that these HIV prevention strategies must be coupled with an understanding of the systemic racism and heterosexism impacting clients' lives.

Abstract 1501 - Linkage and Re-engagement of HIV Clients Using HIV Surveillance Data in Illinois
Author(s): *Fangchao Ma, Annie McGowan, Curt Hicks, Jamie Gates, Cheryl Ward, Andrea Danner*

Issue: Previously HIV surveillance data had been used mainly to provide a framework for targeted HIV prevention planning. A recent paradigm shift in HIV prevention has increased efforts to focus on prevention for positives, particularly in the areas of linkage to care, care retention, and care reengagement. The use of HIV surveillance and other data sources has expanded to identify individuals with unmet needs of HIV care and to link them to HIV case management and treatment. This report describes and discusses Surveillance Based Services (SBS), a data to care project that the HIV/AIDS Section at Illinois Department of Public Health (IDPH) initiated in 2013.

Setting: The SBS project is managed by IDPH and carried out by local health departments (LHDs) and IDPH-funded Community Based Organizations (CBOs) through the use of an electronic system managed by Groupware Technologies.

Project: The SBS project aims to link individuals who are newly-diagnosed with HIV, fallen out of care, or co-infected with an STD, to HIV case management and treatment. Using eHARS laboratory data, supplemented by Ryan White Care and Medicaid data, individuals eligible to receive SBS are identified and transferred securely through an electronic system called Provide Enterprise to local health departments (LHDs) and IDPH-funded Community Based Organizations (CBOs) throughout the state, based on the patient's county of residence. Prevention counselors from those LHDs and CBOs then begin the investigation and casework to attempt to re-engage or link patients to care. Services provided by the

prevention counselors include partner services, risk reduction counseling, and referrals to Ryan White Case Management and Medical Care.

All individuals involved in the SBS project must receive data security and confidentiality training developed by IDPH before being granted access to the confidential data.

Results: Since the inception of the program, 3,208 cases have been investigated and completed. Of those, 802 patients accepted some form of service. Based on data documented in Provide Enterprise, 88 patients were referred to case management and 71 attended an appointment with a medical provider. A total of 259 notifiable partners were identified, and 112 at-risk partners were notified.

Lessons Learned: Despite conducting thorough investigations, counselors sometimes were unable to offer services to the clients due to the patient found to be living outside of the LHD or CBO's jurisdiction, invalid contact information, unresponsiveness, or the patient being incarcerated. Counselors also face a variety of scenarios when making first contact; for example, a patient may not be aware of his or her HIV status, may feel that their privacy is being violated, or, in very rare cases, may not actually be HIV positive due to reporting errors. Communication between providers and program administrators, ongoing program guidance, proper data entry training, and monthly SBS conference calls helped to mitigate problems.

Abstract 1503 - Partnering HIV Surveillance and Prevention to Identify and Provide Linkage to Care for Out of Care Diagnosed Positive Individuals

Author(s): *Melissa Morrison, Dana Hughes, Thomas Shavor, Shanell McGoy, Carolyn Wester*

Issue: HIV Continuum of Care data reveal that 44% of Tennessee's diagnosed HIV positive individuals in TN are not engaged in HIV medical care.

Setting: The Tennessee Department of Health's (TDH's) HIV Surveillance Program partnered with a team of 5 CAPUS disease intervention specialists (DIS) who were strategically located to provide re-engagement services across Tennessee (Memphis, Nashville, Middle Tennessee, and East Tennessee).

Project: Through the CAPUS demonstration project, TDH created a 'data-to-care' feedback loop, in which the HIV Surveillance data was utilized to identify known HIV positive individuals who had been out of care for more than 1 year. CAPUS DIS were tasked with contacting these individuals and providing navigation into care.

HIV-1 RNA viral load and CD4 count data entered into eHARS (enhanced HIV/AIDS Reporting System) served as evidence of being in care. The data-to-care list was constructed by including individuals with any evidence of care in the prior 2 years and then removing any individuals with evidence of care within the past year or believed to have died or moved out of state. Individuals remaining on the list were stratified by county of residence and distributed to CAPUS DIS covering those counties. CAPUS DIS re-engagement specialists then attempted to locate the individuals on their lists, provide patient-centered counseling and navigation to overcome barriers, and link these individuals to care. Details on how a list of client names was generated, DIS training, field experiences, reasons out of care, and how this program has helped improve HIV surveillance data and link individuals into HIV care will be covered in the presentation.

Results: From October 2013 until December 2014, 952 names were distributed to DIS re-engagement specialists. Nineteen percent (169) were determined to be deceased or out of jurisdiction. Of the 783 remaining names, 73% (568) were contacted or investigated, and 57% (444) were either navigated back into care or investigated and found to already be in care.

Lessons Learned: The partnering of TDH's HIV surveillance and prevention programs resulted in identifying and linking known HIV positive individuals who had been out of care back into care. It also provided valuable information regarding the reasons people living with diagnosed HIV in TN have been out of care. Additionally, the program had the unintended benefit of strengthening HIV surveillance data by enabling TDH to identify laboratories failing to report HIV viral load and CD4 data and correct those deficiencies. TDH's CAPUS data-to-care program has improved both the outcomes and the accuracy of TN's HIV Continuum of Care.

Abstract 1591 - Improving Retention in Care and Viral Suppression through Housing and Job Training for Recently Incarcerated HIV Positive Persons

Author(s): *Susan Carr, Marolyn Edmonds*

Issue: There is a lack of appropriate and affordable housing for People Living with HIV/AIDS after release from incarceration which jeopardizes retention in medical care; therefore, a transitional housing program was established to provide housing for eligible individuals upon release from Virginia correctional facilities.

Setting: There are three transitional houses located in Newport News, Virginia. An offender must have been incarcerated for at least three years, be HIV positive, and be considered homeless upon release in order to be eligible for this program. Once eligibility is determined by Department of Corrections (DOC) facility discharge staff, a referral is made to the Minority AIDS Support Services (MASS) case manager. The offender is then enrolled in the Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) program. CHARLI is an 18 month case management program that continues after the individual transitions out of the house.

Project: The transitional housing program provides a room for a recently released offender for up to 6 months. Medication adherence and medical appointment attendance are mandatory for program participants. Staff accompanies residents to their first few medical appointments to overcome possible barriers of going alone. Residents are required to complete a comprehensive skills building curriculum that facilitates assimilation back into the community, gaining employment, and development of skills necessary to live independently. Elements included are a weekly substance abuse group and a biweekly life skills class to assist residents to share goal setting, life experiences, and how to approach stressors of daily life. This gives residents an opportunity to discuss how things have changed over the years of incarceration and how to become a contributing member of society. Transportation is provided to medical and other necessary appointments such as AA and NA groups, social services, and job interviews. A Culinary Arts Training program was recently added that will provide participants an

employable skill to support better access to stable housing. Two additional CHARLI contractors were recently funded to expand the CAPUS housing program for PLWHA.

Results: Twenty two (22) residents lived in transitional houses over 18 months, from July 2013 through December 2014. 85% of the 22 clients completed the Comprehensive Life Skills Curriculum. One (1) person died and four (4) returned to jail. Of the remaining clients 94% (16) are in medical care. 82% (14) clients have transitioned into stable housing, and 82% (14) have a viral load less than 200. Five former residents enrolled in and completed the Culinary Training Program and 60 % are currently employed in the culinary arts field. Six (6) residents are participating in the second class and due to receive certificates in June 2015.

Lessons Learned: It was important to emphasize to DOC personnel that the inmates referred must be self-sufficient without need of nursing care. MASS learned: 1) it was important to ensure the rules were followed to avoid undermining success of the other residents; 2) there is a need for residents to gain an employable skill to support their ability to live independently, thus, the Culinary Training Program was added in August 2014.

Session C12 - Creating System Changes to Advance the Goals of the HIV Care Continuum: The Special Projects of National Significance Model

Room: A706 (Atlanta Marriott Marquis)

Abstract 1996 - Enhancing Re-engagement and Retention in Care in Massachusetts through Health Department-Medical Center Partnerships

Author(s): *Linda Goldman, Sophie Lewis, Betsey John, J. Christian Hague, Kshema Nagavedu, Rebecca Hawrusik, Jonathan Hall, Randie Kutzen, Gerald James, Abbe Muller*

Issue: Of 18,570 individuals diagnosed with HIV through 2012 and living with HIV in Massachusetts as of 12/31/13, approximately 61% are documented to be retained in care. Among those with 2 laboratory results at least 3 months apart, 87% are virally suppressed. The Massachusetts Department of Public Health (MDPH) is working with 2 hospitals and 6 community health centers in high-prevalence cities to examine the impact of 2 service and data-sharing interventions to improve retention in care. These interventions comprise the Strategic Peer-Enhanced Care and Treatment Retention Model (SPECTRuM) and are funded by the HRSA SPNS Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative.

Setting: The HIV/AIDS Surveillance Program (MHASP) and Office of HIV/AIDS (OHA) reside in MDPH's Bureau of Infectious Disease. MHASP and OHA partner with Boston Medical Center (BMC) to pilot SPECTRuM in Greater Boston. BMC is an urban hospital that treats over 1,700 HIV+ patients, including a high number of Hispanic/Latino and African-American and other Black individuals, populations disproportionately impacted by HIV in Massachusetts.¹ BMC identifies many new HIV diagnoses each year (63 in 2013) and serves some of the state's most vulnerable residents, with a high proportion of low income, racial/ethnic minority, and non-US born patients.

1. <http://www.mass.gov/eohhs/docs/dph/aids/2014-profiles/communities-of-color.pdf>

Project: For the service intervention, BMC staff recruit participants based on recent HIV diagnosis and bio-psychosocial acuity of need. An HIV+ peer and a nurse provide site and field-based retention services to approximately 20 clients during a 6-12 month period, with a goal of reducing service acuity. For the data intervention, MHASP sends monthly lists to BMC of patients who appear to be out of care (OOC) based on a gap of 180 days or more in the receipt of CD4+ T-cell count or HIV viral load laboratory results, and lists of patients with a detectable viral load. BMC reconciles the data to identify patients who are truly out of care and/or who may need care team follow-up, and provides monthly feedback to MHASP.

Results: Of the 976 individuals identified on BMC's OOC line list between 6/13 and 5/14, 30% were determined to be truly out of care. Of these individuals, 40% had a subsequent HIV lab result after two months, 53% after three months, and 70% after 6 months. During the same time frame, the peer/nurse team enrolled 33 clients, 17 of whom had graduated from the program by 12/14.

Lessons Learned: The interventions produced by this Health Department-Hospital partnership have been effective tools to help identify, re-engage, and retain high-acuity patients.

Abstract 2074 - Creating a Safety Net for the HIV Continuum of Care in NC

Author(s): *E Quinlivan, Kristen Sullivan, Jenna Donovan, Aimee Wilkin, Nada Fadul, Arlene Sena, Heidi Swygard, Victoria Mobley, Heather Parnell, Amy Heine*

Issue: The National HIV/AIDS Strategy was drafted to identify opportunities to improve HIV care in the US. Minority group health disparities in care and national low rates of viral load suppression were identified as significant issues requiring both improved coordination between existing services and development of new efforts to retain PLWH in care.

Setting: In 2011 (at time of project initiation), 36500 PLWH were estimated to reside in NC and 24,923 had been diagnosed (68%). Using surveillance data, of the diagnosed PLWH, 44% had a single medical visit in the prior year, 31% were retained in care (2 visits / year, >90 days apart) and 30% had VLs. This is an underestimate due to lack of data on patient migration, deaths, and accessibility of laboratory testing at the time.

Project: Using HRSA funds, a statewide response to the NHAS was developed for NC (NC-LINK) to address gaps in the NC HIV Continuum of Care, using learning collaboratives, pilot programs followed by dissemination and expansion of successful approaches (Mar2013 to Jan2015). Quantitative data regarding the implementation processes were collected. Descriptive process analyses were prepared.

Results: Pilot projects included testing initiatives, clinic-prepared out-of-care lists for retention outreach and a statewide public health bridge counseling team (SBC) for provision of field services to PLWH. The 23 month expansion phase was analyzed as 4 intervals (1st, 2nd, 3rd =6m; 4th=5m). Two testing interventions were discontinued (house party testing and ED testing). Four continuum of care needs were addressed: 1)diagnosis, 2)entry to care, 3)out-of-care, 4)lost-to-care by providing these services: 1)testing, 2)linkage, 3)retention, 4)re-engagement. Clinic-based testing was performed at 2 sites and

averaged 2.5 persons tested/month (HIV+: 7%). The SBCs initiated linkage services if the 1st HIV medical appointment after the case was reported was not kept. Approximately, 24 referrals /month (20% of the new HIV cases) required linkage services during the last interval. Retention services (calls, letters, database searches) were provided by clinic staff based on monthly internal out-of-care lists (no visit in prior 6-9 months and no future appointment scheduled). The retention intervention expanded to 5 clinics and from 33 to 66 PLWH/month. Lost-to-care PLWH (those who were not re-engaged by clinic staff) were referred to a regional SBC team member for additional contact attempts including field visits. Re-engagement referrals were received for 29 PLWH/ month in the 1st time period and ending with 100 PLWH /month in the final time period. As a marker of the health disparity experienced by persons lost-to-care, only half of the PLWH who were referred for re-engagement services had a marker of care in the prior year and less than 20% had a suppressed viral load.

Lessons Learned: Each transition point in the Continuum of Care presents challenges to PLWH. A coordinated set of interventions that create a statewide safety net may mitigate the difficulties presented and allow PLWH to fully access care at all points in the HIV continuum.

Abstract 2174 - Enhancing Linkage via Case Management Video Conferencing in Louisiana State Prisons: A SPNS Systems Linkages Initiative

Author(s): *Karissa Page, DeAnn Gruber*

Issue: Persons released from a correctional setting encounter many barriers that impede successful re-assimilation into the community. These same barriers can prove to be even greater for persons living with HIV (PLWH) because their ability to seek and be retained in HIV care may be jeopardized due to competing priorities, such as meeting the conditions of their parole, securing housing, employment, or transportation.

Setting: This initiative was implemented in nine Louisiana Department of Corrections' state prisons and eleven agencies that provide case management to PLWH in Louisiana. The intended audience is state or city Ryan White grantees, entities that conduct discharge planning in corrections, and HIV-related community based organizations.

Project: The Louisiana DHH Office of Public Health STD/HIV Program (SHP) provides pre-release medical and case management coordination for HIV-positive persons being discharged from state prison starting up to 180 days before a client's release. Pre-release services provided by SHP include access to ADAP, a referral to an HIV medical appointment, and referral to Ryan White case management services. Clients who elect to be referred to case management are given the option to participate in a video conference with a case management agency prior to release.

During the video conference, the client has the opportunity to virtually meet face-to-face with a case manager. This interaction provides the client with an opportunity to learn about the services offered by the agency, regardless of where they may choose to relocate in the state upon discharge.

Results: Since 8/29/13, 153 clients were offered the option to participate in a video conference, of which 145 consented (94.8%). Of those who consented, 93 clients have had a successful video

conference session (64.1%), 34 clients had an unsuccessful session (23.5%), and eight clients are awaiting their session to occur (9.0%). The most common reason for a client having an unsuccessful session is due to unexpected release date changes and insufficient time to then schedule a session.

Of the 87 clients who experienced a video conference and have been released from prison, 53 have linked to case management and HIV medical care (60.9%), five have linked to case management only (5.8%), one client has linked to HIV medical care only (1.2%), 17 clients are still within the 90 day time period and are being followed (19.5%), eight clients have exceeded the 90-day time period and are considered lost to care (9.2%), and one client has re-entered the correctional system within the 90 day time period (1.2%). Of clients who have completed the intervention (excluding the clients who are still being followed), the linkage rates to case management and HIV medical care are 82.9% and 77.1%, respectively.

Lessons Learned: Using telemedicine equipment to conduct video conferencing with case management services in the corrections setting is an innovative and promising strategy to enhance linkage efforts and provide clients with the opportunity to become more engaged in their HIV care and treatment.

Abstract 2238 - A Statewide System of Patient Navigation for Improving Linkage and Re-Engagement in HIV Care: The Virginia Experience

Author(s): *Anne Rhodes, Diana Jordan, Steve Bailey, Elaine Martin, Lauren Yerkes, Kate Gilmore*

Issue: The National HIV/AIDS Strategy called for a focus on increased access to care for persons living with HIV (PLWH), along with improvements in retention and viral suppression. Patient navigation (PN), which provides services to PLWH to address barriers to medical care, has been an effective tool for linkage and engagement and can reduce gaps in the HIV continuum of care.

Setting: The Virginia Department of Health received funding under the Special Projects of National Significance (SPNS) Systems Linkages grant in 2011 and under the Care and Prevention in the United States grant in 2012. Analyses show that of 24,877 persons living in Virginia at the end of 2013, less than half (39%) were retained in care and only 37% were virally suppressed.

Project: SPNS and CAPUS funding was utilized to established PN networks throughout the state which provided linkage, re-engagement and retention services for PLWH, with CAPUS focusing on 3 health regions and SPNS on the other 2 regions. While the SPNS model focused on the use of motivational interviewing techniques for client communication and progress, a community health worker curriculum was the training focus for CAPUS. All SPNS PN sites were medical providers, while CAPUS funded both medical providers and community-based organizations (CBOs). A statewide system of active referral was designed for initial referral to PNs from HIV testing sites and Disease Intervention Specialists (DIS).

Results: For persons served by PN, under either SPNS or CAPUS from 9/1/2013 to 11/29/2013 (n=90), 72.2% were retained in care in 2014 and 58% were virally suppressed in 2014. These results show a significant increase over the outcomes for all PLWH. The use of the active referral protocol also increased linkage rates for those newly diagnosed with HIV, which were 78% in 2013 and 82% in 2014.

Lessons Learned: The establishment of a patient navigation network has fostered collaboration among CBOs, DIS, and medical sites, and preliminary outcomes show the effectiveness of PN across the HIV continuum of care.

Session C13 - Getting to Work Expanding Employment and Housing in a Changing HIV Epidemic Initiative

Room: A705 (Atlanta Marriott Marquis)

Abstract 1638 - Getting to Work Expanding Employment and Housing in a Changing HIV Epidemic Initiative

Author(s): *Benjamin Ayers, Elizabeth Malloy, Dylan Orr*

Issue: AIDS/Service providers historically have not provided access to employment programs for individuals living with HIV/AIDS. In the early and mid-years of the epidemic, side effects of medications and the debilitating nature of the disease prevented individuals living with HIV/AIDS from participating in employment. As a result, HIV/AIDS service providers began to implement a service model focused on complete reliance on local and federal resources for housing, food, clothing, medical care, etc... The paradigm shift occurring in the epidemic today provides an opportunity for individuals living with HIV/AIDS to return or enter into the workforce system.

The Office of HIV/AIDS Housing conducted a yearlong pilot initiative that evaluated AIDS service providers who implemented employment programs, which aimed to assist HIV positive individuals enter or reenter the work force system. The initiative led to a two year long partnership with the U.S. Department of Labor and the U.S. Department of Justice, which resulted in developing an HIV and employment curriculum designed to educate HOPWA grantees on employment and HIV issues. The employment initiative is expected to assist in eliminating the old service model of complete beneficiary reliance on federal and local resources, and provides opportunities for beneficiaries to become self-sufficient and reduced their reliance on federal resources. A few of the topics covered in the curriculum include:

- The changing epidemic;
- Why employment is beneficial;
- Episodic disabilities;
- Reasonable accommodations;
- Benefits planning;
- SSI/SSDI and their employment incentives;
- Earned Income Disregard;
- Employment laws that protect beneficiaries and individuals with disabilities;
- The process flow for a beneficiary engaging in employment services;
- The process flow for organizations in developing employment programs;
- Work Force Investment boards and partnerships;
- WIA services and partnerships;
- Ticket to work programs and partnerships, and
- American Job Centers and partnerships.

Setting: National Marketing of HUD/DOL Employment Training Curriculum

Project: Getting to Work

Results: 1 year pilot initiative with 9 grantees resulted in 79 new local partnerships and 110 previously unemployed persons living with HIV receiving and maintaining employment.

Lessons Learned: People living with HIV want access to employment programs and can sustain employment. Low income persons living with HIV can enter/ re-enter the workforce without losing their public benefits by utilizing benefits planning tools such as: SSI/ SSDI employment incentives and earned income disregards. Persons living with HIV/AIDS can utilize labor protections under the law and can address/manage their HIV symptoms in the employment environment through reasonable accommodation requests. Individually both Employment and Housing have been proven to assist in preventing the spread of HIV by impacting improved health outcomes, lowering viral loads, increasing T-Cell counts, and reduce social service costs. This is an effective tool as a long-term strategy for stretching grant funds and serving additional households as well as preventing the spread of HIV.

Abstract 1688 - Reporting Outcomes From Three Innovative Programs Addressing Employment Needs Of People With HIV As A Social Determinant Of Health

Author(s): *Liza Conyers*

Issue: In its ongoing effort to improve health outcomes and increase engagement in care, the White House Office of National AIDS Policy has recently included the goal of expanding access to employment and vocational services as one of its top 10 priorities. The inclusion of employment as a top priority is supported by research. For example, a recent meta-analysis of 23 studies examining the relationship between being employed and achieving optimal adherence to ART found that employed individuals are 39% more likely to have optimal adherence than those who are not working (ILO, 2013). Furthermore, use versus non-use of vocational rehabilitation services is associated with key outcomes of the National HIV/AIDS Strategy (Conyers and Boomer, 2014). In light of the role that vocational services and employment can play as a social determinant of health, this presentation will provide a brief overview of three projects including a report of key outcomes from the program evaluations and qualitative and/or quantitative analyses of outcomes.

Setting: This presentation will highlight three projects that address the integration of employment needs/services in HIV service provision in varied geographical settings and contexts. One setting is within housing services for people with HIV in Rochester and Albany, New York. The second setting involves PWH living in Pennsylvania (PA) receiving services funded by the PA Department of Health and the third setting is a project addressing the vocational development and HIV prevention needs of African American , primarily from the South (e.g., Texas, South Carolina, Washington DC).

Project: The first project to be discussed is the Foundations for Living project in upstate New York. This project provided employment services to individuals receiving housing subsidies and evaluated employment, health and prevention outcomes. The second project integrated vocational assessments

into the Pennsylvania Department of Health Unmet Needs Assessment and the third is the development of Common Threads, an integrated HIV employment and prevention intervention for African American women primarily from the south.

Results: Key outcomes from each of the above listed projects will be reported to illustrate the role of employment and employment services as a social determinant of health related to the NHAS. Outcomes include reduction in viral load, engagement in care and HIV prevention. Discussion will also highlight the challenges of research and service provision in this area and the need to evaluate and consider the impact of negative outcomes.

Lessons Learned: Employment is a social determinant of health and we need to better understand the employment conditions that facilitate improved health and prevention outcomes and those that do not. Although PWH want or need to work, many face significant barriers and are not familiar with the services available to address these barriers. There is a need for more services in this area and for the evaluation of these services to include an assessment of the health and prevention outcomes associated with employment status and employment transitions.

Abstract 1720 - Building HIV Care and Prevention Responses to Employment Needs Across the U.S.: Activating Complementary HIV, Workforce Development and Vocational Rehabilitation Services

Author(s): *Mark Misrok*

Issue: Poverty, unemployment, and underemployment are key social and economic determinants of health, and critically influence outcomes along the HIV care continuum. Achievement of the goals of the National HIV/AIDS Strategy - increasing access to care and improving HIV health outcomes, reducing HIV-related health disparities, and reducing new HIV infections - requires both medical and structural interventions, including strategies to prevent unnecessary loss of employment, and reduce poverty, unemployment and underemployment among people living with or at higher risk for HIV. The integration of service responses to employment needs in HIV care and prevention services is needed, as well as coordination of HIV providers with workforce development, vocational rehabilitation and other service systems.

Setting: Development of policy and service responses to employment needs of people living with or at higher risk of HIV will be reviewed, including national, state, community and programmatic level initiatives. The report will include the perspective of an individual involved in advancing HIV employment initiatives alongside changes in the HIV epidemic, under mentorship from and in collaboration with diverse experts, designed to encourage consideration of opportunities available in various communities to individuals, organizations and communities.

Project: The individual perspective provided in this presentation will review lessons learned in the development of community-based employment services for people living with HIV, ahead of prioritization by government agencies or community planning bodies, but with service demand from individuals living with HIV. The focus will expand from program development within a community-based organization to efforts among a researchers, practitioners, policymakers and advocates initially working

to understand and address employment needs of people living with HIV, extending to the needs of communities at higher risk of HIV infection.

Results: Through the development of a community-based vocational rehabilitation program for people living with HIV, and activities of a coalition focused on HIV and employment services, research, education and advocacy at local, state and national levels, system change is developing to increase employment opportunities for people living with or at higher risk of HIV. An increased understanding has developed of effective cross-sector collaboration and coordination strategies among HIV, workforce development and vocational rehabilitation programs. Employment and economic, as well as HIV health and prevention outcomes achieved benefit individuals, families, and communities and contribute to sustainability of under-resourced service initiatives.

Lessons Learned: A broad range of individuals need assistance gaining and retaining employment that supports maintaining and improving their health and economic stability. Interventions have been effective based on expansion of the HIV continuum of care and prevention services. Effective service approaches have also been focused on collaboration and coordination between HIV care and prevention providers and existing service systems including the state-federal vocational rehabilitation system for individuals with disabilities, and the workforce development system designed for all jobseekers, including those with or without a range of barriers to employment including disabilities or chronic health conditions.

Abstract 2127 - Overview of Nationwide Vocational Rehabilitation Programming for People with HIV/AIDS, and Reflections Regarding Reframing Employment as Treatment Modality

Author(s): *Sandy DeRobertis*

Issue: 1) How can we increase participation of PLWHAs within Vocational Rehabilitation (VR)- Supported Employment(SE) programs? 2) Should employment be considered a treatment modality? Note: DeRobertis was the director of Multitasking Systems (MTS), the first PLWHA Workforce Program in the U.S., from 1991 to 1993. MTS commenced operations in 1989 with funding from the Rehabilitation Services Administration (RSA) and the NYS VR Program. Linda Laubenstein, M.D. (1947 – 1992) was a founding member and president. Laubenstein, published the first article linking AIDS with Kaposi's sarcoma. Kramer's play, "The Normal Heart," features a wheelchair-using doctor, Emma Brookner (based on Laubenstein). MTS' motto was, "Employment is a treatment that works."

Setting: RSA oversees the State VR - SE Services programs. RSA's Fiscal Year (FY) 2013 appropriations were \$3,435,385,000. RSA funded State VR Agencies reported 182,663 employment outcomes in FY 2013; of these over 49% worked 35+ weekly hours with a mean hourly wage of \$11.40. 1,002,096 consumers had ongoing employment plans at year end.

Project: Under the VR/SE Services Programs, RSA provides grants to assist States in operating statewide programs to help individuals with disabilities who have substantial disability-specific barriers to employment, including PLWHAs who have one or more disabilities specific to HIV, i.e., HIV-associated neurocognitive disorders, or other disabilities, regardless of whether related to HIV, i.e., substance abuse. HIV+ serostatus doesn't make an individual eligible. Rather, individuals with HIV/AIDS must meet

the following criteria: 1) Documentation establishing a disability diagnosis; 2) the resulting medical or psychological disability must cause a substantial employment handicap; and, 3) there must be a reasonable expectation that VR services will result in gainful employment.

Results: HIV/AIDS was reported on the RSA-99 ("911") in FY 2013 as the primary or secondary disability cause for 0.5% of those served. UNICEF/WHO estimates 0.6% of the U.S. population aged 15 – 49 to be HIV+. RSA's coding systems doesn't accurately report the number of PLWHAs served. State VR Agencies reported Drug Abuse or Dependence (other than alcohol) on the 911 as the primary or secondary disability cause for 7.0% of all consumers served in FY 2013. A significant percentage of them were likewise HIV+.

Lessons Learned: In a NYT article (3/7/89), "Concern Seeks Workers with AIDS," Laubenstein stated: "Patients do much better when they can work." "We noticed that patients were either fired ... or ... unable to continue in physically demanding or psychologically stressful jobs." I conducted research as MTS' director regarding 187 of 198 PLWHAs served between 11/12/91 and 4/30/92. 45.2%, 23.7% and 22.5%, of them, respectively, were Black, Latino and female; compared to the NYC demographics: 36% Black, 29% Latino and 16% female. HIV was frequently not the primary VR impediment. Rather, poverty, homelessness, discrimination, lack of job skills and illiteracy, conditions that predated HIV/AIDS, were their primary vocational impediments. Given the disproportionate impact of HIV/AIDS today, including low levels of viral suppression in the African American community, MTS' findings are particularly relevant today. It is imperative that the VR/SE Service Programs and the HIV/AIDS Services community, increase PLWHA outreach, particularly within disproportionately impacted communities.

Session C29 - Innovative Partner Services Implementation

Room: A601 (Atlanta Marriott Marquis)

Abstract 1484 - Improving Retention in HIV Care through New York's Expanded Partner Services Pilot: Results of a 1 Year Pilot

Author(s): *James Tesoriero, Britney Johnson, Jennifer Cukrovany, Brenda Moncur, Kathleen Bogucki, Bridget Anderson, Megan Johnson*

Background: There were an estimated 132,000 persons living with diagnosed HIV infection (PLWDHI) in NYS at the end of 2012. Surveillance data suggest that many are not accessing HIV medical care: 65% of the 132,000 PLWDHI received HIV care during 2012; 56% received continuous HIV care; and 51% achieved viral suppression. Data to care initiatives, including those that use HIV surveillance laboratory data to identify and intervene with PLWDHI who appear to be out-of-care (OOC), are needed to improve the health of PLWDHI and to reduce further transmission.

Methods: The Expanded Partner Services (ExPS) Pilot used HIV surveillance data to identify PLWDHI presumed to be OOC. Attempts to locate these individuals were initiated, beginning with the last known medical provider. OOC Individuals were targeted for expanded PS, with the primary objective being re-engagement in HIV care. Individuals were interviewed by specially trained Advocates to identify barriers to accessing care and offered comprehensive PS, including linkage to medical care, supportive services, risk reduction counseling and safer sex supplies. Identified partners were also contacted and

offered HIV/STD testing. The ExPS Pilot was conducted September 2013 through August 2014 in four upstate NYS counties: Erie, Monroe, Onondaga, and Westchester.

Results: 1,154 OOC assignments were issued during the pilot, with 85% (n=985) located. Twenty two percent of located cases (n=222) were verified as current to care, while 39% (n=386) were no longer residing within a pilot county jurisdiction. An additional 133 cases (14%) were deceased, but not yet captured by the surveillance system; 11 cases (2%) were closed for other reasons. This left 233 cases (24%) confirmed to be out-of-care, alive, and residing within a pilot county jurisdiction. ExPS advocates successfully relinked to HIV medical care 71% of these cases (n=166). Age was significantly correlated (P<.0001) with successful reengagement: those aged 20-29 experienced the lowest relinkage success (55%); those over age 60 had the highest relinkage (94%). Non-Hispanics were significantly more likely to relink to care than Hispanics (P<.05). Reengagement success did not differ significantly by sex. The most frequently identified reasons for being out of care included day-to-day responsibilities (including work and family commitments) and feeling healthy. Other commonly cited barriers included feeling depressed and lack of medical insurance. Routinely reported surveillance laboratory data revealed that relinked individuals were significantly more likely (P<.0001) to be retained in care, with 93% of relinked cases having at least one CD4 or viral load test conducted following initial relinkage, compared to 51% of those who refused relinkage assistance.

Conclusions/Implications: New York's ExPS Pilot was successful in its primary objective of reengaging OOC PLWDHI in medical care. Most of the barriers to care identified are addressable through patient education and by connection to the state's comprehensive HIV prevention and health care infrastructure. The pilot also provided insight into laboratory reporting exemptions (e.g., Clinical Trials are not reportable), as well as highlighting avenues for improving the quality of data collected via traditional partner services and surveillance systems. The success of the pilot has resulted in statewide expansion of the initiative in 2015.

Abstract 1651 - Leveraging Transferable Skills of Highly Trained STD Partner Services Staff for Effective Linkage of Persons with HIV to Care

Author(s): *Greg Mehlhaff, Denise Tafoya, Julie Dombrowski, Matthew Golden, Alice Gandelman, Linda DeSantis*

Issue: NHAS, HIP and AAPPS all highlight the critical importance of Linkage to HIV Care for PLWH. Linkage is the first and most critical step to increasing the number of individuals in the community with undetectable viral loads. In many public health settings funding restrictions and program consolidation are creating the need to expand the skills of STD PS staff (DIS, PHA) to facilitate linkage to HIV care for newly diagnosed PLWH as part of PS. The core skills are present for conducting interviews and eliciting partners through previous training from ISTDI or Passport to Partner Services. Additional training for DIS who have moved into expanded field services is needed to facilitate the paradigm shift from one-time partner services to building longer term relationships with patients to assure initial linkage and maintenance in care.

Setting: Collaborative project between UW CBA and the CA DISTC to develop a Linkage to Care curriculum for DIS and other linkage staff. The intent of the training is to build capacity to assure initial

linkage and PS activities are conducted in a manner that will establish the foundation for continued successful interactions with services along the continuum of care. The training will be available to state and local jurisdictions implementing Linkage to Care programs or seeking to enhance existing programs.

Project: CA DISTC assessed the training needs through shadowing and interviews of Public Health of Seattle Kings County (PHSKC) staff conducting Linkage to Care PS services. Other evidence of need was gathered by UW from several jurisdictions comprising a community of practice group for linkage using surveillance data, as well as through consultation with other jurisdictions implementing linkage programs. Content, tools and documents have been used and adapted from the Data to Care page at <http://www.effectiveinterventions.org> and the Data to Care Basecamp site created by JSI and maintained by UW to gather tools and documents used by the various jurisdictions involved in the original JSI pilots and the ongoing UW community of practice.

Results: A curriculum addressing the key skills and awareness building needed to prepare previously trained STD PS staff is in development and will be piloted in at least two jurisdictions. This staff with highly transferable skills is able to fulfill program needs more quickly at a much lower investment in training and capacity building than by hiring and building capacity in new staff. Curriculum development process, course content outline and participant evaluation results from pilots will be presented.

Lessons Learned: Linkage to Care capacity development will continue to grow in demand as more jurisdictions begin to initiate or expand their efforts in this area. CDC DSTDP recently distributed and dear colleague letter “recommending” funded programs implement Linkage to Care programs. It is likely this will become a requirement in the future. Developing tools to quickly and effectively build staff capacity will be invaluable in facilitating implementation of Linkage to Care programs nationally.

Abstract 2397 - Implementing Prioritized HIV Linkage-to-Care and Partner Services Among Individuals with High HIV Viral Load in Baltimore, Maryland, USA: Results from a Pilot Program

Author(s): *Christina Schumacher, Michelle Joe, Christina Ramsey, Patrick Chaulk, Amelia Greiner Safi, Jacky Jennings*

Background: Because of increased transmission potential, the US Centers for Disease Control and Prevention(CDC) recommends prioritizing high HIV viral load (>50,000 copies/mL, HVL) individuals for routine follow-up services, including linkage-to-care and partner services. However, little guidance exists on operationalizing this recommendation. In June 2014, the Baltimore City Health Department developed and implemented a pilot program to prioritize HVL individuals for follow-up services. The objective of this analysis is to describe the pilot program and evaluate process outcomes for follow-up services pre- and post-pilot program implementation.

Methods: This pilot program was modeled after a protocol for responding to congenital syphilis. Disease Intervention Specialists(DIS) were trained to locate, administer partner services interviews and link-to-care HVL individuals with increased urgency and effort compared to other HIV cases. A DIS supervisor reviewed each HVL case before closing to ensure adequate response and documentation. We used a pre-post design to evaluate the pilot and compared linkage-to-care and contact tracing

outcomes for HVL individuals post pilot implementation (post-pilot, June 2014-January 2015) to a similar time period prior to implementation (pre-pilot, June 2013-January 2014).

Results: There were 23 pre-pilot and 17 post-pilot HVL cases (n = 40). DIS were more likely to link HVL individuals to care (59% pre-pilot vs. 65% post-pilot), and complete partner services interviews (39% pre-pilot vs. 59% post-pilot). Among HVL individuals who completed interviews, DIS were more likely to obtain sex partner meeting place information (33% pre-pilot vs. 40% post-pilot) and locating information for disclosed sex partners (16% pre-pilot vs. 39% post-pilot) in the post-pilot period compared to the pre-pilot period.

Conclusions/Implications: This pilot program demonstrates one successful method to operationalize CDC guidelines regarding prioritization of HVL individuals. Future work will evaluate additional outcomes of this program, including HIV testing among sex partners and at sex partner meeting places disclosed by HVL individuals.

Abstract 2410 - HIV Case Finding Using Partner Services in a Low Prevalence State

Author(s): *Andrew Gans, John Murphy*

Issue: Partner Services (PS) is a proven high-impact HIV prevention intervention focusing on identifying, notifying and testing partners who may have been exposed through sex or needle sharing. It is effective because it works within a “pool of infection” with individuals who have had an HIV exposure. In areas with lower HIV prevalence, PS is more effective for case finding than strategies that aren’t targeted such as routine HIV testing. It is particularly valuable for individuals who might not elect to be tested due to stigma, lack of access to testing services, or lack of perceived risk.

Setting: New Mexico has several cities but is primarily rural and frontier. Because HIV prevalence is low, broad-based strategies to find undiagnosed individuals haven’t been effective. Several pilot projects that did routine HIV testing in hospital emergency rooms and with persons experiencing homelessness found a small number of new diagnoses. Targeted strategies such as PS work better.

Project: The New Mexico Department of Health was awarded a 4-year demonstration project grant under CDC PS12-1201, Category C to implement “Expanded HIV Partner Services (EHPS)”. EHPS had two methods to bring persons with HIV to a PS interview: 1) referral of newly diagnosed individuals reported to the state’s HIV surveillance program, and 2) referral of persons in ongoing HIV medical care and support services who had a new “sentinel” risk event. Sentinel events included a new STD diagnosis, mentioning a new sexual partner, and requesting assistance with HIV status disclosure. These referral streams drastically increased PS interviews. HIV Service Provider (HSP) organizations were provided with incentive payments for their work in referring clients with sentinel risk events, thereby normalizing PS and making it more integrated with ongoing HIV care.

Results: EHPS drastically increased PS activity and resulted in a significant increase in persons who were newly diagnosed with HIV. The number of persons interviewed for PS grew from just 95 individuals in 2011 (the last year prior to EHPS) to 168 in 2014, an increase of 77%. During the five years prior to EHPS, there was an average of 6.6 diagnoses annually via PS. During the first three years of EHPS, this

average increased by 127% to 15 new diagnoses per year. This targeted strategy had a very high yield for the effort, especially when compared with other methods such as targeted HIV testing. The state's targeted testing program finds only about four times this number of new diagnoses per year, despite being much larger in scope with between 10,000 and 11,000 HIV tests annually.

Lessons Learned: Targeted strategies such as PS are most effective for rural states and other areas with lower HIV prevalence, as they reach a pool of infection. Referral of newly diagnosed individuals by surveillance was the easiest policy change that led to the greatest impact for the proposed project. In contrast, referral of clients with new sentinel risk events was more difficult, as clinicians and case managers were not always aware of client risks and had to be motivated to make each referral.

Session C37 - Integrated Planning

Room: A602 (Atlanta Marriott Marquis)

Abstract 1595 - I Knew that We Would Become One: The Integration of Prevention, Care and Treatment in Broward County, Florida

Author(s): *Janelle Taveras, Shaundelyn Degraffenreidt*

Issue: Broward County Ryan White Part A Program and the Florida Department of Health in Broward County (DOH-Broward) HIV Prevention Program have taken an integrated approach to prevention and care. It's been reaffirmed in 2013 by a joint letter, where the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) expressed their support for integrated HIV prevention and care planning. Even with the support of integration, little guidance has been provided as to how best initiate the process. There is a need to engage stakeholders in the integration process, identify methodologies for integration, and showcase best practices for other jurisdictions to model.

The aim of integration in Broward County is to streamline HIV prevention and care planning in a manner that will enhance High Impact Prevention efforts for the highest risk populations and best address the continuum of Care for those infected with HIV to create a coordinated response to the HIV epidemic and a seamless provision of HIV services.

Key Points: Collective Impact Methodology (CIM) was applied by the Part A Program and DOH-Broward, creating a mechanism by which the complex issues of achieving a coordinated response to the HIV epidemic could be addressed. This was achieved by using a systematic approach, including collaboration from the federal government, local and state health department, Part A Program, HIV providers and community participation. The processes of the CIM include the creation of a common goal, the creation of a plan, alignment and improvement, reflect and adapt and deciding next steps. Through the use of this methodology, the Ryan White HIV Planning Council (HIVPC) and the Broward County HIV Prevention Planning Council (BCHPPC) have aligned their planning efforts while remaining independent planning bodies to ensure integrated HIV prevention, screening, care, and treatment funding and services.

Implications: Successfully, the HIVPC and BCHPPC bodies have aligned their planning efforts to ensure integrated HIV prevention, screening, care, and treatment funding and services. Both the Ryan White Part A Program and DOH-Broward participate actively in the Joint Planning Committees to undertake

coordinated implementation of the Jurisdictional Prevention Plan and Part A Comprehensive Plan. More recently, the Integration of Prevention and Care in Broward County Committee (IC) was formed to develop various strategies of how to strengthen collaboration and coordination among all Ryan White Parts, HOPWA, and Prevention. The IC has agreed on a common mission and vision statement, identified Joint Planning and program activities to integrate prevention and care and developed detailed work plans to organize these activities. A joint newsletter known as “POZABILITIES” was also developed for the local community to introduce the efforts and continuously educate and inform on the integration of prevention and care in Broward County. Although the EMA has made significant progress, current opportunities exist to maximize these collaborative efforts by finding ways to engage and work to ensure both prevention and care data are understood and are used in decision making and planning. Next steps include establishing Funder and Advisory Group Forums and designing evaluation practices.

Abstract 1923 - Integrated Planning: Beyond the Bounds of Prevention and Care

Author(s): *Jillian Casey*

Issue: By 2014, 27 states reported maintaining integrated HIV planning groups despite the absence of any guidance on integrated planning. Twenty-two had also developed integrated plans. Today, since the release of a new guidance from CDC and HRSA, all jurisdictions are encouraged to construct a single plan that details how they will deploy resources from prevention, care, and other sources to optimize outcomes along the continuum. For jurisdictions that have not integrated their groups and have never developed an integrated plan, the new guidance requires a fundamental shift in how the health department and the community conceptualizes prevention and care. How can jurisdictions refine data-driven planning, and how can they better monitor and evaluate their planning processes to achieve the goals of the National HIV/AIDS Strategy? This conference is an opportune moment for peer learning and exchange to discuss and disseminate engaging models for integration that push past pre-conceived boundaries between prevention and care.

Key Points: Integrating planning groups and/or developing integrated products requires a shift in the mindset of CDC Community Planning Group and Ryan White Planning Council members accustomed to addressing the priorities of prevention or care. Health departments must generate buy-in for integration and facilitate a planning process that dissolves the barriers between CDC- and HRSA-funded activities. This roundtable will provide an opportunity to discuss how jurisdictions are interpreting and applying the new planning guidance - how they are moving beyond the confines of prevention and care to construct comprehensive plans to advance the goals of the National Strategy.

Implications: Time and time again health departments have called for peer-based technical assistance to modernize their programs. Now, as about half the nation has already embarked on the development of integrated plans, this gathering will allow those who have already embarked with integrated planning to share lessons learned, opportunities and challenges with those who are just beginning to work on integration. Participants will discuss how resources can be optimized to support a planning process that is grounded in epidemiology and bolstered by community input in order to address gaps along the care continuum.

Abstract 5026 - Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, CY2017 - 2021

Author(s): *Heather Hauck, Janet Cleveland, Steven Young*

Issue: The context of HIV prevention and care in the United States has evolved due to changes in the health care delivery system, chiefly the implementation of the Affordable Care Act (ACA), and recent advances in biomedical, behavioral, and structural strategies to prevent and control HIV in the US. The National HIV/AIDS Strategy have bolstered further integration of HIV prevention and care efforts and fostered new approaches to addressing barriers to HIV testing and care and treatment. Federal agencies, state and local health departments, community-based organizations, health care providers, and people living with HIV (PLWH) continue to use the goals of the National HIV/AIDS Strategy to measure progress toward the goals of preventing HIV, diagnosing people who do not know their HIV status, linking PLWH to care and treatment, retaining PLWH in care and treatment, prescribing HIV medication treatment to PLWH, and achieving viral suppression. 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 PLWH. Activities to collaborate are supported by HRSA and CDC and are a necessity in the development of an integrated plan. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States.

Setting: CDC DHAP and HRSA HAB funded Health Departments and planning bodies

Project: : In June 2015, the HRSA HIV/AIDS Bureau (HAB) and the CDC Division of HIV/AIDS Prevention (DHAP) released the guidance for the Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) to support Ryan White HIV/AIDS Part A, Part B, and Centers for Disease Control and Prevention (CDC) HIV prevention planning bodies and grantees with accelerating progress toward reaching the goals of the National HIV/AIDS Strategy. This new guidance format will allow jurisdictions to submit one Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), to CDC and HRSA. Submission of the Integrated HIV Prevention and Care Plan not only meets the legislative and programmatic requirements of CDC and HRSA, but also serves as a jurisdictional HIV/AIDS Strategy or roadmap.

Results: The session will provide attendees with an overview of the CDC and HRSA Integrated HIV Prevention and Care Plan guidance.

Lessons Learned: The integrated guidance will increase the efficiency of planning, evaluation, and quality improvement activities within health departments to meet the HIV prevention and care needs in their jurisdictions. Such an integrated guidance will: (1) reduce the burden of separate planning and reporting; (2) align reporting dates; (3) leverage resources across prevention and care; (4) utilize integrated epidemiologic profiles; and, (5) provide for consistency in program terms. The plan developed will result in a roadmap which directs how prevention and care services, interventions, and strategies will be delivered in the jurisdiction.

Track D

Session D01 - Prevention Models for Traditional and Non-Traditional Providers: Guidelines and Practices

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 2144 - African American HIV University, Science and Treatment College: A Model to Strengthen Organizational and Individual Capacity to Address HIV/AIDS in Black Communities

Author(s): *Rebekah Israel, Chassity Griffin, Gerald Garth*

Issue: According to the CDC, Black Americans have the most severe burden of HIV among all racial/ethnic groups in the nation. Research shows that lack of scientific literacy, stigma, conspiracy beliefs and misconceptions of HIV have presented considerable barriers to HIV prevention strategies among Black Americans. Additionally, the Black AIDS Institute's recent report on the state of HIV science and treatment literacy among the HIV workforce indicates that Black members of the workforce score significantly lower than their white counterparts on HIV knowledge questions. The African American HIV University (AAHU) Science and Treatment College (STC) is an intensive training and fellowship program that responds to these barriers in Black communities.

Setting: Any organization serving the Black community in the US can apply, priority is given to:

- (1)CBOs/ASOs serving Black communities at high risk
- (2)Organizations affiliated with the Act Against AIDS Leadership Initiative
- (3)Organizations whose missions align with the goals of the College
- (4)Organizations with a specialized HIV/AIDS treatment or adherence educator.

AAHU STC training modules are taught by faculty experts in Los Angeles, California at the Black AIDS Institute's facility and on the campus at the University of California, Los Angeles. Internship activities take place in the local communities from which the organizations/Fellows are applying.

Project: Aimed at strengthening organizational and individual capacity to address the HIV/AIDS epidemic in Black communities, AAHU STC is a comprehensive training fellowship and scholarship program. The program is designed to decrease stigma and misperception and increase the engagement of the Black community in HIV prevention and treatment services. The STC curriculum prepares community-based and AIDS service organizations (CBOs/ASOs) to serve as liaisons between people living with HIV/AIDS (PLWHA). STC focuses on HIV and its relationship to human biology, virology, pharmacokinetics, epidemiology, and treatment strategies.

Four Training Modules include:

- Training 1: Science Academy (30 Days),
- Training 2: Program Planning, Implementation, & Evaluation (7 Days),
- Training 3: Community Mobilization (7 Days),
- Training 4: Advanced Science and Presentation Skills (7 days).

During the four structured 60-90 day internships, Fellows apply the skills and knowledge gained during trainings. Internships allow Fellows to demonstrate proficiency in executing key components of each training that establishes or contributes to a Black Treatment Advocates Network (BTAN).

Results: An evaluation of the 2013-2014 AAHU STC cohort reveals a substantial increase of HIV science and treatment literacy among the Fellows (38% increase), their organizations (54% increase) and the communities they serve (42% increase). Fellows reported being more prepared to educate their organizations and communities on HIV science, provide exemplary linkage to care services to their clients and implement HIV programming at the local and regional levels due to skills learned at AAHU STC.

Lessons Learned: AAHU is a successful model in improving science and treatment literacy of Black HIV/AIDS workforce and organizations serving Black PLWHA. AAHU STC incorporates UNAIDS' capacity building recommendations by utilizing both long and short term training and leadership strategies. Additionally, AAHU STC responds to the National HIV/AIDS Strategy's charge to increase HIV education among those serving highly-impacted communities.

Abstract 2282 - Public Health Detailing: A Strategy on the Path to Improving Population Health
Author(s): *Susan Myers, Kirsten Durzy*

Issue: The Centers for Disease Control and Prevention (CDC) recommend that everyone between the ages of 13 and 64 be tested for HIV at least once in their lifetime. In New Hampshire, 50% of people who are newly diagnosed with HIV infection develop AIDS within one year of their diagnosis, indicating they have had the virus in their blood for a significant period of time. Increasing routine HIV screening initiatives within the medical home will assist in identifying HIV-positive clients who may be unaware of their infection. Early identification will ensure clients are linked with appropriate treatment, as well as prevention education and partner services, reducing the likelihood of virus transmission.

Setting: The NH DPHS Bureau of Infectious Disease Control launched a Public Health Detailing (PHD) Program in 2014. The goals of the program are to, 1) Improve prevention, screening and management of infectious diseases, 2) Expand the scope and reach of infectious disease prevention services within existing health care programs, and 3) Build partnerships with primary care to improve population health. A Public Health Nurse conducts visits with primary care physicians and staff in order to provide relevant data, clinical information and evidence-based recommendations.

Project: The PHD Program promotes evidence-based recommendations through educational outreach to clinicians. The nurse also partners with the clinician to enhance TB testing/treatment and promote timely notification of reportable diseases. In addition, the PH Detailing program allows the opportunity to address emerging issues, such as Outbreak focused information or PrEp treatment in a timely manner. This presentation will highlight the development, implementation and outcomes evaluation of the Public Health Detailing Program.

Results: Since October, 2014, a total of 48 detailing visits were conducted, with 156 providers receiving education or technical assistance. Currently, 21% of the sites are partnering with the NH DPHS on

follow-up presentations/projects. Based on data from the initial 6 months, 55% of providers visited are not routinely offering HIV testing to their patients and 65% are not routinely offering Hepatitis C testing to patients born between 1945-1965. These data underscore the need for focused provider education on screening recommendations.

Evaluation data available for presentation will include satisfaction feedback from providers; percentage of providers with a specific knowledge shift; percentage of providers with specified intention to adjust protocols or practices and percentage and type of providers that have implemented actual change as a result of the PHD visit. We will also be able to share the types of changes implemented and any barriers to implementation that are identified by the providers.

Lessons Learned: The PHD model can be conceptualized to virtually any topic. In addition to education, the physician focused intervention provides the forum to identify opportunities for integration with primary care to align leadership, build community engagement and achieve sustainable improvements in population health.

Abstract 2352 - Expanding Capacity of ASO/CBOs Leaders to Strategically Respond to Changes in the Healthcare System

Author(s): *Marissa Tonelli, Michael Shankle*

Issue: Implementation of healthcare reform, advancement of the National HIV/AIDS Strategy, development of new public health strategies, and biomedical prevention advances are just some of the fundamental shifts impacting HIV service providers. Reduction and re-direction of HIV funding and increased focus on accountability and quality-based funding requires ASOs and CBOs to remain adaptable and responsive to the ever-changing healthcare landscape. Health departments estimate that over 50% of CBOs will close in the next two to five years as a result of system-level changes and funding limitations. In HealthHIV's assessment conducted with more than 300 ASO/CBOs from late 2013 to 2015: 78% indicated limited understanding of how healthcare reform will impact ASO/CBOs; 63% acknowledge limited business planning; 70% of non-clinical CBOs hadn't considered formal partnerships with clinical organizations; and 75% relied solely on public funding. HealthHIV's needs assessments with ASO/CBO leaders in the development of the curriculum identified the need to better engage executive-level leaders and Boards of Directors in training and TA processes to prepare their organizations for change. The leaders indicated that barriers to engaging leaders include limited funding to pay for training, limited time away from work/office, and lack of information that is specific to leadership staff.

Setting: The ASO/CBO Leadership Training & Certificate Program is a national program for ASO/CBO leaders to expand their capacity to lead their organization in responding to the impact of healthcare reform. This online curriculum reaches ASO/CBO executive-level leaders and Boards of Directors across the US and in Puerto Rico.

Project: The curriculum aims to improve ASO/CBO executive-level leaders' knowledge, skills, and competencies to be able to implement organizational change, plan for the future, and maintain the viability of their organization. The first-of-its-kind online training and certificate program for ASO/CBO leaders and emerging leaders includes six, self-paced, one-hour modules that address strategic business planning, change management, biomedical and strategic advances in HIV/AIDS, funding diversification,

impact of Medicaid and health care exchanges, and partnerships, mergers, and acquisitions. Program participants receive a Certificate of Proficiency in ASO/CBO Leadership upon completion of the six modules.

Results: Over 500 ASO and CBO leaders have enrolled in the training and certificate program since November 2014 and almost 150 have completed the course with another 150 set to complete by May 2015. Thus far the curriculum has been highly reviewed with certified leaders saying it was extremely thorough, the platform was easy to use, and the presenters were very articulate.

Lessons Learned: ASO/CBO leaders are just as time-constrained and resource-constrained as other healthcare professionals. Just like clinical providers, they prefer to learn online in a self-paced manner and prefer to be incentivized (i.e. certificate). HealthHIV learned that offering a certificate program is not enough, but needs to be a part of a larger, ongoing engagement initiative (ASO/CBO Leadership Initiative) that includes regular engagement with other ASO/CBO leaders (Leadership Link Portal) and sharing of effective practices from leaders in healthcare beyond HIV (Leadership Lunch & Learn webinar series).

Abstract 2365 - HIV and Primary Care: A Mentoring Model Expands Access to Quality HIV Prevention & Care

Author(s): *Julio Fonseca, Brian Hujdich*

Issue: The implementation of health reform, evolution of HIV as a chronic disease, advancement of the National HIV/AIDS Strategy, recent biomedical advances, measurement of health outcomes across the HIV Care Continuum, and the medicalization of HIV prevention services, have challenged the capacity of health systems to rapidly adopt and implement programmatic innovation, while elevating the role primary care providers (PCPs) will play as the healthcare system evolves.

Setting: The HIV Workforce Capacity Building Initiative is a national program for primary care physicians and other health professionals that wish to expand their capacity to provide quality HIV prevention and care. Efforts have been focused in areas of high HIV incidence, including the southern United States, and in practice settings where multiple providers can be engaged at one time, such as residency programs and within medical schools.

Project: An HIV Workforce Capacity Building Initiative was developed and tested in various primary care settings to expand access to quality HIV prevention and care. PCPs were matched with HIV clinical experts for one-on-one coaching, education, and training. Mentees determine level of clinical care competency through self-assessment. HIV clinical experts used HIV clinical proficiencies, peer-reviewed articles, literature, case studies, and other tailored medical education materials to engage PCPs in building HIV clinical proficiencies and confidence in providing HIV care.

Results: Thirty PCPs were matched with HIV clinical experts. Mentors reported the vast majority of PCPs participating had the clinical skills to provide HIV care, but lacked confidence in managing HIV. Practice leadership played a significant role in PCPs participation. Similar professional designation was the most

important aspect of successful pairs. The relationships formed between HIV experts and PCPs extended to clinical consults.

Lessons Learned: Mentoring offers a pathway to build HIV clinical confidence and expand access to quality HIV care. Methods to access expert providers must be examined to further impact workforce development. Expanded provider networks formed in high-incidence areas alleviates demands on HIV specialists.

Session D03 - It's the Media Age: Dating Apps & Websites and HIV Prevention

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1660 - Swipe Left: Dating/Hookup Website and App Use among Men Who Have Sex with Men
Author(s): *Hannah Badal, JoEllen Stryker, Nickolas DeLuca, David Purcell*

Background: Efforts to reach gay, bisexual and other men who have sex with men (MSM) with HIV benefit from employing innovative ways to reach those at highest risk for HIV. Highly targeted digital channels (e.g., dating/hookup websites and apps) offer cost-effective ways to disseminate tailored messages that are specific to the intended audience. Given the dynamic and continuously evolving nature of social media, it is important to utilize evidence-based, appropriate channels to reach target audiences. This study explored dating/hookup website and app use among MSM to identify effective channels for HIV prevention messages to reach MSM overall and specific segments of MSM.

Methods: A web-based survey was conducted among sexually active gay and bisexually identified men from December 2014–March 2015 (N=3,104, but results reported here are from provisional dataset N=2,194). Participants were recruited from an online LGBT consumer panel. The survey oversampled younger (18–39), African American/black, and Hispanic-Latino (H-L) men. Measures used in this analysis include dating/hookup website and app use in general as well as use of Manhunt, Adam4Adam, Grindr, Tinder, Match.com, Okcupid, Plentyoffish.com, BCGLive, Craigslist, BarebackRT, Scruff, and Jack'd. Descriptive statistics and regression analyses examined the frequency and variability of channel usage.

Results: The majority of respondents use dating/hookup websites and apps (59%) at least once a week. Respondents who use dating/hookup websites and apps at least once a week reported an average of 10.6 casual partners in the past 12 months (SD=16.2) and were more likely not to have a main partner (77% versus 43% of those with a main partner; $p>.001$), and be living with HIV (64% versus 57% of HIV-negative men; $p=.038$). There was some variation with specific website and app usage. Respondents indicated using Grindr (40%), Adam4Adam (27%), Scruff (23%), and Jack'd (18%) at least once a week. All websites/apps except Match.com, PlentyofFish.com, and BGCLive had a significant relationship with age. Bivariate analyses indicate a significant positive relationship between respondents who reported having multiple casual partners, anal sex without a condom with a casual partner, HIV-negative status and use of Adam4Adam, Jack'd, Grindr, Tinder, Match.com, OKCupid, BGCLive, BarebackRT and Scruff ($p<.05$). African American/black MSM (BMSM) were more likely to report use of Jack'd (33%) and BGCLive (13%) than white MSM (1.5% and 10% respectively; $p<.001$). There were few differences in channel usage by sexual identity and perception that being gay is an important part of identity. Of the 851 write-ins for

frequently used websites, 83% were dating/hookup websites and apps including GROWLr (202 mentions), Hornet (63 mentions) and RECON (34 mentions).

Conclusions/Implications: Sexually active gay and bisexual men in this online sample are frequently using dating/hookup websites and apps, indicating that these websites and apps can be an effective way to reach MSM overall. Men at higher risk for HIV in this sample are using Grindr, BarebackRT and BGClive among others at a higher frequency than other MSM. Findings suggest that specific dating/hookup websites and apps (e.g., Jack'd and Scruff) are effective channels to reach subgroups of MSM at high risk of HIV infection.

Session D03 - It's the Media Age: Dating Apps & Websites and HIV Prevention

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1762 - Sex Sells: Utilizing Effective Digital Channels to Reach Men Who Have Sex with Men with HIV Testing and Prevention Messages

Author(s): *Nickolas DeLuca, Hannah Badal, JoEllen Stryker, Vanessa Boudewyns, Alex Stine, David Purcell*

Background: CDC's Act Against AIDS initiative has 3 campaigns for MSM: Testing Makes Us Stronger, Reasons/Razones, and Start Talking. Stop HIV. These campaigns utilize multiple channels to reach priority audiences, including digital and online outreach. Online strategies include two distinct types of Google advertising: 1) mobile app advertising placements (AdMob), where campaign banner advertisements (banner ads) are placed on mobile apps; and 2) keyword search term ads (AdWords), where the campaign website is advertised at the top of Google search results, based on the key words searched by the individual. Also, campaign banner ads are available to anyone in the public domain to download and embed on external websites. Although the campaign did not actively facilitate partnerships with certain adult themed sites, many such sites have downloaded campaign advertisements. This study made 3 comparisons of ad performance based on where they were advertised: 1) mobile app ads, with dating/hookup apps compared to all other apps; 2) Google Adwords with sexually explicit content versus no sexually explicit content; and 3) websites that downloaded ads and placed them on sexually explicit sites versus websites that downloaded ads and placed them on sites without sexual content.

Methods: Internet advertising impressions, cost, clicks for AdMob, AdWords and external websites hosting campaign banner ads were collected monthly from campaign launches through August 2014. Websites, mobile apps and keyword search terms were categorized/classified by type: 1) dating/hookup apps versus non-dating/hookup apps; 2) sexually explicit Adwords (e.g. bareback) versus non-sexually explicit Adwords (e.g. HIV); and websites with sexually explicit content versus websites without sexually explicit content. Click-through-rates (CTR) and cost-per-click (CPC) were calculated.

Results: Since the launch of the campaigns, mobile app ads on dating/hookup apps (e.g. GROWLr, Jack'd, Scruff and u4Bear) had a higher overall CTR (0.30%) than mobile ads on other types of apps (e.g. Gay FM and Gender Bender; CTR: 0.15%). Mobile ads on dating/hookup apps also had a lower average CPC (\$0.22) than mobile ads on other types of apps (CPC: \$0.74). Sexually explicit keyword searches had a higher CTR (0.74%) than other types of keyword searches (CTR: 0.55%). Sexually explicit keyword

searches also had a lower CPC (\$2.24) than other types of keyword searches (CPC: \$3.87), exceeding industry standards. Among all websites using downloaded ads, 8 of the top 10 referring websites to the campaign websites had sexually explicit content.

Conclusions/Implications: These data demonstrate that gay and bisexual men are willing to access HIV prevention messaging while they are active on dating/hookup apps and websites, as well as searching for sexual content on the internet. Promoting HIV prevention messages and social marketing campaigns on these websites/apps can be an effective way to reach gay and bisexual men overall. In addition, reaching gay and bisexual men through these channels may also be more cost effective. Men at risk for HIV are using websites and apps with sexual content and websites and apps should offer HIV prevention messaging. This targeted message dissemination will maximize message and campaign reach to the target audience.

Abstract 1792 - Building Healthy Online Communities: Outcomes from a Meeting of Gay Dating Website and App Owners and Public Health Leaders

Author(s): *Jennifer Hecht, Daniel Wohlfeiler*

Issue: Public health has sought to use gay dating sites and apps as a means of reaching large numbers of MSM with HIV/STI prevention messages. Yet the field has spent limited time coordinating and planning for how best to use the sites/apps to reduce the likelihood of HIV/STI transmission. Sites and apps receive thousands of requests from departments of health and community-based organizations with little way to know which ones will be the most effective use of their time and money.

Setting: We held a meeting in September 2014 with 8 site/app owners, whose reach is national (or international) in scale and public health leaders in the HIV/STI prevention field throughout the US. In 2015, we collaborated with European health officials regarding HIV/STI prevention on mobile apps.

Project: The meeting had three goals:

- 1) Create efficient and productive relationships between website/app owners and HIV/STI prevention
- 2) Critically evaluate current strategies for online HIV/STI prevention and generate new ideas
- 3) Develop an ambitious and feasible action plan for implementing new strategies.

Key activities and discussion topics were designed to build trust and share perspectives. They included: a review of HIV/STI epidemiology in the US; a review of findings from a previous survey of owners, users, and HIV/STI directors; discussion of partner services; sites/apps sharing examples of how they support healthy online communities; discussion of benefits and challenges of partnerships between site/app owners and public health; small group brainstorm of new ideas for online prevention; group activity to prioritize ideas.

Results: Several themes emerged, including: sites/apps want to support HIV/STI prevention, want to know what is most effective, and want to provide accurate information to their users; promoting HIV/STI testing and reducing HIV stigma online are high priorities; streamlining and coordinating requests can improve quality and lower cost; and online partner services should be adapted for use on apps.

The meeting led to the development of a consortium of public health and site/app owners who are committed to effective partnerships, with three key priorities: promoting HIV/STI testing, fighting stigma, and improving coordination between site/app owners and public health.

The consortium began during World AIDS Day 2014 by promoting 2 websites focused on HIV/STI testing and CDC's Start Talking campaign. From December 1-15th, 8 participating MSM dating websites/apps donated ad space, leading to 19 million impressions. One of these websites/apps was the top referrer to CDC's Start Talking campaign website during this time period, suggesting both broad reach as well as receptivity of MSM to receiving public health messages on dating websites/apps.

Lessons Learned: Engaging website and app owners in a thoughtful and meaningful way that incorporates their priorities and perspectives enables effective partnerships with public health. All parties agreed to prioritize promoting HIV/STI testing, reducing stigma, and streamlining communication. Ensuring internal coordination among public health agencies will increase our effectiveness with site/app owners. Additional work is needed to improve coordination and reduce the number of individual requests to owners, to continue to identify best practices for online HIV prevention strategies, and to improve evaluation strategies for online interventions.

Abstract 2204 - Two Decades of Putting Structural Interventions into Practice: The Use of Sexual Network Concepts to Build Healthy Communities Online as a Practical Outcome

Author(s): *Dan Wohlfeiler, Jen Hecht*

Issue: The first meeting to discuss the need for structural interventions (SI) for HIV prevention, and to brainstorm what they might be, took place 20 years ago in San Francisco. Community-based organizations, researchers, and government funders attended. Since then, all three of these groups have struggled to implement feasible, effective SI's, with limited success. Using network approaches helped us identify the need to collaborate with the owners of online dating sites and apps, and with them, identify feasible SI with potential to reduce transmission among MSM who meet new partners online.

Setting: SI's aim to create conditions and environments in which people can be healthy. In the case of websites and apps frequented by MSM, the audience includes all users of the website and apps, regardless of whether or not they participate in a public health-supported intervention.

Project: Identifying online sites and apps as optimal settings to implement feasible SI, and conduct formative research on them in collaboration with key stakeholders.

Results: Barriers to implementing SI include: a) a lack of clarity regarding the definition, scope, and goals of SI; b) difficulty of measuring SI effectiveness using randomized control trials; c) funding mechanisms; d) practitioners' over-reliance on service provision, including behavioral and biomedical interventions. To overcome some of these barriers, we focused on sexual networks as a pathway through which large social determinants may affect transmission. Network concepts, such as concurrency being fueled by disproportionate incarceration of African Americans, suggest the need to address sentencing reform to undo one of the most pernicious outcomes of racism. Similarly, using the concept of sexual networks to help identify SI for MSM suggests working with the businesses (dating websites and apps) that facilitate men meeting new partners. These businesses can affect many aspects of sexual networks, including

mixing between men with different sexual risk, drug use profiles, serosorting, and usage of biomedical interventions including treatment and PrEP.

Many interventions have focused on using messaging and behavioral approaches to reach men online. We conducted formative research with dating site and app owners, users, and HIV/STD program directors to determine levels of support for both behavioral risk-reduction and SI with potential to help address network-level factors. Interventions with high levels of support included creating automated HIV-testing reminders and expanding profile options to allow users to seek partners by risk preferences, HIV status, and ready access to geocoded test site directories. We were also able to identify some behavioral interventions, such as outreach, that had less support among users. This suggests that program managers examine current program prioritization.

Lessons Learned: By applying network concepts we were able to identify several SI with varying levels of sustainability without relying on public health resources and that have potential to reduce HIV and STD transmission online. Users supported many SI, and were thankful for being asked which interventions should be implemented. These findings laid the groundwork for a 2014 meeting of HIV/STD program experts with seven site and app owners (described in Abstract # ORLH5477083333) and for developing, implementing, and evaluating structural interventions.

Track E

Session E05 - Advancing HIV and Hepatitis Prevention for Drug Users

Room: Hanover E (Hyatt Regency Atlanta)

Abstract 2034 - Ending the Ban on Federal Funding for Syringe Service Programs: New Environments, New Data, New Messages, New Messengers

Author(s): *Mary Beth Levin, Bill McColl*

Issue: Funding and political support continue to be issues for syringe services programs (SSPs), perhaps most prominently because Congress restored the ban on the use of federal funding for syringe service programs (SSPs) in 2011. However, the need for such services is greater than ever given the epidemics of HIV, viral hepatitis, opiate overdose, and prescription drug misuse with its concomitant increase in heroin use.

Setting: After a two-year reprieve, Congress restored the 21-year ban on the use of federal funding for SSPs. This was both surprising and discouraging given that syringe access is among the most effective and well-researched methods of HIV prevention available. Myths and misunderstandings still persist despite abundant and unambiguous data about their success. The restored ban has had a chilling effect on other funders who misperceived the reinstatement as an indictment of effectiveness. Given the demands of service provision, individuals and programs often do not have the capacity to develop and test advocacy materials and approaches.

Project: In response, advocates from 18 national organizations have come together to re-evaluate efforts, taking a harm-reduction approach in advocacy strategies, meeting policymakers “where they are at”. New partners, new messages and new data informed this response. It involved a broader look

beyond HIV to include viral hepatitis, prescription drug misuse, drug overdose, access to addiction treatment, health disparities, costs and cost-effectiveness, public safety, and local perspectives. A collection of “ready to use” materials have been developed and successfully utilized to meet this need.

Results: We have data that didn't exist two years ago, reinforcing and renewing support for SSPs. We now know:

- Every dollar invested in SSPs results in seven dollars in savings in HIV treatment. -SSPs also reduce other health costs (research in progress).
- SSPs clean-up neighborhoods by ensuring that used syringes are safely disposed.
- SSPs reduce hepatitis C.
- SSPs are 25% more effective in serving as a bridge to treatment for substance use disorder than others in the field.
- African-Americans are 11X and Latinos are 5X more likely to contract HIV via injection drug use.
- Local enabling legislation is not required for SSPs to receive public funding.
- The largest source of funding is public (state and local).
- There is increased support for SSPs among law enforcement and faith communities.

Lessons Learned: The largest misperception about lifting the ban is its cost (there is none). It is a point that needs to be made every time and at the very beginning of any interaction.

Traditional supporters found the new data, particularly the disparity data, helpful, reinvigorating interest and enthusiasm which has waned over the years.

Those who had not supported syringe exchange previously found the cost-effectiveness data, law enforcement support, bridge to drug treatment data, and the states' rights argument, most compelling (in that order).

High turnover in congress and among congressional staff means that efforts must be continuous.

The misunderstandings and nuances involved require a specific conversation on this topic, rather than merely including it on a list of advocate concerns.

Many have found our approaches helpful in their advocacy at the local level.

Abstract 2217 - Hepatitis C Testing Guidelines: Engaging Stakeholders at the State Level

Author(s): *Michelle Scavnicky, Michael Ruppel, Phil Reichert*

Issue: An estimated 3.2 million people are living with chronic Hepatitis C (HCV) infection in the United States, and the number of new annual infections remains steady at approximately 17,000. In 2013, the United States Preventive Services Task Force (USPSTF) recommended adding one time testing of “baby boomers” - those born between 1945 and 1965 – to their current “B” grade recommendation of screening for those at high risk of HCV infection. The USPSTF grade change acknowledges the benefits of screening the “baby- boomer” population, which represents more than 75% of HCV cases in the United

States, while also aligning with the Centers for Disease Control and Prevention hepatitis c testing guidance. It also reconfirms that other “high risk” individuals, no matter their age, should also be tested.

Setting: The AIDS Institute, along with the CDC Foundation and Florida Department of Health, embarked on a project to advance adoption and implementation of the hepatitis C (HCV) birth cohort testing guidelines at the state level by engaging a cross-section of stakeholders from public health, health systems, government and academia.

Project: The AIDS Institute began working with the Florida Department of Health (FDOH), Hepatitis Prevention Program to identify and recruit key stakeholders through public health, health systems, government and academia within the hepatitis arena in Florida to engage in the advancement and adoption of hepatitis C testing guidelines at the state level. After months of comprehensive planning, TAI, in collaboration with FDOH and the CDC Foundation, hosted a one-day stakeholder’s forum where 37 key stakeholders were in attendance. The forum agenda included presentations and interactive discussions on the rationale for the hepatitis C testing guidelines, suggestions on how each organization is supporting or can support the implementation of the guidelines and discussion of quality measures regarding HCV testing of the birth cohort and reinforcement of existing risk-based testing recommendations. Discussion focused on known barriers to implementation and identify ways to support implementation. TAI conducted 3 and 6-month follow-up to the key stakeholders around what strategies have been taken, discussed or implemented within their respective organizations or what barriers, challenges, and successes, if any since they attended the forum. TAI also developed a recommendation report that is transferable and appropriate for other states to use as a basis for implementing the guidelines.

Results: TAI will provide a comprehensive overview of the process which led to a summary of key outcomes from the forum discussions; development of a one-year action plan; further enhanced relationships among local stakeholders to support CDC/USPSTF recommendations and how individual stakeholders will continue to be engaged and involved in implementing the one-year action plan. TAI will review the 3 and 6-month follow-up and the results will be shared with the participants as part of the ongoing process to engage key stakeholders.

Lessons Learned: The overarching message for the participants attending this session is to help them work with their particular state and begin to engage key stakeholders and further develop relationships to support CDC/USPSTF recommendations for HCV testing.

Abstract 2428 - Necessary, but not Sufficient: The Impact of Funding Policy on Integration of HIV/Viral Hepatitis

Author(s): *Richard Cotroneo, Shannon Mason, Kirsten Rowe*

Background: In 2011, the CDC/NCHHSTP, Division of HIV/AIDS Prevention (DHAP) issued a 5 year funding opportunity announcement (FOA) titled Comprehensive HIV Prevention Programs for Health Departments (PS 12-1201). To support CDC’s Program Collaboration and Service Integration (PCSI) goals, PS 12-1201 actively encouraged service collaboration and outlined an allowable percentage of funds that could be used toward integrating Hepatitis B and C testing. DHAP guidance encouraged health

departments to consult with NCHHSTP Division of Viral Hepatitis (DVH)-funded Viral Hepatitis Prevention Coordinators (VHPCs) when preparing their applications for PS 12-1201. The National Viral Hepatitis Technical Assistance Center sought to assess the extent to which VHPCs, also located in health departments, were actually consulted or involved in preparation of their jurisdiction's application for PS 12-1201.

Methods: A brief 10 question, on-line survey was administered between January and February of 2012 to all CDC funded VHPCs. The survey explored: 1) the extent to which VHPCs were asked for input or were involved in preparation of their jurisdiction's application for PS 12-1201; 2) the extent to which jurisdictions included viral hepatitis activities in the application; and, 3) the level of funding jurisdictions allocated to these activities. Survey questions explored VHPC beliefs about the impact of inclusion of language requiring consultation with VHPCs. Specifically, they were asked about the anticipated impact on the level of integration of viral hepatitis activities and about other factors related to the PS 12-1201 FOA which may effect viral hepatitis services. The survey was completed by 46 of 53 eligible VHPCs. A follow-up webinar with 29 VHPCs was held in April 2012 to interpret the results and the survey.

Results: Only one third of VHPCs (15) who completed the survey indicated that they were asked for input or were included in development of their health department's application for PS-12-1201. However, 26% (12) of VHPCs surveyed indicated that their health department HIV program staff were aware of the needs of the hepatitis program, and that the coordinator's input was not necessary. Thirty seven percent (16) were aware that their jurisdiction included specific activities related to hepatitis screening services. Only 10 VHPCs reported that their program received funds for hepatitis testing services in their jurisdiction's award for the FOA. Only half of VHPCs (23) indicated that inclusion of language addressing program collaboration or viral hepatitis facilitated integration of viral hepatitis services in their jurisdiction's HIV program. Close to half of VHPCs (46%) responded that DHAP's efforts to promote PCSI in PS 12-1201 resulted in no change in integration of viral hepatitis services in health department HIV programs. Over one-third (39%) reported that the shift in focus of PS 12-1201 to high impact HIV areas made it more difficult to integrate viral hepatitis and HIV program services.

Conclusions/Implications: The inclusion of language in CDC FOAs that is supportive of viral hepatitis integration is necessary, but alone is not sufficient to promote program collaboration and service integration. More robust direction regarding integration is needed in order to affect integration of viral hepatitis services in health department HIV programs.

Abstract 2502 - HIV and Hepatitis Prevention through a Drug User Health Framework

Author(s): *Chris Taylor, Mariah Johnson, Magalie Lerman*

Issue: Although HIV transmission rates for PWIDs have decreased, there continue to be high frequencies of injection drug use (IDU) practices associated with HIV acquisition. The current injection drug use-related HIV outbreak in southern Indiana, where there are now 130 confirmed cases, is one critical example of this. According to CDC, 7% of the estimated 47,352 diagnoses of HIV infection in 2013 in the U.S. were related to injection drug use, with an additional 3% related to male-to-male sexual conduct and IDU. Of the estimated 3,096 diagnoses of HIV infections attributed to IDU in 2011, 46% were among African Americans and 21% were among Latinos. At the end of 2010, an estimated 147,608 adult and

adolescent s PWIDs were living with a diagnosed HIV infection in the U.S., meaning that 21% of known living HIV cases in 2010 were related to IDU. While the surveillance system for hepatitis C is very limited, it is estimated that some communities of PWID have hepatitis C infection rates as high as 90 percent.

NASTAD has long been committed to addressing drug user health, from the 1992 issuance of the policy statement “Reusing Transmission of HIV through Increases Access to Clean Needles and Syringes,” to its most recent publication “Maximizing Health, Minimizing Harm: The Role of Public Health Program in Drug User Health,” released in early April 2015.

Setting: Harm reduction services can be provided in a variety of settings. This session will include discussion of activities in health departments, community based organizations and outreach settings.

Project: The recent outbreak of 130 confirmed HIV cases – the majority of which also involved hepatitis C co-infection – among a network of PWIDs in Scott County, Indiana has made clear that a strong public health infrastructure that prioritizes prevention, public health and client-centered approaches to substance use is necessary to reduce new transmission of infectious diseases within this population. While Indiana Governor Mike Pence has responded to the outbreak with the authorization of a temporary syringe exchange program, Kentucky has recognized the inextricable link between the sharing of needles and HIV and HCV transmission among networks of people who inject heroin and other opiates by allowing needle exchange programs across the state to combat the hepatitis epidemic in the state.

Results: These aren’t isolated cases, as the CDC recently reported that more than 30 states have reported increases in HCV cases, 75% of which are among young PWID. Comprehensive approaches to drug user health and harm reduction that prevent opioid overdose, prevent transmission of HIV and hepatitis, treat those currently living with HIV and cure those with HCV, and link PWID to substance use and mental health services as needed are necessary on the local, state, and federal levels.

Lessons Learned: This presentation will explore effective collaborations between policymakers, health departments, providers, and community based organizations in addressing drug user health, in addition to a detailed overview of new opportunities for coverage of drug user health services through the ACA, Medicaid expansion, and the Mental Health Parity and Addiction Equity Act (MHPAEA).

MONDAY, DECEMBER 7 | POSTER SESSION A | 12:00 PM – 1:30 PM

AP01

Abstract 1932 - Epidemiology and Surveillance

Author(s): *Yingbo Ma, Kwa Sey, Amy Wohl*

Background: Pre-exposure prophylaxis (PrEP) is recommended for persons who are at ongoing risk of acquiring HIV. These include Men who have sex with men (MSM) who have an HIV positive partner or MSM who are diagnosed with a recent bacterial sexually transmitted infection (STI). This analysis compared knowledge of PrEP and willingness to take PrEP in two cross sectional samples of urban MSM recruited through the National HIV Behavioral Surveillance System (NHBS) in 2011 and 2014. NHBS conducts behavioral surveillance among persons at high risk for HIV infection in rotating annual cycles in Los Angeles County (LAC).

Methods: Venue-based, time-space sampling was used to recruit men to participate in NHBS. Eligible MSM completed an interviewer-administered behavioral risk survey that included questions on knowledge, utilization and willingness to use PrEP and were offered HIV testing. Prevalence ratios (PR) and 95% confidence intervals (CI) were calculated using a Poisson model with a robust standard error to assess the changes across time. A subgroup analysis was performed among MSM who reported an HIV positive partner or recent bacterial STI diagnosis. Participants who self-reported as HIV-positive were excluded from this analysis.

Results: The 2011 (n=444) and 2014 (n=468) samples were comparable with respect to age, race/ethnicity, education and regular medical care. Overall, the proportion of men who had heard about PrEP increased from 28% in 2011 to 63% in 2014 ($p<0.01$) and willingness to use PrEP increased from 47% in 2011 to 58% in 2014 ($p<0.001$). The observed increases in knowledge of PrEP (adjusted PR=2.22, 95% CI: 1.88-2.61) and willingness to use PrEP (adjusted PR=2.09, 95% CI: 1.66-2.62) persisted regardless of age, race, education and history of healthcare utilization. Though PrEP use increased significantly from 2011 to 2014, it remained fairly uncommon (0% in 2011 vs. 3% in 2014, $p<0.001$). Five percent of respondents in both 2011 and 2014 reported having an HIV positive partner while 12% in 2011 and 17% in 2014 had recently been diagnosed with a bacterial STI. Of these arguably PrEP eligible MSM, 39% in 2011 and 82% in 2014 had heard of PrEP (adjusted PR=2.05, 95% CI: 1.50-2.81), and 54% in 2011 and 69% in 2014 were willing to take PrEP (adjusted PR=3.18, 95% CI: 2.11-4.78). However, 0% in 2011 and 8% in 2014 had ever used PrEP ($p=0.02$).

Conclusions/Implications: In LAC from 2011 to 2014, knowledge of PrEP and willingness to use PrEP increased significantly among MSM irrespective of race/ethnicity, age group, education or history of healthcare utilization. Although current PrEP utilization is low, the data suggest a willingness to use PrEP among at-risk MSM.

AP02

Abstract 1418 - Epidemiology and Surveillance

Author(s): *Angela Hernandez, Alexandra Oster, Cheryl Ocfemia, Neeraja Saduvala, Jeffrey Johnson, Walid Heneine, H. Irene Hall*

Background: Transmission of HIV drug resistance may impair the effectiveness of first-line and subsequent antiretroviral treatment (ART) options and may lead to HIV treatment failure. Moreover, transmission of HIV variants that are resistant to ARTs used for pre-exposure prophylaxis (PrEP) can limit the efficacy of this intervention. All states and U.S. territories report demographic, risk, clinical, and laboratory data on persons diagnosed with HIV infection to the CDC National HIV Surveillance System (NHSS); jurisdictions conducting Molecular HIV Surveillance (MHS) also report HIV sequences from genotypic resistance testing conducted as a part of standard HIV care. Here, we describe the prevalence of transmitted drug resistance in antiretroviral-naïve individuals associated with PrEP and commonly used ART regimens among persons newly diagnosed with HIV.

Methods: Our analysis included subtype B HIV-1 pol sequences collected within 3 months of initial diagnosis for antiretroviral-naïve persons who were newly diagnosed with HIV infection during 2010–2012 in 8 HIV surveillance jurisdictions (Colorado, Connecticut, California [Los Angeles County only], Michigan, New York, South Carolina, Texas, and Washington). The CDC HIV-1 surveillance mutation list was used to identify drug resistance mutations associated with TDF/FTC (PrEP) and three commonly used HIV ART regimens (efavirenz-based: EFV/TDF/FTC, atazanavir-based: ATV/r/TDF/FTC, and darunavir-based: DRV/r/TDF/FTC). We compared resistance to PrEP and commonly used ART regimens by age, race/ethnicity, and population density of area of residence.

Results: Of 13,415 persons with sequences during 2010–2012 in these 8 jurisdictions, 0.7% had resistance to PrEP mostly due to M184V; 8.7% to the efavirenz-based regimen, 1.3% to the atazanavir-based regimen, and 0.9% to the darunavir-based regimen. The percentage of persons with resistance to the efavirenz-based regimen increased 3.1% from 2010 to 2012; no significant changes were observed in resistance to other regimens. Resistance to PrEP did not vary by demographic characteristics. Resistance to the efavirenz-based regimen was significantly higher among persons aged 13-19 years (14.4%) (PR=1.7; 95% CI=1.37, 2.12) compared with persons aged 30-39 years (8.5%) and among blacks/African Americans (9.8%) (PR=1.31; 95% CI=1.13, 1.51) and Hispanics/Latinos (8.8%) (PR=1.17; 95% CI=1.01, 1.51) compared with whites (7.5%). Resistance to the atazanavir-based regimen was significantly higher among persons aged 13-19 years (2.3%) (PR=2.17; 95% CI=1.19, 3.94) compared with persons aged 30-39 years (1.1%). Resistance to the darunavir-based regimen did not vary by any demographic characteristics. No difference in resistance to PrEP or any of the three ART regimens were observed by population density of area of residence.

Conclusions/Implications: Transmission of HIV variants resistant to PrEP was uncommon; however, ongoing assessment of PrEP resistance is important for monitoring the continued effectiveness of this prevention intervention. Although resistance to protease inhibitor (atazanavir and darunavir)-based regimens was low, resistance to the efavirenz-based regimen was high. These results highlight the importance of timely resistance testing among newly diagnosed persons to ensure optimal ART provision and reduce transmission.

AP03

Abstract 2373 - Epidemiology and Surveillance

Author(s): Erin Kahle, R. Craig Sineath, Patrick Sean Sullivan, Travis Howard Sanchez

Background: In the United States, young men who have sex with men (YMSM: 13-24 years old), are at particularly high risk of HIV infection and contribute a significant proportion of new infections. Understanding sexual risk and HIV testing behaviors of YMSM is critical in developing targeted prevention programs. Therefore, we assessed HIV risk behavior among YMSM participating in an online survey of HIV behavior.

Methods: We used data collected from the 2013 cycle of the American Men's Internet Survey (AMIS), an annual cross-sectional HIV behavioral survey of MSM in the United States. MSM, at least 18 years old and residing in the United States, were recruited through banner advertisements on select social media websites. We compared sexual risk behavior and internet use among young HIV-uninfected MSM respondents 18-20 and 21-24 years of age using regression models ($p < .05$).

Results: Among the 10,377 eligible, completed surveys from MSM, 1,892 (18.2%) were HIV-uninfected and age 18-24 years old. Of these, approximately one-third ($n=646$, 34.1%) were 18-20 years old and two-thirds ($n=1246$, 65.6%) were 21-24 years old. Most young MSM respondents were white, had at least some college, and were lived in urban areas. In the previous 12 months, 547 (28.9%) reported six or more male sex partners, and 1217 (61.4%) reported anal intercourse without a condom. Compared to younger YMSM age 18-20, older YMSM were more likely to report anal intercourse without a condom (66.5% vs. 60.2%, $p=0.007$). Binge drinking alcohol was significantly higher among the older YMSM (77.5% among 21-24 vs. 59.3% among 18-20, $p<0.001$), but illicit substance use was similar (35.6% vs. 37.6%, $p=0.42$). Nearly a third ($n=589$, 31.1%) of all YMSM met their last sexual partner through the internet; this did not differ significantly by age. Most ($n=1224$, 64.7%) reported ever receiving an HIV test, but less than half (815, 43.1%) had an HIV test in the previous 12 months. The proportion of YMSM with an HIV test in the past year was significantly higher in the older age group ($p<0.001$).

Conclusions/Implications: High sexual risk and insufficient routine HIV testing among YMSM may contribute to increasing new HIV infections in this population. The lower engagement in high risk behavior among the youngest YMSM offers an opportunity for earlier intervention, including prevention programs to increase testing. Further, the substantial proportion of YMSM meeting sexual partners through the internet suggests an additional venue for targeting YMSM for prevention.

AP04

Abstract 1289 - Epidemiology and Surveillance

Author(s): Joella Adams, Jennifer Shinefeld, Kathleen Brady

Background: Among cases reported in 2013 to the enhanced HIV/AIDS Reporting System (eHARS), 345 of the 533 (65%) newly diagnosed HIV cases among male Philadelphia residents reported MSM as their transmission risk. Pre-exposure prophylaxis (PrEP) has the potential to prevent HIV transmission among HIV-negative MSM. The aim of this study was to determine the acceptability of PrEP among HIV-negative MSM and factors associated with acceptability.

Methods: This analysis uses survey responses from the National HIV Behavioral Surveillance System (NHBS) conducted in Philadelphia from August to November 2014. Self-reported HIV positive respondents and those not completing relevant questions regarding PrEP use were excluded. We evaluated the relationship between willingness to use PrEP and demographic, risk behavior, and HIV testing variables. Chi-square univariate analysis was performed for each variable. Variables found to be statistically significant at $p < 0.1$ were included in a stepwise multivariate logistic regression model along with age and race.

Results: Of 558 HIV-negative MSM interviewed, 61% ($n=340$) were willing to take PrEP daily. Of those who knew someone in Philadelphia who had taken PrEP ($n=167$, 30%), 77% were willing to take PrEP. Variables not statistically significant in univariate analysis included demographic (age, race/ethnicity, education, employment status, insurance status, visiting a health provider in the past year), sexual risk behavior (an STI or exchange sex in the past year), behavior at last sex (type of partner, length of relationship, unprotected insertive or receptive anal sex, substance use, relative age of partner), and HIV testing (ever tested for HIV, HIV test in past year, and newly identified HIV positive status) variables. Multivariate analysis included the following: age, race/ethnicity, income level, history of homelessness, non-injection drug use in the past year, total number of male unprotected anal sex partners, knowledge of someone in Philadelphia taking PrEP and an HIV-positive partner at last sex. We found that men with a history of homelessness (AOR:1.99, 95%CI:1.16-3.41) and men reporting non-injection drug use in the past year (AOR:1.72, 95%CI:1.17-2.50) were about twice as likely to be willing to take PrEP. Men who knew someone in the Philadelphia area who has taken PrEP were nearly three times as likely to take PrEP everyday (AOR:2.95, 95%CI:1.90-4.57). No other significant associations were found between willingness to take PrEP and other predictor variables included in the multivariate analysis.

Conclusions/Implications: Acceptability of PrEP was high among HIV-negative MSM in Philadelphia. Men who were aware of others using PrEP in Philadelphia were nearly three times as willing to take PrEP themselves. This highlights the importance of increasing knowledge of PrEP as an HIV prevention strategy within the MSM community. Surprisingly, none of the sexual risk behavior variables included remained significant in multivariate analysis. However, certain high-risk behaviors were associated with willingness to use PrEP including homelessness and substance abuse in the past year. Awareness campaigns and working with community based organizations and providers on increasing access to PrEP, particularly to high-risk individuals, could expand use.

AP05

Abstract 1946 - Epidemiology and Surveillance

Author(s): *David Katz, Amy Bennett, Julia Dombrowski, Julia Hood, Susan Buskin, Matthew Golden*

Background: HIV self-testing has the potential to increase testing and thereby result in earlier HIV detection. However, the increase in confidentiality and control that can make self-testing appealing to consumers limits the ability of health departments and prevention programs to monitor the impact of these tests.

Methods: We examined the use of HIV self-tests in King County, Washington, using data from HIV partner services interviews, a computerized intake form at a public health STD clinic (sentinel

surveillance site), and an annual behavioral survey conducted among a convenience sample of men who have sex with men (MSM) attending the Seattle Pride Parade.

Results: From July 2013-December 2014, 349 persons aged 15 and older were newly diagnosed with HIV infection in King County, of whom 262 (75%) were interviewed for partner services. Of the 197 (75%) interviewed cases who were asked about self-testing, 23 (12%) reported having ever used an HIV self-test to test themselves, of whom 47% reported obtaining their last test from a pharmacy in person, 35% a 2013 Pride-based HIV self-test mass distribution campaign, and 17% another source. Twelve (52%) reported that their last self-test was positive, 10 (44%) negative, and 1 (4%) invalid. Of those with a positive self-test, 9 (75%) indicated that it was their first positive test, all of whom were MSM and linked to care within 3 months of their positive self-test. Of 10 with a negative test, 6 (60%) last self-tested within 3 months prior to HIV diagnosis, suggesting they may have tested false-negative during the window period. MSM and transgender persons who have sex with men were more likely to report ever using a self-test (15%) compared with men who sex with women only and women (2%) [$p=.01$].

Among 5467 STD clinic visits where MSM completed computerized intake from August 2013-March 2015, 806 (15%) reported ever having used an HIV self-test to test themselves, of whom 8% reported obtaining their last test from an online store, 28% a pharmacy in person, 32% the HIV self-test mass distribution, 27% another source, and 5% did not remember. HIV-negative men were more likely than MSM living with HIV to report ever using a self-test (16% vs. 7%; $p<.0001$). Fifty-two percent said they used their last self-test instead of seeking facility-based testing. Thirty (3.7%) reported that their last self-test was positive, 767 (95.2%) negative, 4 (0.5%) invalid, and 5 (0.6%) were not sure of the result. Of those with a positive self-test, 14 (47%) indicated it was their first positive test. The proportion of visits where MSM reported ever using a self-test increased from 13% in 2013 to 17% in first quarter 2015 ($p<.01$).

Among Pride survey respondents, the proportion of sexually active, HIV-negative MSM reporting ever having used a “home HIV test” increased from 8% (19/246) in 2013 to 17% (59/339) in 2014 ($p=.0007$).

Conclusions/Implications: A small, but increasing proportion of MSM in King County is using HIV self-tests. HIV surveillance and partner services can be used to monitor the use of these tests and evaluate self-testing interventions.

AP06

Abstract 1690 - Epidemiology and Surveillance

Author(s): *Michael Navejas, Kathleen Reilly, Shavvy Raj-Singh, Alan Neaigus*

Background: In NYC as of December 31, 2013, MSM accounted for 72% of men with known HIV transmission risk living with HIV/AIDS. Sexual risk behaviors, including condomless anal sex, account for most infections among MSM and therefore require closer examination.

Methods: A cross-sectional, probability sample of HIV-infected adults aged ≥ 18 years who received outpatient HIV care in NYC from January 2011 through April 2012 were interviewed for the CDC-funded Medical Monitoring Project (MMP). We describe the frequency and correlates of self-reported

condomless receptive or insertive anal sex in the past 12 months among a sample of sexually active HIV-positive MSM. Crude and adjusted odds ratios (AOR) and 95% confidence intervals (95%CI) are estimated using stepwise logistic regression.

Results: Of the 695 patients interviewed for MMP in 2011-2012, 291 were men (41.9%). Of these men, 139 (47.8%) reported sexual activity with another man in the past 12 months. Among MSM, 35.3% were black, 38.1% Hispanic, 21.6% white, and 5% were of other race/ethnicity. The median age was 42 years. Condomless anal sex was reported by 42.5% of sexually active MSM. In multivariate analysis, the following self-reported variables were independently associated with condomless sex in the past 12 months: stimulant drug use (categorized as: crack, cocaine, crystal methamphetamine or other amphetamine; other drug use; or no drug use) in the past 12 months (AOR=7.4, 95%CI=2.2-25.5); ≥ 3 sex partners in the past 12 months (AOR=5.3, 95%CI=2.3-12.6); and a history of a sexually transmitted disease (STD) in the past 12 months (AOR=3.1, 95%CI=1.1-8.5). Age, race, and education were not independently associated with condomless sex.

Conclusions/Implications: Close to half of the sexually active HIV-positive MSM in this NYC sample reported recent condomless anal sex. Those who reported condomless sex were more likely in the past 12 months to have used stimulant drugs, to have had an STD, and to have had multiple male sex partners. High risk sexual behaviors among this sample of MSM underscore the need for initiation and continuation of preventive interventions as a central component of HIV primary care to reduce HIV transmission and STD infection. This prevention strategy should include frank discussions between health providers and patients about stimulant drug use, multiple sex partners, and STDs, as well as consistent condom use.

AP07

Abstract 1750 - Epidemiology and Surveillance

Author(s): *Lawrence Ouellet, Mary Mackesy-Amiti, Jeremy Young, Jeannette Bailey-Webb, Dorothy Murphy, Chad Zawitz*

Background: In the United States, about 15% of persons living with HIV (PLWHIV) – and 20% of Black and Hispanic PLWHIV – are incarcerated annually, making jails a key place for identifying infections and linking PLWHIV to medical care. Access to, and retention in, appropriate medical care post-release is essential for the individual's health and to prevent HIV transmission. While health insurance facilitates access to care, serious racial and ethnic disparities exist, with 33% of Hispanic and 22% of Black adults aged 18-64 being uninsured compared with 14% of non-Hispanic (NH)-Whites. Implementation of the Affordable Care Act is expected to narrow these disparities. This study examines health insurance coverage among PLWHIV in a large urban jail, including enrollment predictors, facilitators and barriers.

Methods: Men and women with HIV and detained in Cook County Jail, Chicago, Illinois were interviewed for the study as a part of the Seek, Test, Treat, Retain (STTR) HIV Consortium. Interviews began July, 2013 and included questions about type of health insurance, when and where enrolled, types of persons who assisted in enrollment, and barriers to enrollment. We conducted logistic regression analyses to examine associations between demographic, mental health (depression, trauma) and substance use (TCU scores) factors and having health insurance.

Results: The sample (n=268) was 82% Black, 9% Hispanic and 72% male, and 32% reported having no health insurance. Among the insured, the most common forms of insurance were Medicaid (61%) and Medicare (24%). Only 6% of the insured reported a private provider and 3% reported a State plan. Dental or vision insurance was reported by 17% of subjects. Among those who enrolled in insurance in 2013 or later (n=99), 58% (n=57) reported assistance by others. Assistance was provided most often by a non-HIV case manager or other social service professional (34%), HIV case manager (20%), medical staff personnel (14%), relative/friend/spouse (13%), or health insurance navigator (9%). Enrollment most often took place where the person normally obtained medical care for HIV (38%), another clinic or hospital (19%), jail (15%) or a government social service office (9%). Not obtaining health insurance was most often attributed to drug use, a chaotic life situation or not caring (26%), not qualifying for Medicaid and unable to afford insurance (20%) not knowing about the availability of insurance (18%) or where to enroll (14%), and not having a bank account (17%) or identification (7%). Independent positive predictors of having insurance included older age, being Black and having higher income. Gender, depression, trauma symptoms, and substance use were not associated with having health insurance.

Conclusions/Implications: Incarcerated PLWHIV in this sample were more likely to be without insurance than the U.S. population as a whole and the U.S. population of Blacks and Hispanics. Medicaid was the primary insurance provider in this population. While the majority of recent insurance enrollments took place in a medical setting, a notable minority occurred in jail. Interventions to promote insurance coverage in this population need to address substance use, gaps in awareness of options, and barriers to having required documentation.

AP08

Abstract 2470 - Epidemiology and Surveillance

Author(s): *Lori Mizuno, Ses Soltani, Alexander Goncalvez, Jorge Montoya, Noah Bardach, Aaron Plant, Whitney Engeran-Cordova*

Issue: AIDS Healthcare Foundation (AHF) conducts over 155,000 HIV tests annually in the U.S. across 12 states and the District of Columbia through a network of mobile testing units, wellness centers, thrift stores, and event-based testing. Traditionally, AHF captured HIV testing data using various paper and pencil forms and electronic systems. This bifurcated approach hampered surveillance and program improvement due to the time required for data entry, merging, and analysis. In 2013, AHF decided to create a unified, online system to capture and facilitate retrieval of client testing data in real time from all national testing locations. Moreover, this system shifted testing records from a test-based system to a client-based system that can facilitate the delivery of tailored prevention and linkage services while allowing clients to access their own testing records.

Setting: The Client Health Access Management Portal (CHAMP) was initially deployed on November 17, 2014 at four fixed testing sites and through three mobile testing units (MTUs) that rotate through 15 locations in Los Angeles County.

Project: CHAMP is a HIPPA compliant, web-based application designed to capture and report client information on HIV testing, risk behaviors, and linkage activities from multiple HIV testing locations.

CHAMP has many advantages, including the ability to monitor and generate reports of data in real-time, which facilitates surveillance and quality assurance to enable rapid improvements in testing strategies. In addition, CHAMP has automatic features like instant notification to linkage coordinators when a client tests positive, which can speed up and streamline linkage services. Furthermore, data can be exported to a given jurisdiction in whatever format they require. CHAMP also personalizes the client testing experience by enabling counselors to review individual testing and risk history for each client before testing and allowing clients to access their testing information and update their profile. Finally, CHAMP can be deployed from any location with Internet access making it extremely scalable. A process evaluation was conducted in April 2015 to assess CHAMP usage by clients during the system's implementation at AHF test sites in Los Angeles County.

Results: From November 17, 2014 through April 8, 2015, 3,462 clients registered for HIV screening through CHAMP, provided contact and location information, and completed a risk assessment at four fixed testing locations and at three MTUs. Of these clients, 3,088 (89.2%) were tested for HIV and 131 (3.7%) completed their online registration so that they could access their testing history by logging into their client account. As of April 8, 2015, 58 positive test results were obtained out of 5,180 HIV tests for a positivity rate of 1.1% (some clients have tested more than once). All 58 cases have been followed-up for linkage services.

Lessons Learned: The initial launch of CHAMP has shown it is a feasible client management tool that streamlines data capture and retrieval for client-centered HIV testing and linkage services, and can be used in many HIV screening situations without compromising the collection and use of important client information. Upcoming CHAMP features include real-time sexual network analysis, risk indexing, and delivery of testing reminders.

AP09

Abstract 2436 - Epidemiology and Surveillance

Author(s): *Sandi Brown, Kimi Sato, Shaniqua Smith, Jeffery Todd, Pascale Wortley, Cherie Drenzek*

Background: Studies have indicated that, when taken regularly, pre-exposure prophylaxis (PrEP) can significantly reduce the risk of HIV infection. Limited data are available about awareness and willingness of high risk populations to take PrEP, especially in the South. This study explored the awareness and willingness to take PrEP among men who have sex with men (MSM) in Atlanta, Georgia, in 2014.

Methods: The National HIV Behavioral Surveillance System survey was completed by 542 MSM who were recruited in Atlanta venues during fall 2014. Respondents who reported that they were HIV-negative or had never had an HIV test (N=419) were asked about awareness of PrEP ("Before today, have you ever heard of people who do not have HIV taking anti-HIV medicines, to keep from getting HIV?"). Willingness to take PrEP ("Would you be willing to take anti-HIV medicines every day to lower your chances of getting HIV?") was asked of participants who had not heard of anti-HIV medications and of those who had heard of anti-HIV medications but had not taken them (N=392). Awareness and willingness to take PrEP among MSM were analyzed using the chi-square test and multivariate logistic regression using SAS 9.3.

Results: Of the 419 MSM participants who were asked about awareness of PrEP, 217 (52%) said yes. Awareness was lowest among participants who were black (43%), 18–29 (44%) and 50+ years old (44%), had a high school diploma or less (31%), had an income of \$0–19,999 (37%), had receptive anal sex (RAS) with a condom at last sex (42%), did not use non-injection drugs (51%), did not know their last sex partner’s HIV status (43%), and did not have an HIV test in the past 12 months (34%). In multivariate analysis, lack of PrEP awareness was positively associated with being black, ages 18–29 and 50+ years, having a high school diploma or less, not being tested for HIV in the past 12 months, and not knowing last partner’s HIV status or responding that it was negative.

Overall, 65% (N=256) responded that they were willing to take PrEP. Willingness was highest among participants who were black (69%), 30–39 years old (74%), had a high school diploma or less (70%), had an annual income of \$0–19,999 (77%), had RAS without a condom at last sex (81%), used non-injection drugs in the past 12 months (72%), knew their last sex partner was HIV-positive (80%), had an HIV test in the past 12 months (70%), and were aware of PrEP (71%). In multivariate analysis, willingness to use PrEP was positively associated with being 18–39 years old, having an annual income of \$0–19,999, having RAS without a condom at last sex, and being aware of PrEP.

Conclusions/Implications: Approximately half of MSM surveyed had heard of PrEP, and nearly two-thirds were willing to use it. Awareness tended to be lower among demographic groups associated with higher risk of HIV infection, and willingness was higher among persons with high risk behaviors. Ensuring that PrEP education efforts reach target populations is an integral part of PrEP implementation planning.

AP10

Abstract 1257 - Epidemiology and Surveillance

Author(s): *Bonnie Hardy, Berry Bennett, Sally Fordan, Leah Gillis, Susanne Crowe*

Background: Early HIV diagnosis, especially during the acute infection phase, coupled with timely patient-oriented linkage and engagement into care will improve individual health outcomes. The initiation of antiretroviral therapy, drug adherence with retention in care will invariably lead to viral load suppression. HIV-1 viral suppression (<200 copies/ml) will ensure management of the disease. In addition, viral suppression in HIV-infected individuals will significantly decrease HIV transmission rates and thus reduce HIV incidence.

This prospective public health study had two objectives: 1) to identify algorithm-defined acute HIV-1 infections(AI)from blood samples that were submitted for routine HIV serostatus determination of follow-up on point-of-contact (POC)negative HIV-1/2 rapid test from a patient with recent high-risk activity and 2) to provide expedited clinical management HIV-1 viral load baseline testing on confirmed acute HIV-1 infections. The lab report/s would be immediately relayed to the healthcare provider so that follow-up with care could be provided in a timely manner.

Methods: From April 2012 to February 2015, blood specimens were tested with the new HIV Diagnostic Algorithm (recently released CDC guideline, June 272014). Established versus acute HIV-1 infections were determined by the 3-test algorithm findings. Healthcare providers were called on the same day as an algorithm-defined AI was identified. A subsequent blood (EDTA plasma) for clinical management

baseline testing was requested. Upon receipt the plasma was immediately tested for HIV-1 antibody seroconversion and the baseline HIV-1 viral load (CD4 and genotyping performed only upon request from the provider). Results were electronically reported to the provider. In addition, a review of the public health STD database was conducted on each AI case to verify that the client had no previous HIV diagnosis.

Results: Of the 305,434 bloods tested with the new algorithm 5,773 (1.9%) were determined to be HIV-1 confirmed positive; of those, 38 (0.6%) cases were identified as algorithm-defined AIs. Thirty two baseline HIV-1 viral loads were completed and the results immediately submitted to the HIV healthcare provider. The remaining six cases were lost to follow-up. The mean time for baseline viral load reporting was 25.5 days (2 - 210). Seventy-nine percent (30/38) of the AI cases met the CDC 2013 surveillance performance standard for viral load testing within 3 months. The average viral load for 32 patients was 1,589,942 RNA copies/ml (5,101- 10,000,000). Of the 38 AIs, 30 were questioned about prior HIV testing history, 80% (24/30) provided affirmation and previous test date. In addition, 55% (21/38) of the AIs had a history of other STDs with 12 presenting with another STD at the time of HIV diagnosis.

Conclusions/Implications: Identification of acute HIV infection is profoundly important. The elevated viral load and the virulence of the virus in new infections intensify the likelihood of transmission and infection during high risk activity. Expedited clinical management testing after identification of acute HIV-1 infection with initiation of antiretroviral therapy has the potential to minimize new infections.

AP11

Abstract 1282 - Epidemiology and Surveillance

Author(s): *Judith Tejero, Amy Wohl, Shihui Bian, Eric Daar*

Background: Receipt of recommended clinical care is important for HIV-infected patients to maintain individual health, achieve viral suppression and prevent forward transmission. We analyzed Los Angeles County (LAC)'s 2009-2011 Medical Monitoring Project (MMP) data to (a) examine the proportion of HIV-infected patients who are receiving recommended HIV clinical care as defined by national HIV quality of care measures and (b) examine differences in receipt of recommended care by socio-demographic, clinical and risk behavior characteristics.

Methods: Data were collected via face-to-face interviews and medical record abstractions at the patients' usual source of HIV care between June 2009 to April 2012 (N=692). Data were weighted to adjust for known probabilities of selection and predictors of non—response to MMP sampling. The average combined response rate (facility participation rate multiplied by the adjusted patient response rate) was 53%. Care measures included guideline appropriate viral load (VL) and CD4 testing, antiretroviral (ART) prescription, sexually transmitted infection (STI) screening, influenza immunization, pneumocystis prophylaxis, and documented HIV prevention counseling. Prevalence estimates and 95% confidence intervals (CIs) were generated. Bivariate analyses were conducted, and unadjusted and adjusted prevalence ratios (APRs) were calculated using logistic regression with predicted marginal means in SAS and SUDAAN.

Results: Receipt of annual recommended HIV care included: VL (71%) and CD4 (97%) testing, ART prescription (92%), pneumocystis prophylaxis (74%), influenza immunization (72%) and STI screening for gonorrhea (66%), chlamydia (69%) and syphilis (87%). Only 35% were documented to receive HIV prevention counseling. Socio-demographic differences were found for receipt of HIV labs and treatment ($p < 0.05$): men who have sex with women were more likely to have received VL testing compared to men who have sex with men (MSM) [APR=1.15, CI (1.03-1.28)]; patients age 18—29 years were less likely to have received ART compared to those ≥ 50 years [APR=0.88, CI (0.78-0.99)]. Patients 18—29 years [APR=1.60, CI (1.04-2.48)] and 30—39 years [APR=1.46, CI (1.03-2.06)]; and Latino patients [APR=1.94 CI (1.22-3.10)] were more likely to have been documented to receive HIV prevention counseling compared to persons age ≥ 50 years and whites, respectively. In addition, patients receiving care at non-Ryan White—funded clinics were less likely to have received STI screening for gonorrhea [APR=0.14, CI (0.06-0.31)], chlamydia [APR=0.14, CI (0.07-0.32)] and syphilis [APR=0.66, CI (0.54-0.82)] compared to those receiving care at Ryan White—funded clinics; and patients with less education were more likely to have received influenza vaccination than those with higher education [APR=1.12, CI (1.01-1.24)].

Conclusions/Implications: Continued monitoring of patient receipt of recommended HIV care is needed to meet the National HIV/AIDS Strategy goals to reduce HIV infections, improve health outcomes and decrease disparities for people living with HIV. In particular, improvements in receipt of VL testing for MSM, ART prescription for younger patients, as well as STI screening and HIV prevention counseling for all sexually active persons are needed.

AP12

Abstract 1640 - Epidemiology and Surveillance

Author(s): EMILY CHEW, Rupali Doshi, Pamela Klein, Marlene Matosky, John Milberg, Vimal Rao

Background: The rate of new HIV diagnoses among black men who have sex with men (MSM) in the United States is two times that of white MSM. Among black MSM under the age of 30, the rate is even higher—three times that of white MSM. The Ryan White HIV/AIDS Program (RWHAP) works with states, cities and local community-based organizations to provide services to low-income people living with HIV who do not have adequate health care coverage to cover HIV-related medical and support services. With this funding, the RWHAP has been able to reach the most vulnerable and underserved populations living with HIV, including younger and older black MSM. This study aims to further identify services that may benefit black MSM.

Methods: Ryan White Services Report data from 2013 were used to examine viral suppression among younger (aged 13-24) and older (aged 25-44) black MSM, by Census regions (i.e., South, Northeast, West, and Midwest). Within each region, the top five RWHAP services utilized by younger and older black MSM with and without viral suppression were examined.

Results: In 2013, black MSM in the Midwest and Northeast regions had the highest levels of viral suppression among 13-24 year olds (59.18% and 59.37%, respectively) compared to those in the South (57.12%) and the West (52.40%). Black MSM aged 25-44 years in Midwest and Northeast regions had better viral suppression (73.84% and 71.78%, respectively) compared to the South and West regions

(68.28% and 68.39%). Black MSM aged 25-44 across all regions had higher percentages of viral suppression than their younger counterparts. Across all regions, regardless of viral suppression and age group, medical case management was the most utilized service. Across all regions, regardless of age group, those who were virally suppressed in 2013 mostly received medical case management, non-medical case management, mental health services, and health education services. Among individuals who were not virally suppressed, medical case management was also a primary service utilized, although smaller proportions of people utilized these services compared to those who were suppressed (e.g., 65.20% of black MSM aged 13-24 in the south who were not virally suppressed received medical case management, compared to 73.10% of those who were virally suppressed).

Conclusions/Implications: Young black MSM in all regions have lower percentages of viral suppression than their older counterparts. Some key services may encourage better outcomes for this population. Health education campaigns and public health initiatives related to treatment adherence and health education may help to increase engagement in care and treatment services among young, black MSM which may, in turn, enhance viral suppression for this population. Further research is needed to better understand viral suppression disparities across regions and age groups of black MSM.

AP13

Abstract 2234 - Epidemiology and Surveillance

Author(s): *Jeff Capizzi, Sean Schafer*

Background: The President's Emergency Plan for AIDS Relief (PEPFAR) defines the Tipping-point Ratio (TPR) as the number of new infections divided by the net number of cases that achieved viral load suppression (viral load <200 copies per milliliter blood) in a calendar year. TPRs have been employed as an accessible and intuitive measure of HIV transmission dynamics in underdeveloped countries where HIV surveillance is limited but these two data are available. Centers for Disease Control and Prevention recently calculated TPRs for calendar year 2011 for 10 U.S. jurisdictions, not including Oregon. We calculated TPRs for Oregon during 2008–2014 using the CDC approach and an alternate approach that restricted TPRs to non-negative numbers and was independent of the baseline relative proportions of suppressed and unsuppressed cases.

Methods: We calculated TPRs for Oregon for each year, 2008–2014, using two methods. In the first (CDC approach) we divided the number of newly diagnosed cases in a calendar year by the increase in the number of cases virally suppressed. The alternative TPR calculation was the ratio of inputs to the theoretical community-wide infectious (virally unsuppressed) compartment to outputs. Inputs included newly diagnosed cases that did not progress to viral suppression within the year, and cases who became unsuppressed. Outputs included cases who became suppressed, new diagnoses who became suppressed in the same year, and deaths among people with unsuppressed viral load. Group differences were examined using the alternative method.

Results: The CDC method produced TPR estimates >1 (2008–2012) and -5.5 in 2013. The alternate method produced TPR estimates that were consistently less than one and non-negative every year. The highest TPRs were among cases aged 20–24, American Indian/Alaska Natives, and presumed heterosexual women.

Conclusions/Implications: TPRs are intended to be less than one under conditions of declining transmission and greater than one under conditions of increasing transmission. TPRs estimated for Oregon using the CDC method resulted in values greater than one for each year, 2008–2012, being ambiguously negative in 2013. The alternate TPR method produced non-negative values consistent with the observed decline in new diagnoses and increase in viral suppression. TRP estimates are sensitive to the proportion of cases out-of-care and completeness of viral load reporting, and may have limited utility for comparative purposes across U.S. jurisdictions. TPR estimates did not identify groups less likely to get a viral load test or groups less likely to be virally suppressed.

AP14

Abstract 2271 - Epidemiology and Surveillance

Author(s): *Alia Al-Tayyib, Laura Ginnett, Toby LeRoux, Sarah Rowan, Edward Gardner*

Background: Among persons infected with HIV, viral suppression is critical for preventing onward transmission. We sought to describe the association between undetectable viral load and the decision to engage in anal sex without a condom among gay, bisexual, and other men who have sex with men (MSM).

Methods: Between June and November 2014, MSM were recruited using venue-based time-space sampling as part of the National HIV Behavioral Surveillance (NHBS) system in Denver, Colorado. Men were eligible if they were 18 years or older and reported sexual activity with a male partner in the preceding 12 months. Participants completed a behavioral survey and were offered a rapid HIV test. Participants who self-reported being HIV positive were asked a subset of questions regarding the result of their last viral load test and if they had decided to have sex without a condom because their viral load was undetectable during the past 12 months. Analysis is restricted to those who self-reported being HIV positive.

Results: Of the 720 men who were screened, 528 (73%) were eligible to participate. A total of 71 (14%) participants self-reported being HIV positive. Of those, 47 (66%) reported being white, non-Hispanic, 10 (14%) Hispanic, 5 (7%) black, non-Hispanic, and 9 (13%) other or multiple race categories. The median age was 42 (IQR: 32-49) years. Of the 71 self-reported HIV positive participants, 61 (86%) reported an undetectable viral load at their last test, 2 (3%) reported < 5,000 copies/ml, 4 (6%) reported a viral load between 5,000-100,000 copies/ml, 1 (1%) reported > 100,000 copies/ml, and 3 (4%) reported not knowing their result. Men over the age of 30 were significantly more likely to report an undetectable viral load compared to those 30 or younger (93% vs. 62%, $p=0.002$). Viral load did not differ significantly by race/ethnicity. A total of 23 (32%) self-reported positives decided to have sex without a condom because their viral load was undetectable in the past 12 months. Of the 23 who reported deciding to have sex without a condom, 19 (83%) reported that they had discussed both their HIV status and their most recent partner's HIV status before they had sex for the first time. Of the 71 self-reported HIV positives, 16 (23%) reported having one sex partner during the past 12 months, 11 (15%) reported two partners, and 44 (62%) reported having three or more partners. The number of reported partners did not differ significantly by viral load suppression.

Conclusions/Implications: In this sample, approximately one third of HIV positive participants with undetectable viral loads reported deciding to have condomless sex because their viral loads were undetectable. Though the risk of HIV transmission is reduced when viral loads are undetectable, other sexually transmitted infections (STI) such as gonorrhea and syphilis can still be easily transmitted when condoms are not used. There is continued need for STI prevention messaging among HIV positive MSM.

AP15

Abstract 2036 - Epidemiology and Surveillance

Author(s): *Amanda Castel, Jenevieve Opoku, Lindsey Powers Happ, Michael Kharfen, Alan Greenberg, Najj Younes*

Background: Without the availability of a unified health record, there are often gaps between clinical research data abstracted from medical records and surveillance data collected on HIV-infected persons. Further, the completeness of surveillance data is often limited by the complexity of reporting, underreporting, and timeliness of data. The DC Cohort study, an observational longitudinal cohort study of HIV infected persons in care at 13 clinical sites, conducts routine linkages to the District of Columbia (DC) Department of Health (DOH) surveillance databases. We sought to assess differences between data collected through the Cohort study and routinely collected DC DOH HIV/AIDS surveillance data.

Methods: DC Cohort data for participants enrolled between January 1, 2011 and December 15, 2014 were electronically linked to data from the DC DOH HIV, STD, and laboratory surveillance systems. Descriptive statistics were used to assess the completeness of reporting. Pre and post-linkage data were compared with respect to residency, diagnosis dates, prevalence of co-infections, and laboratory reporting. Care seeking patterns and co-enrollment in multiple Cohort sites was also measured.

Results: 6,592 DC Cohort participant records were submitted for linkage with the DC DOH surveillance database; 108 participants were determined to be enrolled at more than one Cohort site and therefore duplicate records. Among the remaining 6,484 individual participants, 5,758 (88.8%) matched to cases in the surveillance database. Among the 726 participants that did not match, 65% were non-DC residents. Among matched participants, pre-linkage the median duration of HIV infection among Cohort participants was 11.7 years; post-linkage it was 13.2 years. Additionally, 722 new opportunistic infections (OIs) were identified resulting in an increase in the proportion of AIDS diagnoses in the Cohort from 42.1% to 62.7%. 132 Cohort participants with previously undocumented STD diagnoses were also identified after the linkage. Post-linkage, an additional 5,794 viral loads (VL) and 7,445 CD4 lab results were added to the DC Cohort database. Using labs as a proxy for visits, 1,277 Cohort participants (19.7%) had evidence of receiving care at more than one clinical site. Among HIV surveillance cases, with the addition of Cohort data, risk was able to be determined for 588 cases for whom it was previously missing, increasing the completeness of surveillance risk factor ascertainment from 86.5% to 96.7%. The addition of VL lab results from Cohort data resulted in an increase in the proportion of matched surveillance cases who had a VL of <200 copies/ml from 75.0% to 87.8% during the study period.

Conclusions/Implications: Linkage of public health surveillance data with clinical cohort data was mutually beneficial and improved the completeness of both systems. For the clinical cohort, linkage assisted in identifying study co-enrollment, care patterns, accuracy of HIV diagnosis dates, and

previously missed STD and OI diagnoses. For surveillance, linkage allowed for improved accuracy with respect to risk factor ascertainment, reported laboratory indicators, and resulted in improved viral suppression rates. Routine linkages such as this are useful to researchers and public health surveillance programs and can assist with more accurately characterizing co-morbidities and care patterns among HIV-infected persons.

AP16

Abstract 2532 - Prevention and Care Programs

Author(s): *Carolyn Wester, Melissa Morrison, Shanell McGoy, Jennifer Randle, Richard Steece*

Background: Accurate and early diagnosis of HIV infection allows infected persons to know their status, access care, and reduce transmission. Point of care (POC) testing allows for rapid results, increasing post-test counseling rates among hard to reach populations. The Shelby County Health Department (SCHD) Laboratory conducts HIV testing for populations served by the SCHD, including two large county jails. The SCHD lab implemented conventional 4th generation HIV testing in April, 2013. Given the utility of rapid access to preliminary HIV test results and the availability of a rapid Ag/Ab POC test, the SCHD laboratory began screening all jail specimens with the Alere Determine HIV-1/2 Ag/Ab Combo test in June, 2014. All specimens with positive POC test results underwent conventional 4th generation testing; inmates received preliminary counseling based on the POC screening results. We report the results from laboratory based experience comparing POC versus conventional HIV-1/2 Ag/Ab testing.

Methods: From June until December, 2014, all blood specimens collected by SCHD testers at the men's and women's county jails underwent laboratory serum-based Alere Determine HIV-1/2 Ag/Ab testing. Specimens that were positive then underwent conventional BioRad HIV-1/2 Ag/Ab testing. Specimens advanced to steps 2 (Multispot HIV-1/2 Ab) and 3 (HIV-1 RNA) of the algorithm based upon step 1 BioRad results.

Results: Between June and December, 2014, 7,204 individuals underwent 4th Generation HIV Testing. 270 (3.7%) were positive on Determine screening, all of which underwent HIV-1/2 Ag/Ab testing using BioRad. Of these, 71.9% (194 of 270) tested positive on BioRad, and 28.1% tested negative. Of the 194 positive BioRad, step 2 confirmed 99.0% (192 of 194) as being positive (191 for HIV-1, 1 for HIV-2). Two specimens went onto Step 3, with one client diagnosed with acute HIV infection.

Conclusions/Implications: Our experience using Determine HIV-1/2 Ag/Ab POC test in the laboratory setting detected one HIV-2 infection and one acute HIV-1 infection that would have been missed if POC screening had been conducted using an earlier generation HIV-1 POC test. However, this approach also yielded an unacceptably high rate of preliminary false positive results, as compared to the BioRad-based conventional 4th generation algorithm. Based on these results, the SCHD lab is implementing plans to accelerate result turn-around utilizing conventional 4th generation testing, obviating the need to conduct POC testing altogether.

AP19

Abstract 1897 - Epidemiology and Surveillance

Author(s): *Christine Khosropour, Julia Dombrowski, David Katz, Lindley Barbee, Matthew Golden*

Background: Pre-exposure prophylaxis (PrEP) use is increasing among men who have sex with men (MSM). How MSM incorporate PrEP use into sexual decision-making has not been well studied.

Methods: MSM attending an STD clinic in Seattle, Washington, from January-March 2015 were enrolled in an ongoing study of seroadaptive behaviors and HIV risk. Men completed a computer-based survey on sexual behaviors in the past 12 months. Respondents with HIV-negative partners were asked if they chose to have sex or use condoms with HIV-negative partners based on whether the partner was taking PrEP. Respondents taking PrEP were asked if they had condomless anal intercourse (CAI) with an HIV-positive partner because the respondent was on PrEP. We describe the proportion of men who incorporated PrEP use into sexual decision-making, and examined associations (Chi-square or Fisher's exact tests) between this behavior and respondent HIV status, CAI, and HIV treatment status.

Results: We enrolled MSM at 363 (56%) of 644 eligible clinic visits including 309 (85%) self-reported HIV-negative MSM and 54 (15%) self-reported HIV-positive MSM. Eighty-seven percent (N=268) of HIV-negative and 61% (N=33) of HIV-positive respondents reported having HIV-negative partners. Discussing PrEP with HIV-negative partners before first sex was common but differed somewhat for HIV-positive compared to HIV-negative respondents (64% vs. 47%; P=0.07). HIV-positive respondents were more likely than HIV-negative respondents to report making a decision about having sex or using a condom with an HIV-negative partner based on the partner's PrEP use (39% vs. 20%; P=0.01). HIV-positive respondents who self-reported taking antiretroviral therapy (ART) were more likely to incorporate partner PrEP use into their decision to have sex or use a condom with that partner compared to those not taking ART (46% vs. 0%; P=0.13), as were those with a self-reported undetectable viral load compared to those self-reporting a detectable viral load (44% vs. 20%; P=0.63). HIV-negative respondents who reported incorporating their HIV-negative partners' PrEP use into their sexual decision-making were significantly more likely to report CAI with an HIV-negative partner than men who did not incorporate partner PrEP use in decision-making (81% vs. 67%; P=0.04) but this was not the case for HIV-positive respondents (62% vs. 67%; P=0.77). Of the 15 HIV-negative respondents who reported taking PrEP, 11 (73%) reported having CAI with an HIV-positive partner because they were on PrEP.

Conclusions/Implications: Discussing partner PrEP use is common among Seattle MSM and may drive sexual decision-making. Ongoing surveillance of these behaviors is critical to understanding their potential individual and population-level effects.

AP20

Abstract 1696 - Epidemiology and Surveillance

Author(s): *Madeline Sutton, Tracy Tie, Emma Frazier*

Background: In 2013, persons age 50 years and older comprised 18.1% of new diagnoses of HIV infection in the United States. Among all persons living with HIV infection, women represented 20% of the total. Yet as persons with HIV live longer, healthier lives, little is known about the social and clinical factors which may be associated with older age among HIV-infected women. We examined social, behavioral and clinical factors among younger vs. older HIV-infected women in care to inform the development of future HIV treatment and care interventions for women.

Methods: We used matched interview and medical record abstraction data from the 2009 through 2011 collection cycles of the Medical Monitoring Project (MMP), a cross-sectional survey of a representative sample of HIV-positive adults in care. We studied women diagnosed ≥ 1 year prior to interview and compared those aged ≥ 50 years at time of interview to women aged < 50 years. We examined variables defined over the 12 months prior to interview, including: demographic data, poverty level, insurance type, incarceration history, practicing sex without condoms, any drug use, current smoking history, sexually transmitted diseases (STD) testing among reported sexually active, geometric mean CD4 cell count, documented prescription of antiretroviral therapy (ART), and most recent HIV viral load. We also reviewed for self-reports of depression (last 2 weeks). We calculated weighted frequency estimates and performed logistic regression to compute unadjusted and adjusted prevalence ratios (aPR) and 95% confidence intervals (CI) for the association between social, behavioral and clinical factors with being aged ≥ 50 years versus < 50 years.

Results: Of 13,194 participants 3,461 were women. Of these, 37.5% (CI 35.5 – 39.6) were aged ≥ 50 years. In bivariate analysis, women aged ≥ 50 years were significantly ($p < 0.05$) more likely to be prescribed ART (91.6% vs. 87.8%), prescribed and currently taking ART (90.1% vs. 84.0%), and virally suppressed (75.8% vs. 66.7%) than women < 50 years. In multivariable analyses, compared with women < 50 years of age, women aged ≥ 50 years were more likely to have ≥ 10 years since HIV diagnosis versus < 5 years (aPR = 1.25; CI 1.07 – 1.46), live above the poverty level (aPR = 1.20; CI 1.07 – 1.34), have any public insurance versus no insurance (aPR = 1.44; CI 1.23 – 1.69), have a geometric mean CD4 count ≥ 500 cells/mm³ (aPR = 1.53; CI 1.23 – 1.90), and if sexually active to have no screening documented in their medical records for gonorrhea, chlamydia and syphilis (aPR = 1.18; CI 1.03 – 1.35). However, women aged ≥ 50 years were less likely to have a history of incarceration (aPR = 0.50; CI 0.29 – 0.85) and to report any depression (aPR = 0.87; CI 0.77 – 1.02) compared with women aged < 50 years.

Conclusions/Implications: These data suggest that HIV-infected women aged ≥ 50 years in care are doing well in several areas, but warrant increased routine STD screenings if sexually active. HIV care interventions that strengthen these clinical activities among providers may be warranted.

AP21

Abstract 1815 - Epidemiology and Surveillance

Author(s): *Anthony Romano, Jonathan Feelemyer, Suzan Walters, Michael Wilczek, Bridget Anderson, Lou Smith*

Background: Knowing one's HIV status is important to reducing incident infections, especially among high risk populations. Those with better health insurance coverage may be more likely to be offered and thus receive HIV testing. Regardless of the result, knowledge of one's HIV status may improve overall quality of life in that such individuals may experience lower stress. Those who test positive and enter care after diagnosis have newfound access to a wealth of supportive services; those who test negative, may be empowered by the post-test counseling and ongoing risk-reduction messaging. In this study we examine different levels of health insurance coverage (public, private and no insurance), levels of HIV testing, and perceived levels of self-reported stress among men who have sex with men (MSM) on Long Island New York in 2014.

Methods: Included in this analysis are 296 participants from the 2014 MSM4 cycle of the National HIV Behavioral Surveillance System (NHBS), which utilized venue based sampling to survey MSM living in Nassau and Suffolk Counties. Interviews were conducted using a standardized questionnaire that included a short form (4 item) version of the Perceived Stress Scale (PSS); voluntary anonymous HIV testing was also offered. Analysis of variance (ANOVA) was used to investigate mean scoring between groups of participants separated by self-reported current health insurance coverage. Multivariable ANOVA (MANOVA) was performed to investigate differences between scale items. Logistic regression examined demographic factors, relationship status, HIV testing frequency and substance use to explore possible associations with health insurance status. Analyses were conducted in SAS 9.3.

Results: There were clear disparities in health insurance coverage with Hispanic MSM less likely to report having public (OR: 0.40, CI: 0.16, 0.99) or private (OR: 0.26, CI: 0.11, 0.62) health insurance compared to white MSM. Overall PSS score analysis showed a significant difference in mean stress scores among all three groups ($p=0.02$). Participants reporting no health insurance scored higher on average on the PSS than those reporting public insurance. Participants reporting public insurance scored higher on average than those reporting private insurance. Multivariate regression documented that MSM reporting private insurance were more likely to report having an HIV test within the last 6 months compared to those reporting public insurance (OR: 2.18, CI: 1.15, 4.15) or no insurance (OR: 2.66, CI: 1.17, 6.04).

Conclusions/Implications: Since 2010, New York State law requires HIV testing be offered to all persons aged 18-64 receiving medical care in primary care and inpatient settings, with the purpose of increasing HIV testing and promoting entry to care. Despite this law, this analysis documented gaps in HIV testing by type of health insurance coverage. This analysis suggests that MSM who are not privately insured are less likely to have been tested for HIV within the last 6 months and face increased levels of stress than those who are privately insured. These results are consistent with other literature which document rates of insurance coverage amongst Hispanics as lower when compared to other races, suggesting a disparity in health care coverage amongst MSM on Long Island.

AP22

Abstract 2270 - Epidemiology and Surveillance

Author(s): *Jose Mulinelli-Rodriguez, Peter Shepard-Rivas, Yadira Rolon-Colon, Sandra Miranda-De Leon*

Background: Men who have sex with men (MSM) are the only group in which HIV incidence has been steadily increasing. Studies have reported that MSM are engaging in high-risk behaviors. Due to the availability of behavioral surveillance systems, opportunities for evaluating behavioral/sociodemographic changes are important in order to target prevention efforts for this community.

Methods: Data from the 2008 and 2011 PR National HIV Behavioral Surveillance (NHBS) MSM was used. This data is completed anonymously and voluntary. Participants were recruited using Venue-based sampling with remuneration for survey participation and HIV testing. Our sample is composed by 648 men of 18 years old or more that have oral or anal sex with other men during the last 12 months, were

born male and self-identify as male and live within the San Juan Metropolitan Statistical Area (SJMSA). Frequencies for socio-demographical and behavioral factors were calculated using chi-square tests.

Results: The mean age was 29 in 2008 and 31 in 2011 and most MSM have some collage or higher education, 79% and 74%, respectively. As well most MSM were employed (63%: 2008 and 57%: 2011). In 2008, 76% MSM had an annual household income of \$0 to \$19,999. However in 2011, 54% had an annual income of \$0 to \$19,999 and 46% had > \$20,000. Regarding their last sexual intercourse, 58% (2008) and 63% (2011), was with a casual sex partner. Each year, 45% of MSM have Receptive Anal Sex during their last sexual intercourse, and 52% (2008) and 53% (2011), use condom during the intercourse. The condom was used during the entire encounter by 84% (2008) and 92% (2011). However, each year 61% of MSM have Insertive Anal Sex during their last intercourse, and 56% (2008) and 55% (2011) use condom during the intercourse. The condom was used during the entire encounter by 91% (2008) and 92% (2011). During this last sexual intercourse, 22% (2008) and 26% (2011) used alcohol, 1% (2008 and 2011) used drugs and 3% (2008) and 4% (2011) used both. The drugs used were Marihuana (85% in 2008 and 56% in 2011), powdered cocaine (23% in 2008 and 28% in 2011) and poppers (8% in 2008 and 11% in 2011). MSM's that has sex with someone else in the past 12 months at same time that has a sexual relationship with last partner, were 44% in 2008 and 27% in 2011. The higher number of venues where MSM's meet their last partner were Bar/Clubs (33% in 2008 and 31% in 2011) and the internet (19% in 2008 and 30% in 2011).

Conclusions/Implications: Due the observed changes as the increase of use the internet to meet partners in MSM population the prevention strategies and interventions to reach this special population need to be enhanced.

AP23

Abstract 1301 - Epidemiology and Surveillance

Author(s): *Katie Macomber, Emily Higgins, Jennifer Mills, Vivian Griffin, Laura Cooley, Katie Salo, Kate Doyle*

Background: It is known that stigma and discrimination deters HIV testing. The National HIV Behavioral Surveillance (NHBS) system samples men who have sex with men (MSM), persons who inject drugs (PWID) and heterosexuals at increased risk for HIV (HET) using venue-based (for MSM) and respondent-driven (for PWID and HET) sampling to conduct interviews and HIV testing in 20 U.S. cities with high AIDS burden. This analysis seeks to examine whether perceived stigma and discrimination is higher in Detroit compared to the other large U.S. cities. Current HIV Care and Prevention activities in Detroit focus on frequent testing, early diagnosis, fast linkage, and continuous care. Stigma and discrimination may be barriers to any of these stages.

Methods: Sampling of MSM occurred in 2011, of PWID in 2012, and of HET in 2013. All participants were asked questions measuring perceived community-level HIV stigma. Participants in the MSM cycle were asked additional questions about individual experiences of discrimination related to their sexual orientation. P-values were calculated by comparing reported stigma and discrimination across all 20 cities (referred to as the NHBS sample) to those reported by Detroit participants. Analysis was conducted in SAS 9.3; p-values were calculated using chi-squared tests.

Results: Reports of perceived stigma and discrimination were consistently higher in all populations in Detroit than in the NHBS sample. Among MSM, the percent reporting being called names or insulted (40% vs. 32%), treated unfairly at work or school (18% vs. 14%), and physically attacked or injured (17% vs. 8%) because people knew or assumed they were attracted to men was higher in Detroit than the NHBS sample ($p=.0011$, $p=.03$ and $p=.0011$ respectively). The percent of MSM in Detroit who strongly disagreed or disagreed that people in Detroit are tolerant of gays and bisexuals was higher (44% vs. 14%) than in the NHBS sample ($p=.0001$). Participants in Detroit, in all 3 cycles, reported higher rates of perceived stigma in their community than those in the NHBS sample ($p=.0001$ for all 4 measures).

Conclusions/Implications: Detroit's demographics differed from the NHBS sample, and stratification among age, race, and sex was difficult due to small sample sizes. Other limitations include that data are not weighted, multivariable analysis has yet to be conducted and significant social desirability or interviewer bias may be possible. Stigma and discrimination are known barriers to HIV prevention activities, such as HIV testing. This analysis suggests stigma and discrimination are more common in Detroit than other U.S. cities. Prevention efforts in Detroit may benefit from efforts to reduce stigma and discrimination against sexual minorities and those infected with HIV. Further analysis is needed to assess the extent of which stigma and discrimination negatively impacts the goals of HIV prevention and care in Detroit, especially in the areas of testing, access to prevention services, and HIV knowledge. By recognizing barriers in any of these areas, programs can be tailored to increase testing and linkage, thus improving health outcomes and transmission rates.

AP24

Abstract 2261 - Epidemiology and Surveillance

Author(s): Dana Meranus, Julia Hood, Alexa Resler, Susan Buskin

Background: To improve the health status of an aging HIV-infected population, preventive care is needed for both HIV-related and unrelated illnesses. The Ryan White (RW) Program provides funding to HIV-care facilities that serve low-income people living with HIV (PLWH). Using data collected by the Medical Monitoring Project (MMP) in King County (KC), Washington, we evaluated the degree to which RW and non-RW funded HIV-care facilities in King County met select HIV/AIDS preventive care performance measures, including smoking cessation counseling, HIV prevention risk counseling, STD screening, influenza vaccination, cervical cancer screening, and prescription of PCP prophylaxis in the 12 months prior to participation in MMP.

Methods: MMP uses a 3-stage sampling design to capture nationally and locally representative population-based surveillance data on patients receiving HIV care. We analyzed cross-sectional MMP interview and medical record data collected in KC from 2009-2012. We generated weighted prevalence estimates that represent KC HIV care patients. Multivariate weighted Poisson regression models estimated the relative risk of achieving performance measures, comparing RW-funded to non-RW funded clinics. Based upon decisions made a priori, covariate inclusion varied by model and comprised combinations of age, race, income, education, health insurance status, nativity, sexual orientation, stimulant and injection drug use, unprotected sex, number of sex partners, and time since HIV diagnosis.

Results: Two RW-funded clinics served an estimated 43% (95% CI: 38% - 48%) of all patients receiving HIV care in KC. Compared to non-RW funded clinics, a larger proportion of patients at RW-funded clinics were Black, female, less educated, younger, lower income, and more recently diagnosed with HIV.

Most KC HIV care patients (76%, 95% CI: 72% - 80%) had received an influenza vaccine. Among smokers, 81% (95% CI: 76% - 86%) had discussed smoking cessation with their medical provider. Among patients with CD4 count <200 cells/mm³, 77% (95% CI: 69%-85%) had been prescribed PCP prophylaxis. Among women, 76% (95% CI: 69% - 83%) had received cervical cancer screening. In adjusted analyses, no difference in the receipt of any of the above preventive services was observed between RW-funded and non-RW funded clinics.

Among KC-PLWH who were sexually active or drug-users, 49% (95% CI: 44%-54%) reported receipt of HIV/STD prevention counseling. Among KC PLWH who were sexually active or had a recent STI or HIV diagnosis, 28% (95% CI: 24% - 33%), 30% (95% CI: 26% - 34%), and 50% (95% CI: 44% -55%) had been tested for chlamydia, gonorrhea, and syphilis, respectively. After controlling for demographics and risk behaviors, patients at RW-funded clinics were more likely to report receipt of prevention counseling (aRR=1.36, 95% CI: 1.10-1.69) and to have been tested for chlamydia (RR: 2.87, 95% CI: 1.71-4.81) and gonorrhea (RR: 2.38, 95% CI: 1.50-3.79).

Conclusions/Implications: The majority of King County HIV care patients had received preventive services related to respiratory disease and cancer. Receipt of sexual health related services was less common, especially at non-RW funded clinics. Strategies to further augment preventive care, including sexual health services, should be implemented in all HIV care settings.

AP25

Abstract 1405 - Epidemiology and Surveillance

Author(s): *Tonja Kyle, Alicia Edwards, Christian Evans, Jason Crow*

Issue: Managing electronic surveillance data collected from multiple sites across different computing platforms and producing analytic datasets in a timely manner to inform HIV prevention programs is challenging. These challenges are compounded by varying levels of electronic data collection experience and expertise within each of the sites.

Setting: The Data Coordinating Center (DCC) located in the Washington, DC area is the central entity responsible for the management and production of data collected within two large HIV surveillance systems at the Centers for Disease Control and Prevention (CDC): the Medical Monitoring Project (MMP) and National HIV Behavioral Surveillance (NHBS). MMP collects care and prevention utilization data from HIV-infected persons receiving HIV medical care (23 sites), and NHBS collects data on HIV risk and testing behaviors from individuals with, and at risk for contracting HIV (20 sites) across the United States and Puerto Rico. Data collected from both systems can provide grantees with information to target HIV prevention and care resources to better address the needs in their communities.

Project: The primary goal of DCC is to implement standardized data management and processing procedures for data collected from multiple sites for MMP and NHBS to produce analyzable datasets in a

timely and efficient manner. To accomplish this goal, DCC developed a secure, web-based application that includes tools to upload data, monitor and manage data collection, correct data errors and reconcile data discrepancies, and generate reports for sites and CDC to monitor data collection progress. DCC trains site staff to use the application and provides technical assistance throughout data collection. Sites receive cumulative reports indicating any data errors or discrepancies and apply corrections through the web application on a monthly basis. The resulting system facilitates and improves data management during data collection, thereby limiting the amount of time at the end of data collection necessary to produce analyzable data sets used to inform HIV prevention programs nationally and locally.

Results: On average, data are cleaned three months after data collection ends. Annually, DCC processes more than 1 million records, produces more than 3,500 datasets, and 165 weighted datasets for MMP and NHBS combined. Data produced by DCC have contributed to more than 80 CDC publications and more than 100 site publications in the areas of HIV prevention, care, and treatment since implementation of the DCC model in 2008.

Lessons Learned: The collection and management of data in multisite projects bring many challenges and complexities which can be addressed by identifying and prioritizing critical needs and building processes and procedures to address these needs. Data management processes and procedures should be standardized by DCC while allowing some degree of flexibility with implementation by sites. It is important to address data errors and discrepancies on an ongoing basis during data collection to expedite production of final analytic datasets. Ongoing data management training and technical assistance are essential due to site staff turnover. Lastly, it is critical to build a DCC system that is flexible to adapt requirements to meet changes in the HIV epidemic and is scalable to expand over time.

AP27

Abstract 2235 - Epidemiology and Surveillance

Author(s): *Feng Xia, Pascale Wortley, Cherie Drenzek*

Background: The HIV care continuum uses HIV surveillance data to monitor steps from diagnosis with HIV through viral suppression, the successful treatment of the infection. In Georgia, among persons diagnosed by 9/30/2011 and alive by the end of 2012, 39% were virally suppressed and 12% had a viral load (VL) >200. Forty nine percent were missing viral load (VL) information. Persons missing lab information are generally assumed to be out of care. We examined death rates and proportion dying outside of Georgia by VL status as an indirect means of estimating the number of persons missing viral load tests who are no longer in Georgia and erroneously included.

Methods: This was a retrospective cohort study. Persons diagnosed with HIV infection by December 31, 2009 and presumed to be living with HIV in Georgia as of the end of December 2009 were eligible for inclusion and followed through the end of 2012. We determined the proportion of people classified as virally suppressed (VS) (<200 copies/ml), not VS, or missing VL, based on the most recent VL test in each year. For each VL category we calculated the death rate and determined the proportion of deaths occurring outside of Georgia.

Results: Of the 42,396 eligible cases, 13,050 (31%) were VS, 7,664 (18%) were not VS, and 21,682 (51%) were missing VL by the end of 2010. Four distinct groups accounted for 70% of the cohort in 2012: 1) among the 13,050 who achieved suppression by the end of 2010, 9,650 remained virally suppressed through 2012. Of these, 93 (0.96%) died in 2012, and 7 (8%) died outside of Georgia; 2) among the 7,664 who did not achieve suppression by the end of 2010, 2,437 remained unsuppressed through 2012. Of these, 111 (4.55%) died in 2012 and 13 (12%) died outside of Georgia; 3) among the 21,682 who were missing VL in 2010, 13,406 had no VL through 2012. Of these, 142 (1.06%) died in 2012, and 59 (42%) died outside of Georgia; 4) among those who were missing VL in 2010, 3,430 achieved suppression in 2011 and maintained it in 2012. Of these, 36 (1.05%) died in 2012, and 3 (8%) died outside of Georgia.

Conclusions/Implications: Persons with missing lab data for several years included a combination of persons who were not in care, persons whose labs were missing due to incomplete reporting, and persons who were no longer in Georgia and were erroneously included in the count of persons living with HIV in Georgia. The proportion of persons with no VL for 3 years who died out of state (42%) was higher than other groups, suggesting that a substantial proportion of persons missing VL for 3 years may not be in Georgia. Additional work is needed to determine which HIV cases are no longer in the state to more accurately estimate the proportion of persons living with HIV that has achieved viral suppression in Georgia.

AP28

Abstract 2323 - Epidemiology and Surveillance

Author(s): *Natasha Crumby*

Background: In 2010, the state of Georgia had an estimated HIV prevalence of 187.1 diagnosed HIV infections per 100,000 people. Three of the four counties in the Metro Atlanta area had rates vastly exceeding the state's rate. Linkage to care in Georgia is disproportional to the amount of new positive cases year.

Methods: Beginning June 1, 2012 and ending October 30, 2014, Opt-out serum HIV screens were offered to all individuals age 13-64 years, with known or unknown HIV status, presenting for a visit in a group of primary care clinics located in the Metro Atlanta area. While, beginning March 1, 2014 and ending November 30, 2014.

Results: During the two years sited, 16822 serum HIV screens were performed with additional testing to confirm positive screens. One hundred eight of the individuals tested (0.64%) were found to be HIV positive. (95%) of the individuals found positive were African-American, (57%) were male and (27%) were between the ages of 23-30 years. Linkage into care in-house at 40%. Of the individuals (108) testing HIV positive, seventy-two (66%) did not know they were HIV positive and thirty-six (34%) later reported they were previously determined positive for HIV prior to the routine HIV screen performed. Of the (108) HIV positive individuals the average CD4 was 346. All one hundred eight (100%) of these individuals, regardless of newly or previously determined HIV positive status, were linked to and completed at least one visit with a medical care provider. (60%) of clients were given treatment related to their positive HIV status with (40%) of the clients receiving HIV treatment in-house. It was also

determined that 66% of the patients newly diagnosed were established patients within the primary care clinics and had not been offered HIV screening until routine HIV screening was established.

Conclusions/Implications: In an effort to align with the shifting responsibility of HIV care, Southside has worked to build treatment capacity to care for their own HIV patients. Collaboration with ID consultants supports Southside's ongoing efforts to care for patients in-house. As a result, 40% of those diagnosed via the routine screening program are currently being cared for in-house. SMC has developed an HIV protocol addition to their Patient Centered Medical Home (PCMH), with an aim to educating and preparing providers to holistically treat HIV-positive patients and retain them in care beyond the first appointment. SMC is making accelerating progress in the maintenance of HIV/AIDS.

With the growing amount of HIV positive clients identified there was a need for integrated care; therefore, a champion provider was trained with SEATEC. After the completion of the 12 month training the primary care provider was equipped to administer HIV Care and help the other providers treat. As clients are identified positive we have found it beneficial to have a patient navigator and care coordinator link client to care within the 30 days of diagnosis. Going forward there are more the 43 client receiving HIV care within Primary Care.

AP29

Abstract 1450 - Epidemiology and Surveillance

Author(s): *Steven Nesheim, Margaret Lampe, Lauren Fitz Harris, Allan Taylor*

Background: The prevalence of HIV diagnoses among delivering women and the proportion of HIV-infected women with deliveries covered by Medicaid are not well established, but these data would be useful in the planning and allocation of resources for HIV prevention and care. Data on the number of HIV-infected women delivering infants in the United States are not routinely reported in national HIV surveillance systems. The most recent estimate is that 8700 HIV-infected women delivered infants in the United States in 2006.

Methods: Using data from the Centers for Medicare and Medicaid Services, women with a delivery code (as defined by HEDIS 2010 PPC-A and PPC-B definitions) during 2010-2011 and at least one ICD-10 diagnosis code indicating HIV infection were identified according to their jurisdiction of residence (50 states and the District of Columbia). Women were counted if they had Medicaid coverage for any period in the calendar year of delivery, prior to or during the delivery hospitalization.

Results: During 2010 and 2011, respectively, 6586 and 5915 HIV-infected women with Medicaid coverage delivered infants. Ten jurisdictions accounted for 76% (4999/6586) of these deliveries in 2010 and 74% (4361/5915) in 2011. The ten states with the highest numbers of Medicaid-supported deliveries of HIV-infected women in 2010 were NY, 955; CA, 863; FL, 824; TX, 606; MI, 383; GA, 323; IL, 309; LA, 257; NJ, 251; MD, 228.

The ten states with the highest numbers of Medicaid-supported deliveries of HIV-infected women in 2011 were NY, 1053; FL, 994; TX, 427; IL, 375; CA, 367; LA, 272; GA, 260; MD, 244; MI, 190; NJ, 179. The prevalence of HIV infection among Medicaid-supported women delivering in all jurisdictions was 0.38% (6586/1731335) in 2010 and 0.46% (5915/1276207) in 2011.

The ten jurisdictions with the highest prevalence of HIV diagnoses among Medicaid-supported deliveries in 2010 were (in descending order) DC, 1.85%; NJ, 0.81%; NY, 0.79%; FL, 0.75%; MD, 0.74%; MI, 0.68%; MA, 0.65%; LA, 0.64%; DE, 0.54%; WV, 0.46%.

The ten jurisdictions with the highest prevalence of HIV diagnoses among Medicaid-supported deliveries in 2011 were (in descending order) DC, 3.08%; FL, 1.45%; NY, 0.95%; NJ, 0.91%; MD, 0.84%; LA, 0.74%; MA, 0.72%; IL, 0.56%; WV, 0.46%; TN, 0.45%.

Overall, in both years, the age distribution of HIV-infected delivering women was, approximately, ≤18 years, 6%; 19-24 years, 32%; 25-35 years, 50%; 36-45 years, 11%; > 45 years, < 1%.

Conclusions/Implications: In the absence of more recent data, assuming the annual number of HIV-infected women delivering remained similar to the most recent estimate of 8700, approximately 2/3 to 3/4 (68% - 76%) had Medicaid coverage in 2010 and 2011. Large states account for a substantial absolute number of HIV-infected women delivering infants while on Medicaid coverage, not all of which have higher prevalence than smaller states. Medicaid eligibility criteria and the availability of private insurance coverage for HIV-infected women delivering might explain some of these differences and should be examined.

AP30

Abstract 1497 - Epidemiology and Surveillance

Author(s): *Kelsey Loeliger, Mary Biggs, David Seal, Michael Gordon, Curt Beckwith, Irene Kuo, Jeremy Young, Carol Golin, Sandra Springer, Redonna Chandler, Wendee Wechsberg, Frederick Altice, William Cunningham*

Background: The objective of this analysis was to describe sexual risk behaviors among HIV-infected and uninfected persons involved, or at risk for involvement, in the criminal justice system (CJS), and to compare these behaviors between men and women. Literature suggests that CJS-involved persons engage in HIV sexual risk behaviors at higher rates than those who are not involved in the CJS. Gender-specific differences related to condomless sex may also exist within CJS-involved populations. Identifying these differences is important to designing interventions to mitigate the risk of HIV transmission within this high-risk population and to their community contacts. However, data from large cohorts exploring potential gender differences are not available.

Methods: The present analysis is based on data from six studies participating in the NIH-funded Seek, Test, Treat and Retain (STTR) Data Harmonization Project, which aims to maximize clinical research on HIV and substance abuse through the use of common measures across studies and integrated data analysis. The studies are based in Washington, D.C., Maryland, Rhode Island, Connecticut, Massachusetts, Wisconsin, and Illinois. While eligibility criteria varied between studies, all participants were ≥18 years old and primarily recruited from CJS-based settings (prison, jail, community supervision); participants had a past or current history of CJS involvement and/or a high likelihood of future CJS involvement by virtue of opioid dependence. A harmonized risk behavior assessment tool was administered to eligible participants to evaluate sexual risk behaviors in the reference period: 30 or 90 days prior to incarceration for detainees, or the previous 30 or 90 days for participants in the community. Means and proportions were calculated to describe demographic and risk behavior characteristics, and differences in proportions were tested using the chi-square test.

Results: The sample of individuals analyzed (both incarcerated and in the community) included 606 HIV-infected participants, of whom 26% were women, and 4,777 uninfected participants, of whom 10% were women. The mean age of HIV-infected and uninfected participants was 45 (SD±11) and 34 (SD±11) years, respectively. Preliminary results showed that although the proportion of participants reporting >1 sexual partner was similar between HIV-infected women and men (23% vs. 25%; $p=0.74$), among sexually active HIV-infected persons, a significantly higher percentage of women compared to men reported engaging in condomless vaginal and/or anal sex in the last 30 or 90 day period (47% vs. 34%; $p=0.03$). Among HIV-uninfected individuals, a smaller proportion of women reported >1 partner (26% vs. 40%; $p<0.01$) but a similar proportion of women and men reported condomless sex (74% vs. 69%; $p=0.09$).

Conclusions/Implications: Findings suggest high rates of condomless sex among HIV-infected and uninfected CJS-involved persons, particularly women, despite their being at higher risk for HIV than the general population. While a higher proportion of HIV-uninfected men report having >1 sexual partner, women may be at higher risk for acquiring and transmitting HIV via unprotected sexual contact. This study supports the development of both CJS- and community-based, gender-specific interventions aimed to improve condom use and reduce the risk of HIV sexual transmission among persons involved, or at risk for involvement, in the CJS.

AP31

Abstract 1596 - Epidemiology and Surveillance

Author(s): *Edna Marrero Cajigas, Sandra Miranda De León, Maritza Cruz Cortés*

Background: The HIV epidemic among men who have sex with men (MSM) is expanding in Puerto Rico. HIV-infected MSM are at greater risk of acquiring an STD and transmitting the infections to their partners. The purpose of this study was to describe high risk sexual behaviors and drug use among HIV-positive MSM with a syphilis occurrence in 2013.

Methods: We analyzed syphilis data reported to the STD Surveillance Program in 2013. To identify HIV status, we conducted a record linkage with HIV/AIDS Surveillance Program data reported through December 2014. A probabilistic matching was used to identify individuals with syphilis who were also diagnosed with HIV, and calculated time intervals between HIV and syphilis diagnosis date. Interview data from STD*MIS were assessed to determine drug use and sexual behaviors among HIV-positive MSM.

Results: Of 497 MSM with a syphilis occurrence in 2013, 162 (32.6%) were co-infected with HIV. Over 90% were diagnosed with syphilis at or after HIV diagnosis. The median number of months between HIV diagnosis and syphilis was 22 months. Over 50% of co-infected MSM reported two or more sexual partners during the past twelve months. Thirty-nine percent reported meeting sex partners through the Internet, 48.8% had sex with an anonymous partner, and 21.6% had sex while intoxicated and/or high on drugs. Twenty-eight percent reported the use of drugs.

Conclusions/Implications: MSM continue to engage in high risk sexual behaviors after HIV diagnosis, increasing their risk of acquiring an STD and most likely transmitting the HIV infection to their partners. Increasing the frequency of STD testing and prevention interventions among the HIV-positive MSM population may improve health outcomes for both infections and reduce the risk of transmission.

AP33

Abstract 1300 - Epidemiology and Surveillance

Author(s): *Jennifer Fagan, Emma Frazier, Ping Huang, Richard Wolitski, Luke Shouse*

Background: HIV-infected persons experiencing homelessness often face comorbidities such as mental health disorders and substance use. Consistent HIV care and prevention services pose a challenge for persons experiencing homelessness as they confront poor social and health conditions. Limited nationally representative data on this population are available to guide care and prevention efforts. We describe the characteristics of and HIV care and prevention services received by HIV-infected patients who reported homelessness in the United States.

Methods: We used combined data from the 2009 through 2011 cycles of the Medical Monitoring Project, an annual cross-sectional survey of a probability sample of HIV-infected adults receiving outpatient medical care in the United States and Puerto Rico. Using matched interview and medical record data, we assessed the clinical characteristics, quality of care, and use of prevention services in the year prior to interview among HIV-infected patients in care who reported homelessness. We defined homelessness as living on the street, in a shelter, in a single residency occupancy hotel, or in a car at any time during the past 12 months. Unweighted frequencies and weighted percentages were calculated and accounted for clustering, unequal selection probabilities, and non-response.

Results: We obtained data for 13,191 HIV-infected patients; of those 1,121 (8%) reported homelessness during the past 12 months. Of patients who reported homelessness, the majority were male (71%), black, non-Hispanic (52%), and aged ≥ 40 years (70%). Additionally, 44% reported injection or non-injection drug use during the past 12 months, 19% were incarcerated during the past 12 months, 22% had major depression, and 62% were current smokers. Although 84% of patients in HIV care who reported homelessness reported taking antiretroviral medication, only 61% had a recent viral load test result that was undetectable or < 200 copies/ml. About 65% reported having sex during the past 12 months. Of those, 25% had unprotected vaginal or anal sex with a partner whose HIV status was negative or unknown. Additionally, 60% of sexually active patients who reported homelessness reported receiving counseling from their healthcare provider about ways to prevent transmission of HIV and other STIs.

Conclusions/Implications: Nearly one in ten (8%) HIV-infected patients in care in the United States experienced homelessness during the past 12 months. HIV-infected patients who reported homelessness faced comorbidities such as major depression, smoking, drug use, and incarceration, which can lead to poor care utilization and poor health outcomes. Furthermore, one in four sexually active patients in care who experienced homelessness had unprotected sex with a partner whose HIV status was negative or unknown. Clinical guidelines indicate that providers should routinely discuss HIV/STI prevention with sexually active patients; nonetheless, only 60% of patients who reported

homelessness received prevention counseling. Care providers might consider screening patients to determine whether they have experienced recent homelessness. For HIV-infected patients who report homelessness, providers may need to dedicate additional time and support to effectively deliver clinical care and prevention messages and link patients to a broad range of ancillary services including housing solutions.

AP34

Abstract 1525 - Epidemiology and Surveillance

Author(s): *Ann Dennis, Dana Pasquale, Steve Beagle, Victoria Mobley, Anna Cope, JoAnn Kuruk, Lynne Sampson, Joseph Sebastian, Charles Walworth, Peter Leone*

Background: A greater than three-fold rise in acute HIV infection (AHI) among MSM was reported in Charlotte and western NC (“outbreak”) regions during early 2014 prompting a state public health investigation. The dynamics of HIV transmission among AHI index cases and their partners were examined using phylogenetic and network analyses.

Methods: We prospectively tracked 33 indexes reported in NC between Dec. 2013 and June 2014 (28 AHI, 5 recent infections), 130 partners identified during contact tracing, and HIV-1 pol sequences sent during clinical care. In cross-sectional analyses contact networks were constructed for indexes and partners. For indexes and HIV-infected partners, maximum-likelihood phylogenies were reconstructed with reference pol sequences from the UNC Center for AIDS Research (CFAR) HIV Clinical Cohort (n=1673, sampled 1997-2011). Transmission clusters were defined as clades with ≥ 1 index sequence with mean pairwise genetic distance $\leq 1.5\%$ and bootstrap support $\geq 98\%$.

Results: Indexes were predominately MSM (94%), young (median age 27 years), and black race (64%). Mean of 2.9 first-degree partners were reported per index. Of partners: 44% were HIV-infected (only 5% newly diagnosed during tracing), 29% tested HIV-negative, and 27% had unknown status. For previous HIV-infected, median of 4.7 years had elapsed since diagnosis and 48% had HIV viremia at last reported viral load. In the outbreak regions, 20 independent network components were identified involving 22 indexes and 91 partners, with low overall density of 0.030. No components connected to those from other regions across NC; however, 27% of partners resided outside the region. The mean index node degree was low at 0.76 (SD 0.81) for HIV+, 1.4 (SD 1.2) HIV-negative, and 1.2 (SD 1.6) status unknown partners. Sequences were available for 76% indexes (86% in outbreak region) and 35% HIV-infected partners. All were subtype-B. 48% (12/25) of indexes were found in 10 transmission clusters (all n=2 members); 2 were all indexes, 5 were index and partner (3 partners were newly diagnosed), and 3 were an index linked with a local CFAR sequence.

Conclusions/Implications: Phylogenetic analysis revealed that the spatiotemporal clustering observed is not a product of a single clustered outbreak but the concurrent expansion of several smaller clusters, fueled by both previously known and undiagnosed infections. Networks were largely disconnected within regions, with parameters suggesting low yield of case finding. The findings underscore the need for innovative ways to reach networks and disseminate a combination of primary and secondary prevention measures.

AP35

Abstract 2491 - Epidemiology and Surveillance

Author(s): *Kristina Larson, Matthew Mietchen, Allyn Nakashima*

Background: Linkage and retention of HIV infected individuals to treatment has been set as a standard for preventing the spread of HIV. Understanding the demographics of people living with HIV (PLWH) not receiving medical care and/or achieving viral suppression is an important step towards a suppressed community viral load. Viral suppression is the focus of HIV prevention from the public health perspective. The objective of this analysis was to establish a baseline assessment of those lacking HIV care and viral suppression in Utah.

Methods: HIV surveillance data exported from the enhanced HIV/AIDS Reporting System (eHARS) were utilized for analysis. PLWH were defined as those diagnosed with HIV through December 31, 2012 and currently living in Utah through December 31, 2013. Demographic data included Race/Ethnicity (White, non-Hispanic; Hispanic, any race; Black, non-Hispanic) and Risk Category (MSM – Men who have Sex with Men; IDU – Infection Drug Use; MSM/IDU – combined risk; Heterosexual). Cross tabulation of demographic data was performed for those who were Ever in Care, Linked to Care, Currently in Care, Retained to Care, and those who had achieved Viral Suppression.

Results: Of the 2,872 PLWH in Utah, 2,694 (94%) were Ever in Care, 1,421 (49%) were Linked to Care, 1,694 (59%) were Currently in Care, and 1,157 (40%) were Retained to Care. Of those Currently in Care, Viral Suppression was achieved in 1,420 (84%). Analysis of Race/Ethnicity revealed that ethnic minorities (54% Hispanic and 51% Black) were less likely to be Currently in Care than Whites (61%). Furthermore, fewer ethnic minorities were Ever in Care (91% Hispanic and 93% Black compared to 95% White) and Retained to Care (36% Hispanic and 38% Black compared to 42% White). However, Hispanics were more likely Linked to Care (57%) followed by Whites (61%) and Blacks (43%). Cross-tabulation by risk category revealed that 44% IDU, 60% MSM, 65% MSM/IDU and 58% Heterosexual were defined as Currently in Care. IDUs were more likely to drop off at every step of the HIV care continuum. Only 91% of IDUs were Ever in Care compared to 95% MSM, 97% MSM/IDU and 95% Heterosexual. IDUs were less likely to be Linked to Care (41%) compared to MSM (49%), MSM/IDU (54%) and Heterosexual (55%) and Retained to Care (26% IDU, 42% MSM, 45% MSM/IDU and 40% Heterosexual). For Viral Suppression, of those Currently in Care, only 76% of Blacks achieved Viral Suppression compared to 85% of Whites and 83% of Hispanics. Viral suppression stratified by transmission category revealed that 70% of IDUs achieved viral suppression compared to 88% among both MSM and Heterosexual.

Conclusions/Implications: By understanding what populations are in or out of care and what populations are not achieving viral suppression, linkage and retention to care can be improved for the entire HIV population. Our analysis revealed that retaining ethnic minorities and IDUs in HIV medical care and implementing interventions that aim to achieve viral suppression need to be prioritized.

AP36

Abstract 1746 - Epidemiology and Surveillance

Author(s): *Robyn Fanfair, Rulin Hechter, W-L Joanie Chung, Sean Anand, Lauri Markowitz*

Background: We assessed clinical and laboratory characteristics among HIV-infected (+) and HIV-uninfected (-) cases with neurosyphilis (NS) at Kaiser Permanente Southern California.

Methods: We performed a retrospective analysis of incident syphilis cases from 2006-2012 and ascertained demographic, clinical and laboratory data. Inclusion into the study required a new positive syphilis serologic test, documented syphilis treatment and at least one follow-up rapid plasma reagin (RPR) within 365 days from date of syphilis diagnosis. Patients were defined as having NS if they had both: (a) NS ICD-9 code and (b) NS treatment defined as aqueous crystalline or procaine penicillin.

Results: A total of 1,600 incident syphilis cases met the inclusion criteria; 1,062 (66.4%) HIV+ and 538 (33.6%) HIV-. The majority of cases were male (1481;93%); median age, 42 yrs (range 18-88). A total of 40 cases met criteria for NS; 35 (3%) of the HIV+ syphilis cases and 6 (1%) of the HIV- cases. Among HIV+ and HIV- NS cases, 18 of 35 (53%) and 4 of 6 (67%) were diagnosed with NS at time of initial syphilis diagnosis. Among these cases, 17 (94%) and 1 (25%) had initial lumbar puncture (LP). Among 35 HIV+ syphilis cases meeting NS criteria, initial syphilis treatment included benzathine penicillin G (9 cases), IV aqueous penicillin (13 cases) and both (11 cases). Neurologic symptoms (including ocular, tabes dorsalis and paresis) were present in 8 of 35 HIV+ NS cases and 4 of 6 HIV- NS cases. Compared with 757 HIV+ cases that did not have NS, the 35 cases with NS had a lower median CD4 count (317 vs 493 cells/ml) and higher median VL (21,695 vs. 15,618 copies/mL). 19 of 35 (54%) were on ARVs vs 74% of HIV+ cases without NS. The median RPR titer at time of diagnosis was 1:128 among HIV+ cases with NS vs 1:64 among HIV+ cases without NS. Among all syphilis cases meeting NS criteria, 91% of HIV+ and 100% of HIV- achieved \geq 4-fold decline in RPR titer at 12 months.

Conclusions/Implications: HIV+ syphilis cases were three times more likely to meet the NS criteria compared with HIV- syphilis cases. HIV+ syphilis cases meeting the NS criteria had lower CD4 counts and higher RPR titers at time of syphilis diagnosis compared to HIV+ cases that did not. A small proportion of HIV+ syphilis cases that met NS criteria had neurologic manifestations at time of diagnosis.

AP37

Abstract 2469 - Epidemiology and Surveillance

Author(s): *Wen Lin, Supriya Rao, George Han, Pamela Stoddard*

Background: Hispanics are disproportionately affected by HIV infection and are more likely to be diagnosed late and less likely to receive prompt care after diagnosis than non-Hispanic whites. The few studies comparing survival of Hispanics with HIV by nativity have conflicting results. This study examined risk factors associated survival after HIV diagnosis among Hispanics born in Mexico, U.S.-born Hispanics, and U.S.-born non-Hispanic whites in Santa Clara County, California, where Hispanics accounted for 39% of newly diagnosed HIV cases in 2013.

Methods: We followed individuals from the three groups aged 15 years and older who were newly diagnosed with HIV in 2000–2010 from their date of diagnosis through December 31, 2013. Foreign-born Hispanics who were born in countries other than Mexico were excluded due to small numbers and diverse countries of origin. Mortality rates were calculated, and the Kaplan-Meier method was used to compare the cumulative survival probability among the three groups. Associations between survival and

predictors were examined using univariate and multivariate Cox proportional hazard modeling. Variables considered were gender, age at diagnosis, mode of transmission, year of diagnosis, race/ethnicity and nativity, use of anti-retroviral therapy, late diagnosis (defined as being diagnosed with AIDS within 12 months of initial HIV diagnosis), and early linkage to care (defined as having a CD4 count or viral load performed within three months of HIV diagnosis).

Results: Of 1,240 individuals with HIV, 319 were U.S.-born Hispanics, 352 were Mexico-born Hispanics, and 569 were U.S.-born non-Hispanic whites. More Mexico-born Hispanics were diagnosed late (57%) compared to U.S.-born Hispanics and U.S.-born whites (44% for both groups; $p=0.002$). The mortality rate among Mexico-born Hispanics was similar to that of U.S.-born Hispanics and U.S.-born whites (1.09 per 100 person-years vs. 1.54 and 1.50, respectively). The Kaplan-Meier method did not find significant differences in survival among the three groups (log rank=2.09, $p=0.3514$), even after controlling for other factors. Overall, poor survival was significantly associated with late diagnosis (adjusted hazard ratio (AHR)=3.57, 95% confidence interval (CI): 2.19–5.80). Compared to men who have sex with men (MSM), injection drug users (IDU) and MSM who also injected drugs (MSM&IDU) had worse survival (IDU: AHR=2.38, 95% CI: 1.35–4.20; MSM&IDU: AHR=2.18, 95% CI: 1.21–3.94). Individuals <40 years had better survival than those ≥ 50 years (ages 15–29: AHR=0.22, 95% CI: 0.11–0.47; ages 30–39: AHR=0.37, 95% CI: 0.21–0.64; ages 40–49: AHR=0.79, 95% CI: 0.49–1.26). Gender, year of diagnosis, use of anti-retroviral therapy, and early linkage to care were not significantly associated with survival.

Conclusions/Implications: We found no significant differences in survival after HIV diagnosis for Mexico-born Hispanics, U.S.-born Hispanics, and non-Hispanic whites. Older age at diagnosis, injection drug use, and late diagnosis were significantly associated with poorer survival. Further studies are needed to understand the relationship between survival and other factors not routinely reported in HIV surveillance, such as comorbidities, healthcare access, health insurance, retention in care, and participation in safety net programs. Such investigation may inform development of programs to improve survival across subgroups.

AP38

Abstract 1801 - Epidemiology and Surveillance

Author(s): Rudy Patrick, Sara Glick, Jonjelyn Gamble, Anthony Rawls, Jenevieve Opoku, Manya Magnus, Michael Karfen, Irene Kuo

Background: Given the continued HIV epidemic affecting Black men who have sex with men (MSM) in the US, they remain a priority population for HIV prevention efforts. Sexually transmitted infections (STI) increase the risk of HIV transmission and acquisition, and a higher STI prevalence among Black MSM has been consistently identified as a potential driver of the observed racial disparities in HIV. However, STI testing behaviors among Black MSM – especially among young Black MSM – have not been well characterized. This study assessed racial disparities in STI prevalence and correlates of STI testing among MSM in Washington, DC.

Methods: MSM in Washington, DC were recruited between July and December 2014 using venue-based time-space sampling as part of the Center for Disease Control and Prevention's (CDC) National HIV Behavior Surveillance system (NHBS MSM-4). Men age ≥ 18 years who reported ≥ 1 male sex partner in

the last 12 months completed a behavioral survey and voluntary rapid HIV testing. We examined racial disparities in self-reported STI in the past year by age (<25, ≥25) for chlamydia, gonorrhea and syphilis. Using multivariate logistic regression, we assessed independent demographic, drug use, HIV status, and sexual risk behaviors as correlates of STI testing in the past 12 months.

Results: Of 510 MSM enrolled in the study, 42.0% were Black, 37.7% were White, 12.8% were Hispanic, and 20.0% were <25 years old. More than half (56.9%) reported seeking STI testing in the past 12 months. Among MSM who had received STI testing, the prevalence of any STI in the past year was twice as high among Black young MSM (29.2%) than White (13.3%) and Latino (11.8%) young MSM ($p=0.17$). Specifically, among Black young MSM, 14.6% reported a chlamydia diagnosis, 12.5% reported gonorrhea, and 20.8% reported syphilis. Younger MSM (<25 years) reported a higher prevalence of chlamydia, gonorrhea, and syphilis than older MSM (≥25 years) across all racial/ethnic groups. MSM who reported any STI testing in the past year were more likely to be <25 years old (adjusted odds ratio (aOR): 2.1, 95% confidence interval (CI): 1.2-3.8), report visiting their healthcare provider in the last year (aOR: 3.3, 95% CI: 1.9-5.8), report receiving the HPV vaccine (aOR 2.4, 95% CI: 1.3-4.4) and have ≥6 male sexual partners in the last year (aOR: 2.5, 95% CI: 1.4-4.6). Black MSM were more likely to seek STI testing than White MSM, but this finding was not statistically significant (aOR: 1.5, 95% CI: 0.9-2.3).

Conclusions/Implications: The CDC recommends at least annual STI screening for sexually active MSM, yet in this study of MSM in Washington, DC, 43% of MSM did not follow this recommendation. STI prevalence among young MSM, and especially among Black young MSM, was very high. Consistent with prior research, MSM at higher risk of HIV, particularly young MSM and those with multiple sexual partners, were more likely to be tested for STIs. STI testing, including increased testing frequency and follow-up after STI diagnosis and/or exposure, should be emphasized as a potential intervention point for HIV prevention services, specifically among Black young MSM.

AP39

Abstract 1379 - Epidemiology and Surveillance

Author(s): *Kristen Hess, Catlainn Sioanean, Elizabeth DiNunno, Wade Ivy, Kathy Hageman, Gabriela Paz-Bailey*

Background: Heterosexual anal intercourse (HAI) is not uncommon and confers an increased risk for HIV acquisition compared to vaginal intercourse, yet HAI remains under-emphasized in heterosexual prevention messages. Studies show HAI is associated with a variety of risky behaviors and suggest that people who engage in HAI are at higher risk for exposure to HIV. Better characterization of the groups who engage in HAI and factors associated with condom use during HAI are needed to inform prevention messages for heterosexuals.

Methods: We examined data from heterosexuals recruited in 20 US cities for the 2013 National HIV Behavioral Surveillance system. Participants eligible for this analysis had at least one sex partner of the opposite sex in the previous year, were of low socioeconomic status, defined as having at most a high-school education or living at or below the federal poverty level, and did not report being HIV-positive. Using multivariable Poisson models with robust standard errors, we first assessed correlates of reporting HAI in the previous year. We then limited our analysis to persons reporting HAI in the past year and used

data on participants' last sexual encounter to assess what partner- and event-level factors are associated with having had HAI at the last sexual encounter. Adjusted prevalence ratios (aPR) and 95% confidence intervals (CI) are presented separately for men and women.

Results: Thirty percent of women and 35% of men engaged in HAI in the past year. Among people who had HAI in the past year, those who had HAI at last sex were more likely to have a partner who was potentially HIV-discordant (HIV-positive or unknown status partner; women: aPR=1.55, CI=1.25-1.92; men: aPR=1.24, CI=1.03-1.50) or to have exchanged money or drugs for sex at last sex (women: aPR=1.22, CI=1.01-1.47; men: aPR=1.55, CI=1.28-1.88). Among those who had HAI at last sex, 93% of women and 87% of men did not use a condom. Among women who had HAI at last sex, those who had a potentially HIV-discordant partner (aPR=1.09, CI=1.01-1.18) or a partner who has had sex with men (aPR=1.04, CI=1.00-1.09) were more likely to have had condomless HAI. Among men who had HAI at last sex, using drugs or alcohol at last sex (aPR=1.12, CI=1.01-1.24) and having a partner who had injected drugs (aPR=1.11, CI=1.04-1.19) or was potentially HIV-discordant (aPR=1.20, CI=1.10-1.32) were associated with condomless HAI.

Conclusions/Implications: About one-third of heterosexuals in our sample engaged in HAI, and, among those who had HAI, the majority did not use a condom. Those who reported HAI were also more likely to have partners who engaged in risky behaviors, further increasing the risk of the behavior. Information that highlights the risk of HIV transmission associated with HAI would complement existing HIV prevention messages focused on HIV-negative heterosexual adults in the U.S.

AP40

Abstract 1788 - Epidemiology and Surveillance

Author(s): *Anthony Romano, Suzan Walters, Jonathan Feelemyer, Michael Wilczek, Bridget Anderson, Lou Smith*

Background: In NYS, HIV disproportionately affects men who have sex with men (MSM). While other transmission risk groups have demonstrated significant decreases in incidence and prevalence, new diagnoses among MSM remain disproportionately high, with MSM accounting for over half of new diagnoses and 70% of estimated incident infections in 2012. Research suggests that the persistent burden of HIV among MSM may be the result of fundamental shifts in partner seeking behavior. This analysis explores behaviors among MSM recruited at sites of gay congregation on Long Island who utilize the internet to locate sexual partners.

Methods: Data was obtained from the 2011 (n=305) and 2014 (n=306) rounds of the National HIV Behavioral Surveillance System (NHBS), which utilized venue based sampling to survey MSM living in Nassau and Suffolk Counties. Interviews were conducted using a standardized questionnaire along with voluntary anonymous HIV testing. Demographic and sexual behavior variables were used to explore factors associated with online community (OCSB) and sexual partner seeking (OPSB). These were operationalized as binary variables and included participants who used the internet or phone apps to meet MSM for the purposes of friendship or sex (OCSB) and sex only (OPSB). The data collection rounds were analyzed separately to account for the increasing use of mobile phone applications to arrange sexual liaisons (34.2% in 2011 to 59.3% in 2014). Analyses were conducted in SAS 9.3.

Results: In multivariable analysis, age was negatively associated with OCSB and OPSB for both years. Hispanic MSM were less likely to report OPSB in 2011 (OR: 0.37, CI: 0.17, 0.82) and OCSB in 2014 (OR: 0.31, CI: 0.15, 0.64). In 2011 respondents who reported never or rarely attending gay venues were more likely to report OCSB than those who reported weekly attendance (OR: 2.72, CI: 1.14, 6.50). MSM who identified as gay in 2011 were more likely than those who identified as bisexual to report OCSB (OR: 2.50, CI: 1.24, 5.01). College graduates were less likely to report OCSB (OR: 0.37, CI: 0.17, 0.80) than those with advanced degrees. Respondents who reported having only 1 sexual partner in 2011 were less likely to report OCSB (OR: 0.34, CI: 0.16, 0.72) or OPSB (OR: 0.32, CI: 0.11, 0.91). In 2014, respondents who reported being in a relationship were less likely to report OCSB (OR: 0.42, CI: 0.22, 0.81). Number of sexual partners was positively associated with OPSB (OR: 1.18, CI: 1.08, 1.28) and use of mobile apps for partner seeking (OR: 1.25, CI: 1.04, 1.50) in 2014.

Conclusions/Implications: Data from NHBS indicates a significant moderate increase in OCSB and OPSB from 2011 to 2014 among the MSM recruited from gay venues on Long Island. However, differences in the composition of the 2011 and 2014 study samples suggests that younger MSM, particularly non-Hispanic white MSM, rarely frequent gay venues and primarily use the internet or phone apps for OCSB and OPSB. Non-venue based recruitment strategies are likely needed to better understand the impact of OCSB and OPSB among younger, more technologically savvy MSM.

AP42

Abstract 1448 - Epidemiology and Surveillance

Author(s): *Steven Nesheim, Margaret Lampe, Tiffany Covas, Lauren Fitz Harris, Dawn Smith*

Background: The number of HIV-discordant heterosexual couples (HDC) of reproductive age (RA) in the United States is not well established, but has been estimated as at least 140,000 (AJPH 2011;204:e1-8). The number is of public health interest because it approximates populations (1) that might need preconception care and/or interventions to prevent perinatal HIV transmission and (2) for which antiretroviral (ARV) therapy as prevention or ARV pre-exposure prophylaxis are options.

Methods: We estimated the number of HDC of RA by three methods. Method #1 multiplies the number of persons of RA (men, 15-59 years of age [n=95,051,939]; women 15-44 years [n=62,374,964] [US Census 2010]) by the proportion of individuals reporting an HIV-infected partner in a nationally representative study (the National Survey of Family Growth, [NSFG]) (assuming all respondents are HIV-uninfected). Methods #2 and #3 estimate the numbers of males (13-54 yr in Method #2; 13-59 yr in Method #3) and females (13-44 yr) of RA with either heterosexual exposure or injection drug use as their mode of HIV acquisition. Method #2 used a study estimating the number of persons living with HIV in 2011 which accounts for those with undiagnosed HIV status (Bradley et al. MMWR 2014;63(47):1113-1118). Method #3 used CDC National HIV Surveillance System data for 2012; these numbers were adjusted to account for the estimated 14% of HIV-infected persons not diagnosed. The estimated numbers of HIV-infected men (Method #2, n=160,106; Method #3, n=137,048) and women (Method #2, n=119,994; Method #3, n=90,966) of RA with either heterosexual or IDU mode of acquisition were multiplied by the proportion reporting a committed relationship and by the proportion reporting an HIV-uninfected or unknown HIV status partner. These proportions were obtained from one nationally

representative study of men and women (HIV Cost and Services Utilization Study, Chen et al, Family Planning Perspectives 2001;33(4):144-152) and 5 other studies reporting on partner status of HIV-infected women.

Results: By Method #1, in NSFG, both sexes reported HIV-positive status in 0.1% of partners, yielding an estimated 62,374 partners of women and 95,052 partners of men, for a total 157,426 HIV-discordant couples.

By Method #2, committed relationship ranged from 55-76% and negative or unknown status among partners ranged 52-78%. The number of HIV-infected women in HDC ranged from 43,678-71,133 and the number HDC was 130,874. By Method #3, the number of heterosexual or IDU women in HDC ranged from 38,502-62,703, and the number of HDC was 123,188.

Conclusions/Implications: The estimated number of HDC of reproductive age in the United States was similar in all three Methods, similar to the previously published estimate, and ranged from 123,188-157,426. It is likely that in the majority of HDCs, the HIV-infected individual is the male. The magnitude of the population of HIV-discordant heterosexual couples underscores the need to encourage HIV testing of partners of known HIV-infected persons and to provide preventive interventions.

AP43

Abstract 1455 - Epidemiology and Surveillance

Author(s): *Muazzam Nasrullah, Emeka Oraka, Pollyanna Chavez, Christopher Johnson, Elizabeth DiNenno*

Background: Inconsistent or lack of condom use increases the risk of acquiring or transmitting HIV among heterosexually active adults. This study characterized the prevalence of condom use at last sex, and identified factors associated with condom use at last sex among unmarried/single and married/cohabitating adults in the United States.

Methods: National Survey of Family Growth data from cycle 2006–2010 were analyzed for sexually active men and women aged 18–44 years who reported having sex (vaginal, anal, or oral) with opposite-sex partners in the past year. Logistic regression models assessed factors associated with use of a condom at last sex (vaginal or anal) among adults in the United States. Models controlled for significant demographic and health-related covariates, including the following HIV-related sexual risk behaviors (SRBs) in the past year: sex with ≥ 4 opposite sex partners, sex with an injection drug user, sex with a male who previously had sex with a male [women only], sex with a male [men only], exchanged sex for money or drugs or sex with a partner who had sex with other partners.

Results: Overall prevalence of condom use was 24.7%, and only 34.5% of adults with at least one SRB reported the use of a condom. Among unmarried/single respondents with SRB, 43.1% of men (vs. 20.8% married/cohabitating men) reported using a condom and 35.9% of unmarried/single women (vs. 12.8% of married/cohabitating women) reported condom use. Among unmarried/single women, those aged 18-24 years (Adjusted Prevalence Ratio [aPR]=1.76; 95% Confidence Interval [CI]: 1.47-2.10), or 25-34 years (aPR=1.31; 95% CI: 1.09-1.57) compared to those aged 35-44 years, and non-Hispanic black

women (aPR=1.57; 95% CI: 1.33-1.84) compared to white women were more likely to use a condom at last sex. Among unmarried/single men, those aged 18-24 years (aPR=1.66; 95% CI: 1.43-1.92) or 25-34 years (aPR=1.28; 95% CI: 1.08-1.52) as compared to unmarried/single men aged 35-44 years, and non-Hispanic black men (aPR=1.26; 95% CI: 1.13-1.40) or non-Hispanic other race men (aPR=1.36; 95% CI: 1.12-1.64) as compared to white men were more likely to use a condom at last sex. Unmarried/single men who reported at least one SRB (aPR=0.77; 95%CI: 0.69 - 0.86) were less likely to use a condom at last sex as compared to those who did not report any SRB. Factors associated with condom use at last sex among married/cohabitating adults were similar to those of unmarried/single adults with regard to age, and race.

Conclusions/Implications: Only one quarter of adults aged 18-44 in the U.S. used condoms at last sex, and only one third of adults who were at increased risk for HIV infection used condoms at last sexual act. Unmarried/single men who reported SRB were less likely to use condoms at last sex than those who did not report any sexual risk behavior. Continued efforts are needed to promote condom use among heterosexually active adults in the U.S., especially those at high risk for HIV.

AP44

Abstract 1991 - Epidemiology and Surveillance

Author(s): *Deanna Lewis, Shoshanna Nakelsky, Amy Wohl*

Background: African American women comprise approximately 9% of Los Angeles County (LAC) women but account for over 35% of new HIV diagnoses among women. National HIV incidence estimates show decreases in the number and rate of HIV incidence and prevalence for African American women. We present HIV incidence trend estimates and examine HIV testing patterns to better understand the factors influencing HIV incidence in African American women in LAC.

Methods: LAC HIV incidence estimates for African American women are presented over three time periods: 2008-2009 (Time 1), 2010-2011 (Time 2) and 2012-2013 (Time 3). Using data collected through the Enhanced HIV/AIDS Reporting System (eHARS) and HIV Incidence Surveillance (HIS), we examined trends in the proportion of cases diagnosed with AIDS within 6 months of HIV diagnosis (late detection) and HIV testing history. We used the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS) results to estimate the proportion of cases diagnosed within 12-months of acquiring HIV. Incidence estimates were calculated using CDC-developed methodology.

Results: We estimated a non-significant, but increasing trend in HIV incidence rates in African American women from Time 1 (21/100,000; 95% CI: 7-36/100,000) to Time 2 (25/100,000; 95% CI: 4-46/100,000 and 29/100,000; 95% CI: 8-49/100,000). The proportion of African American women who reported a history of previous HIV testing decreased from 58% in Time 1 to 55% in Time 2 ($p<0.05$). The mean time between the last negative and first positive HIV test lengthened from 22 months in Time 1 to 25 months in Time 3 ($p<0.05$). From Time 1 to Time 3 there was a decrease in the percentage of African American women diagnosed late, 26% compared to 21% ($p<0.05$), and a greater proportion of cases tested within 12-months of infection (23% vs 30%; $p<0.05$).

Conclusions/Implications: While estimates suggest a trend towards increasing HIV incidence rates for African American women in LAC, this trend may be driven by significantly earlier diagnosis from Time 1 to Time 3. We found both a significant decrease in the proportion of African American women with late detection and a significant increase in the proportion of African American women diagnosed within one year of infection. However, with a mean time from first positive to last negative HIV test of about 2 years African American women overall do not adhere to CDC-recommended annual HIV testing guidelines for at-risk populations. Furthermore, we found a significant decrease in the proportion of women who reported a previous HIV test and an increase in the number of months between the last negative and first positive HIV tests for African American women. These results highlight successes in providing HIV testing services to newly-infected HIV- positive African American women in LAC while demonstrating the continued need for awareness campaigns targeted to African American women and their clinicians to promote routine HIV testing.

AP45

Abstract 1789 - Epidemiology and Surveillance

Author(s): *Nicole Dzialowy, Victoria Mobley, Jason Maxwell, Jacquelyn Clymore, Erika Samoff*

Background: Early diagnosis and treatment of HIV infection supports improved patient outcomes; therefore, the public health goal is to diagnose people early in infection. North Carolina surveillance data were analyzed to describe people infected with HIV who were not diagnosed early in infection, with the goal of identifying populations missing the early opportunity for treatment and care.

Methods: Late testers were defined as persons diagnosed with AIDS within six months of their initial HIV diagnosis. The North Carolina Disease Surveillance System (NC EDSS) and enhanced HIV/AIDS Reporting System (eHARS) were used to abstract demographic and risk factor information on women diagnosed with HIV in 2013. SAS version 9.2 (Cary, NC) was used to calculate chi square tests and confidence intervals.

Results: While late diagnosis of males remained stable in 2013, the proportion of females diagnosed late in infection increased significantly. Of the 286 females newly diagnosed with HIV in 2013, 187 did not have an AIDS diagnosis within six months; however the remaining 99 were also diagnosed with AIDS within six months and were therefore late testers. The proportion of female late testers increased significantly from 23% in 2012 (95% CI: 18%-28%) to 35% in 2013 (95% CI: 29%-40%). Women of minority race/ethnicity comprised 86% of late testers in 2013, an increase from 77 % in 2012. The largest increase in the proportion of female late testers was among Black/African-American women, increasing from 23% (71/ 306; 95% CI: 19%-28%) in 2012 to 38% (78/204; 95% CI: 32%-45%) in 2013. The mean age at diagnosis for female late testers was 45 years (95% CI: 43-47), and 63% had clinical symptoms, such as weight loss, nausea, and opportunistic infections, consistent with HIV/AIDS at time of diagnosis. Of the female late testers, 42% were diagnosed during a hospital admission due to an AIDS-associated illness, and 6% were diagnosed during a prenatal screening. Although the late testers were spread across the state, around 70% of the tests were conducted in urban areas. There was a higher proportion of injection drug use (IDU) among late testers (7%) as compared with non-late tester (3%). Approximately 15% of late testers had a prior sexually transmitted infection (STI) or hepatitis B virus diagnosis and more than half of these were reported within five years of their HIV/AIDS diagnosis. The

proportion of late testers with a previous STI was similar to the proportion of non-late-testers diagnosed with an STI prior to their HIV diagnosis. Similarly, 23% of these women had a documented HIV test prior to their diagnosis, compared to 25% of non-late-testers.

Conclusions/Implications: In North Carolina, we found that one third of women are diagnosed late in the course of their HIV infection, suggesting the need for improved public health efforts to identify women earlier. Although our data suggest that the full population of women accessed medical care, the late diagnoses suggest missed opportunities for HIV testing. It is worth revisiting existing or exploring new prevention strategies that target women and in particular minority women.

AP46

Abstract 1652 - Epidemiology and Surveillance

Author(s): *Rhodri Dierst-Davies, Linda Bourque, Amy Wohl*

Background: Substance use among HIV-infected individuals is strongly correlated with increased morbidity and mortality. Historically, lower income HIV-infected persons in the United States accessed services through programs funded by the Ryan White (RW) Care Act the “payer of last resort” for primary medical and ancillary service needs. This study examined the effects of substance use on ancillary service gaps among a representative sample of RW recipients in Los Angeles County (LAC), California.

Methods: Data from the 2011 Los Angeles Coordinated HIV/AIDS Needs Assessment were utilized. A two-stage, stratified, probability-proportional-to-size sampling design was used to identify a representative sample of agencies and clients in the RW system. Individual level weighting was used to adjust the effective sample size from 400 to 18,951 persons, similar to the 19,915 RW recipients in LAC during the surveillance period. Approximately 30% (119 unweighted, 5,743 weighted) of recipients reported recent substance use. Nested Poisson and logistic regression analysis techniques were utilized to determine factors associated with both reporting any service gap(s), as well as the number of gaps reported.

Results: Nested logistic regression revealed an elevated risk for reporting any service gap(s) (RR range: 2.87-3.45) among substance users. Nested Poisson regression revealed that the risk of reporting additional gaps by substance users was less robust (RR range: 0.89-1.30). Among substance users, those who reported stimulant use (RR range: 1.54-1.75) and more types of substances (RR range: 1.32-1.56) were at an elevated risk for reporting additional gaps. Increased risks for service gaps were also reported among those with current mental health conditions, females and persons who reported past lapses in medical care. When stratified by barrier type, both stimulant users (RR=1.62), and those reporting more types of substances used (RR=1.24), who identified resource-based barriers were at increased risk for reporting a gap compared to those reporting information-based barriers only.

Conclusions/Implications: Findings suggest that substance users were not only at increased risk of reporting service gaps, but within this group, certain factors such as stimulant use and number of substances used affected the number of gaps reported. Additionally, substance users are more likely to report lacking sufficient resources to obtain these needed services. As the Affordable Care Act is

changing how RW monies are allocated, providers should focus efforts to ensure that substance users have the resources to obtain the full spectrum of needed services.

AP47

Abstract 1158 - Epidemiology and Surveillance

Author(s): *Caroline Stamatakis, Sabrina Clark, Mercedes Wilkinson, Tommi Lightfoot Holloway, Matthew McKenna*

Background: In 2012, the Fulton County Department of Health and Wellness (FCDHW) HIV prevention program staff noted an increase in infants with perinatal HIV exposure. As a result, an enhanced surveillance system for expedited detection of perinatal HIV exposure was implemented at the local level. FCDHW evaluated this system to characterize its attributes, identify strengths and weaknesses, and provide recommendations for system improvement.

Methods: FCDHW conducted interviews with internal and external partners and obtained exposure and case data from 2012–2014. System usefulness, simplicity, data quality, acceptability, timeliness, and stability were assessed qualitatively. Data from a state-based perinatal exposure database maintained by Georgia Department of Public Health (GDPH) were used to estimate sensitivity.

Results: Analysis included 72 mother and infant pairs of perinatal HIV exposures and cases identified through reports from clinical facilities in the County during 2010–2014. Usefulness for case management and partner services was determined to be high. Partner investigations of the mothers of these children identified 118 contacts and 25 HIV positive men. The system is complex and engages 11 reporting agencies. Each exposed infant requires extensive follow-up to 18 months for definitive determination of HIV infection status. Databases in this system are fragmented and three different surveillance tools are used, resulting in high variability of data collected for each case. Acceptability was high in maternal interviews with a 97% participation rate. Timeliness of reporting to FCDHW before delivery ranged from six weeks to delivery date, and after delivery average time was 22 weeks (range: 1 week–5 years). Based on a database maintained by GDPH there were an estimated 15 perinatal exposures per year in Fulton County while FCDHW identified an average of 14.4 exposures per year.

Conclusions/Implications: While data quality, timeliness, and stability were identified as weaknesses of this system, the usefulness, acceptability, and sensitivity were strong. Though sensitivity of the system appeared high, the generalizability of the state database to derive estimates for Fulton County needs further assessment. To improve the surveillance system it is recommended that coordination between GDPH and FCDHW be strengthened, a single electronic system should be created and utilized, relationships with partners should be augmented, and trainings for providers on reporting should be developed. Interventions generated from this evaluation will strengthen the system's sensitivity, ability to detect exposures and cases in a timely manner, and efficiently generate high quality data that will be used to inform prevention priorities.

AP48

Abstract 1673 - Epidemiology and Surveillance

Author(s): *Tina Jiwatram-Negron, Nabila El-Bassel, Xin Ma, Stacey Shaw, Louisa Gilbert*

Background: Community supervision (probation, parole) represents the largest segment of the criminal justice system in the U.S. Almost 4 million adults, one-quarter of them female, are currently under community supervision. Sex trading has been found to be prevalent among women in jail and prisons, yet limited research exists on the prevalence of sex trading and associated HIV-risk behaviors among women in alternative to incarceration programs. Women who trade sex recruited from different settings have been shown to have low levels of HIV knowledge, engage in unprotected sex with multiple partners and drug/alcohol risk behaviors, and have limited access to services.

Methods: This abstract examines the prevalence of sex trading and associated risk factors among a sample of 337 drug-involved women under community supervision in New York. Specifically, we used bivariate and multiple logistic regression analyses to examine the association between sex trading and socio-demographic variables, individual and partner drug and alcohol use, trauma, mental health, prior incarceration, and sexual risk behaviors.

Results: Of the total sample, 137 (40%) women reported sex trading in the past 90 days. Multivariate logistic regression analyses showed significant relationships between sex trading and age (OR=1.030; 95% CI=1.003, 1.059), race - Black or African American compared to other races (OR=2.463; 95% CI=1.140, 5.320), being married (OR=0.420; 95% CI=0.205, 0.859), having poor mental health (OR=1.735; 95% CI=1.003, 3.001), binge drinking (OR=1.790; 95% CI=1.012, 3.167), and having been in jail/prison in the past six months (OR=1.692; 95% CI=1.000, 2.863). Among women with a main partner, those who reported concurrent crack/cocaine use with their partner or one partner who used crack/cocaine were more likely to report sex trading than women where neither partner used in the past 90 days.

Conclusions/Implications: The findings underscore an urgent need for multipronged HIV/STI prevention efforts and policies for women under community supervision that simultaneously address risk rising from sexual and drug-risk behaviors, and a need to improve access to mental health services, support systems, and other resources.

AP49

Abstract 2475 - Epidemiology and Surveillance

Author(s): *Betsey John, John Christian Hague, Rebecca Hawrusik, Dawn Fukuda, Kevin Cranston*

Issue: The HIV Care Continuum is useful in measuring the effectiveness of efforts to combat the HIV epidemic in the country and the Commonwealth. Timely linkage to care after an HIV diagnosis and consistent engagement in medical care are both critical to ensure access to treatment and promote health for persons living with HIV infection. High rates of viral suppression are associated with improved health outcomes and substantially lower risk of HIV transmission.

Key Points: Massachusetts Department of Public Health (MDPH) amended its reporting regulations to collect all CD4+ T-cell count and all HIV viral load results beginning in January 2012. Since the implementation of this amendment, the Massachusetts HIV/AIDS Surveillance Program (MHASP) is able to look at the different stages of the care continuum by measuring linkage to care, retention in care and viral suppression rates using CDC guidelines.

Among 18,570 persons living with HIV/AIDS (PLWHA) in Massachusetts, 76% were engaged¹ in HIV care and 61% were retained² in care in 2013. Individuals who were engaged and retained in care were found to have high rates of viral suppression. Eighty-four percent of those engaged in care and 87% of those retained in care in Massachusetts were virally suppressed. Among all PLWHA in Massachusetts, 64% were virally suppressed³, 10% had a detectable viral load and 26% were missing viral load laboratory data.

Females had higher rates of engagement and retention in medical care compared to males, but lower rates of viral suppression. Seventy-eight percent of females were engaged in care compared to 75% of males; 63% were retained in care compared to 60% of males; and 62% were virally suppressed compared to 64% of males. Engagement in care and viral suppression were higher among white non-Hispanic (NH) PLWHA compared to black NH and Hispanic/Latino PLWHA. However, retention in care was similar across racial/ethnic groups. Sixty-eight percent of white NH individuals were virally suppressed compared to 60% for black NH and Hispanic/Latino individuals. Engagement and retention in care are similar among exposure mode groups. However, rates of viral suppression are higher among men who have sex with men (MSM) compared to other exposure mode groups. Sixty-eight percent of MSM individuals were virally suppressed compared to other risk groups, which ranged from 60% to 63%.

Implications: Although engagement and retention in care were similar across racial/ethnic groups, viral suppression rates were lower among black NH and Hispanic/Latino individuals compared to white NH individuals. Additional information regarding these individuals is needed to understand the reasons why viral suppression was not accomplished. Additional or different types of public health intervention or support services may be needed to ensure access and adherence to ART, particularly for racial/ethnic minority residents who are living with HIV/AIDS.

AP50

Abstract 1172 - Epidemiology and Surveillance

Author(s): Heather Clayton, Richard Lowry, Euna August, Sherry Everett-Jones

Background: Substance use is associated with sexual risk behaviors among youth, but little is known about whether non-medical prescription drug use, an increasingly common behavior, is associated with sexual risk behaviors.

Methods: Data from the 2011 and 2013 national Youth Risk Behavior Surveys, cross-sectional surveys conducted among a nationally representative sample of students in grades 9–12 (N=29,008) were used to examine the association between ever taking prescription drugs without a doctor's prescription and sexual risk behaviors (lifetime sexual experience, current sexual activity, lifetime number of partners, and condom use and alcohol or drug use before last sexual intercourse). Logistic regression models (adjusted for sex, race/ethnicity, grade, ever injection drug use, and use of alcohol, marijuana, heroin, cocaine, methamphetamines, ecstasy, and inhalants) estimated adjusted prevalence ratios (aPRs) and 95% confidence intervals (CI).

Results: Students who took prescription drugs without a doctor's prescription were more likely to have had sexual intercourse (aPR: 1.16; 95% CI: 1.11-1.22), be currently sexually active (1.26;1.20-1.33), have >4 sexual partners (1.45;1.33-1.58), drink alcohol or use drugs before last sexual intercourse (1.32;1.17-1.48) and not use a condom at last sexual intercourse (1.14;1.05-1.23). A dose-response relationship was observed for each sexual risk behavior and the frequency of prescription drug use.

Conclusions/Implications: Non-medical use of prescription drugs is associated with sexual behaviors that put youth at risk for sexually transmitted infections (STIs) and HIV infection. Prevention efforts should focus on limiting access to prescription drugs and integrating education on substance use, STI, and HIV prevention in schools.

AP51

Abstract 1122 - Epidemiology and Surveillance

Author(s): Amy Baugher, Linda Beer, Jennifer Fagan, Christine Mattson, Mark Freedman, R. Luke Shouse

Background: Discrimination in healthcare settings has been associated with lower healthcare utilization and medical adherence, and reducing discrimination is a goal of the National HIV/AIDS Strategy. Understanding HIV-infected persons' experiences of discrimination in healthcare settings may help efforts to reduce discrimination and improve their care. This analysis aims to describe the prevalence of discrimination in healthcare settings among HIV-infected patients, the demographics of patients who experienced discrimination, and why the patient thinks the discrimination occurred.

Methods: We analyzed cross-sectional data from a population-based sample of 4,461 HIV-infected U.S. adults who received medical care during January-April in 2011 and participated in the Medical Monitoring Project. Three questions asked whether patients experienced healthcare discrimination since their HIV diagnosis. Patients who experienced ≥ 1 discriminatory situation(s) were asked if the discrimination occurred because of their HIV status, gender, sexual orientation, race/ethnicity, or drug-injecting habit. We compared discrimination by socio-demographic variables using chi-square tests.

Results: We estimated that 24.5% of adults in care experienced healthcare discrimination since their HIV diagnosis. Patients reported experiencing hostility or lack of respect (21.1%), getting less attention than other patients (15.3%), and being refused service (7.7%). Patients who were homosexual or bisexual, were non-Hispanic white, older, had achieved higher than high school education, were above poverty level, were born in the U.S., or were diagnosed with HIV ≥ 5 years ago were significantly more likely to report discrimination ($p < 0.05$).

Most patients experiencing discrimination attributed it to their HIV status (84.4%). Among those who experienced discrimination, transgender persons were more likely than males and females to attribute it to their gender (42.9% vs 11.2% vs 8.5% respectively, $p = 0.01$). Homosexuals and bisexuals reporting discrimination were more likely than heterosexuals to attribute it to their sexual orientation (54.1% vs. 41.2% vs. 7.3% respectively, $p < 0.0001$). Non-Hispanic black and Hispanic/Latino patients were more likely than Non-Hispanic white patients to attribute discrimination to their race/ethnicity (20.5% vs. 19.7% vs. 4.1% respectively, $p < 0.0001$). Among persons who injected drugs in the last 12 months and reported discrimination, 42.0% attributed the discrimination to their drug-injecting habit.

Conclusions/Implications: One in four HIV-infected persons in care in the United States reported experiencing discrimination in healthcare settings since their HIV diagnosis, and the majority attributed it to their HIV status. Racial/ethnic and sexual/gender minorities, who bear the greatest HIV burden and are vulnerable to poor health outcomes, were more likely to experience discrimination. Consistent with previous literature, non-Hispanic white patients were more likely than other racial/ethnic groups to report discrimination; however, they were not as likely as other racial/ethnic groups to attribute discrimination to their race/ethnicity. These findings may support efforts to reduce healthcare discrimination towards HIV-infected patients.

AP52

Abstract 1962 - Epidemiology and Surveillance

Author(s): *Donna Futterman, Lindsay DuBois, Stephen Stafford, Hong Shao*

Background: Objective: Montefiore Medical Center (MMC) in the Bronx has built an integrated service delivery system informed by innovative information technology (IT) tools. Since 2010, when New York State mandated the offer of HIV testing, MMC has employed multiple strategies to ensure patients ages 13-64 are offered HIV testing when they visit any of its inpatient, outpatient or emergency sites. Prior to this initiative, there was no easy way to systematically track HIV testing, results and linkage to care (LTC) of HIV+ patients across MMC, as different sectors have different data systems. To improve HIV monitoring and evaluation efforts, a continuous quality improvement (CQI) tool drawing from existing MMC laboratory data was sought.

Methods: Methods: Montefiore's Adolescent AIDS Program provided HIV data parameters and Montefiore's Care Management Organization IT team designed the CQI tool to provide historic and ongoing data. In 2011 a tool was developed to track HIV testing and positive diagnoses, and in 2014 it was expanded and refined to track LTC and identify newly diagnosed versus previously diagnosed HIV patients—an innovation that revealed almost half of MMC's HIV+ results were among those previously diagnosed. Each indicator was validated by chart reviews and triangulated with existing data sources. Refreshed monthly, the tool draws from MMC laboratory evidence of testing and results as well as CD4 and/or HIV Viral Load test results within three months of diagnosis as a proxy for linkage to care. The tool thus identified both newly diagnosed and HIV+ patients who had fallen out of care but were relinked to care through routine testing efforts.

Results: Results: Using the tool MMC observed the following results: in 2011 61,755 patients were tested, of whom 359 were HIV+ (.30% prevalence in the ED, 1.44% inpatient, .55% outpatient) and 91% were linked to care at MMC; in 2014 78,946 patients were tested, 296 of whom were HIV+ (.38% ED, .71% inpatient, .33% outpatient) and 79% were linked to care at MMC.

Conclusions/Implications: Conclusion: Large, complex medical centers like MMC that operate multiple inpatient, outpatient and emergency sites serviced by different data systems can struggle to create effective monitoring and evaluation tools. As HIV testing becomes more routine in all sectors of MMC, tools like the one described here provide crucial institution-wide HIV testing, diagnosis, and linkage and retention in care data that help strengthen all steps of the HIV treatment cascade.

AP53

Abstract 1288 - Epidemiology and Surveillance

Author(s): *Suzanne Marks, Dolores Katz, Melissa Pagaoa, Amy Davidow, Edward Graviss, Larry Teeter*

Background: HIV infection significantly increases the risk for progression to TB disease. Persons with HIV comprise only 7% of TB patients having reported HIV status, but historically have high risk for HIV/TB mortality. Blacks comprise 15% of TB patients with reported HIV, the highest percentage of any race/ethnic population.

Methods: In a representative cohort of 603 U.S.-born black and white TB patients reported in 2009-2010, we describe patient characteristics and TB outcomes associated with HIV. Data were abstracted from the National TB Surveillance System and medical records for all patients and from death certificates for 111/130 patients who died. Interviews were conducted with 477 patients. We calculated crude relative risks (RR) with 95% confidence intervals for associations with HIV. Multivariable log-binomial regression was used to estimate adjusted RRs (ARR) for characteristics significantly associated with TB mortality.

Results: Of 552 patients with known HIV status, 118 (21%) were HIV-positive. HIV infection was significantly associated with black (25%) versus white (8%) race (RR=3.2), homelessness (37%) versus no homelessness (18%) (RR=2.0), and drug use (44%) versus none (20%) (RR=2.2). Compared to HIV-negative patients, more patients with HIV/TB had fever (60% versus 45%), weight loss (81% versus 69%), glandular involvement (35% versus 16%), or any TB symptom (97% versus 90%). HIV/TB pulmonary patients showed less cavitation on chest radiography (25% versus 45%). The use of nucleic acid amplification testing to diagnose TB disease did not statistically differ in HIV/TB patients versus HIV-negative patients (44% versus 48%). Of 81 HIV-positive patients with known HIV diagnosis dates, 32 (40%) knew their HIV diagnosis > 3 months prior to TB diagnosis, 46 (57%) were diagnosed with HIV < 3 months of TB diagnosis, and 3 (4%) were diagnosed with HIV after starting TB treatment. Of 91 interviewed patients with HIV, 56 (62%) were on ≥ 1 HIV anti-retrovirals, and 36 (40%) were on ≥ 3 medications. CD4-cell counts (median 75.5, IQR 26-199) around TB diagnosis were available for 102 patients. For the 86% of HIV/TB patients who ever had a tuberculin skin test for latent TB infection (LTBI), the test was less likely to be positive than for HIV-negative patients (71/101=70%, versus 327/395=83%). Only 7% (5/71) of TST-positive HIV/TB patients were known to have taken treatment for LTBI to prevent TB. Of 118 persons with HIV, 29 (25%) died, two of whom were interviewed prior to death: 11 (9%) were diagnosed with TB at death, 18 (15%) died a median of 38 days after starting TB treatment. From multivariable analysis, higher risk of TB mortality was associated with HIV/TB (ARR=2.9, 2.0-4.3), other chronic illnesses (ARR= 3.2,1.3-7.8), or being aged ≥ 65 (ARR=2.2,1.5-3.2); lower risk of TB mortality was associated with homelessness (ARR=0.4,0.2-1.0) or drug use (ARR=0.5,0.3-1.0).

Conclusions/Implications: More than half of HIV/TB patients were diagnosed with HIV at the same time as TB diagnosis. HIV/TB, but not race, was independently associated with greater TB mortality. Prevention and treatment of HIV could reduce HIV/TB mortality. Greater emphasis on LTBI treatment for persons with HIV could reduce HIV/TB morbidity.

AP54

Abstract 1698 - Prevention Research and Implementation Science

Author(s): *Marlene LaLota, Tom Bendle*

Issue: Florida continues to be heavily impacted by HIV/AIDS. Approximately 125,000 Floridians are infected with HIV and one in six do not know they are infected. CDC estimates that half of new HIV infections are transmitted by those who do not know they are infected. Therefore, undiagnosed infection remains a significant factor in fueling the spread of HIV infection. Early recognition of HIV infection is essential for preventing onward transmission as well as for treating individuals with HIV infection before clinically significant injury to the immune system occurs. Implementation of a laboratory-based 4th generation HIV testing assay has led to earlier detection of HIV infection, allowing persons to be diagnosed in the acute infection stage; linked to care and prevention services; and partners to be tested and linked to care.

Key Points: Florida has one of the largest publicly funded HIV testing programs in the nation, offering conventional and rapid testing in a wide variety of settings. Now accounting for almost 3/4 of all testing, rapid testing, especially in high prevalence areas, has succeeded in identifying large numbers of people who would otherwise have remained unaware of their infection. However, acute HIV infection (AHI) cannot be identified from a rapid test (RT). Over the last few years laboratory tests used for diagnosis have evolved considerably, including the development of 4th generation immunoassays (IAs) with improved sensitivity for acute as well as established infections. These advanced IAs can detect HIV infection up to three weeks earlier than the traditional Western Blot. In April 2012, the Florida Department of Health state laboratories implemented a new HIV diagnostic algorithm, which makes use of the 4th generation HIV-1/2 antigen/antibody IA, an HIV-1/HIV-2 antibody differentiation assay, and nucleic acid amplification tests (NAAT). Between April 2012 and December 2014, 394,000 HIV screens were performed and 37 AHIs were detected. AHIs were geographically distributed throughout the state; were racially and ethnically diverse; 34/37 were male; ages ranged from 19-51; and 28 were men who had sex with men. 93% of AHI were linked to partner services and care within 90 days versus 71% of non-AHI.

Implications: Individuals with AHI pose a greater transmission risk than most chronically HIV-infected patients and prevention efforts targeting these individuals are important for reducing the spread of HIV infection. The per-person probability of transmitting HIV correlates with the height of viremia, which peaks during AHI: Every 10-fold increase in viremia is associated with an estimated 2.5-fold increase in transmission risk. Since symptoms of AHI are nonspecific, its diagnosis requires a high index of suspicion and appropriate HIV laboratory tests. We implemented protocols for enhancing detection of AHI which has led to: increased case ascertainment; successes in conducting partner services and follow-up testing for partners; increased linkage and retention in care; and reduced transmission. We will discuss how drawing blood from RT-negative individuals with recent high-risk exposure has been a successful strategy in increasing detection and how identification of AHI impacts each of the stages of the continuum of care in Florida.

AP55

Abstract 1179 - Epidemiology and Surveillance

Author(s): Andrew Mitsch, Aruna Surendera Babu, Omar Whiteside, Dean Seneca

Background: The HIV Care Continuum Initiative addresses measurements of progress toward national prevention goals. Steps of the continuum include linkage to care, retention in care, and viral suppression. Improving linkage to and retention in HIV care and viral suppression among American Indians/Alaska Natives (AI/AN) can improve quality of life for those already infected. Viral suppression can also decrease transmission of the virus.

Methods: Using national HIV case surveillance data from 18 states and D.C. for adults and adolescents ≥ 13 years, statistically adjusted for missing risk factor information, we determined the number and percentage of AI/AN: linked to care, defined as ≥ 1 CD4 (count or percent-age) or viral load (vl) test performed within 3 months after HIV diagnosis; retained in care, ≥ 2 CD4 or vl tests performed ≥ 3 months apart during 2011; and virally suppressed, vl result of ≤ 200 copies/mL at the most recent vl test during 2011.

We stratified by sex, age, and transmission category and performed chi squared tests to further assess sub-group differences, having reduced to one-to-one all comparisons with the most favorable outcome group selected as referent.

Results: Of 96 persons classified as AI/AN diagnosed with HIV infection during 2010-2012, 75 (78.1%) were linked to care (Table). Compared to those 35-54, the lowest linkage was among those 13-34 years at diagnosis (70.9% [p val = 0.03]). For linkage, sub-group differences by sex and transmission category did not reach statistical significance (all p values ≥ 0.05). Of 514 AI/AN living with HIV infection at year-end, 2011 in 18 areas, 217 (42.2%) and 207 (40.3%) were retained in care and virally suppressed, respectively. AI/AN males with prevalent infections attributed to injection drug use had the lowest viral suppression (27.4% [p val = 0.03]).

Conclusions/Implications: To improve individual health and decrease the number of HIV infections among AI/ANs, the percentage of newly diagnosed patients linked to care, retained in care and virally suppressed must increase. Subgroups in apparent need of strengthened prevention efforts to improve linkage to care include those 13-34 years of age. Male AI/AN who inject drugs appear to be in greatest need of improved viral suppression.

BP02

Abstract 1364 - Prevention Research and Implementation Science

Author(s): Jorge Alonzo, Lilli Mann, Amanda Tanner, Christina Sun, Thomas Painter, Arin Freeman, Beth Reboussin, Eunyong Song, Scott Rhodes

Background: The southeastern United States has the fastest-growing Latino population in the country and carries a disproportionate HIV burden. Among Latino males, those who have sex with other men (MSM) are at elevated risk of HIV infection; however very few efficacious behavioral HIV prevention interventions are available for use with these MSM. With CDC support, our community-based participatory research (CBPR) partnership is currently evaluating the efficacy of the Spanish-language HOLA en Grupos intervention to increase condom use and HIV testing among Latino MSM. The small-group intervention is based on social cognitive theory and the theory of empowerment education.

Methods: Our CBPR partnership recruited 304 Latino MSM who were randomized to receive the 4-session small-group HOLA en Grupos intervention (N=152) or a 4-session small-group general health education comparison intervention (N=152). Changes in principal behavioral outcomes – consistent condom use and HIV testing – among participants in both study conditions will be assessed by comparing participant self reports at baseline and 6-month post-intervention follow-up assessments. Near the conclusion of the fourth and last session of the HOLA en Grupos intervention, facilitators asked participants to anonymously write down the sexual health-related behaviors they intended to change. All of their intentions were written in Spanish. Information on intended behavior changes was not collected from participants in the general health education comparison intervention. The research team created a data table to summarize and inductively analyzed these intentions.

Results: All HOLA en Grupos participants self-identified as Hispanic/Latino. Their mean age was 30.4 years (SD=8.9) and 61.7% were of Mexican origin. Over 10% reported sex with both men and women in the past 12 months, 63.8% self-identified as gay, 22.7% as bisexual, 5.3% as transgender, 4.9% as heterosexual, and 1.6% as other. We identified 6 types of health-promoting behaviors the intervention participants intended to implement: increasing condom use; being tested for HIV and other sexually transmitted infections; using other strategies (e.g., reducing the number of sexual partners, monogamy, and abstinence; and avoiding sex while using alcohol and drugs); increasing communication and negotiation with partners about safer sex; increasing actions that contribute to improved personal health and self-care (e.g., correcting negative health habits and being “cautious” and “responsible”); and sharing sexual health information from the intervention with peers in their social networks.

Conclusions/Implications: Most risk-reduction intentions aligned with the intervention’s key messages: using condoms consistently and getting tested for HIV. However, stated intentions depended on which behavior changes each participant perceived as most needed and were most salient after participating in the intervention. Participants’ intentions to share information with peers may result in elements of the intervention content reaching others within their social networks. These results suggest that a culturally congruent HIV prevention intervention for Hispanic/Latino MSM has the potential to contribute to health-promoting intentions and behaviors by participants that include and may go beyond planned participant-level intervention outcomes, resulting in a broader community-level impact.

BP03

Abstract 1438 - Prevention Research and Implementation Science

Author(s): *Juli Carlos, Kwa Sey, Jeffrey King, Gabriel Maldonado, Brittany Garnett, Jocelyn Patterson Mosley, Damian Denson*

Issue: There are at least 7,651 black men living with HIV infection in L.A. County (LAC), 90% of whom are men who have sex with men (MSM). Although blacks represent 8% of the LAC population, black men account for 18% of LAC men living with HIV infection. Furthermore in 2010, AIDS incidence rates were 3.4 times as great among black men as compared with white men. Given this disproportionate HIV burden, there is an urgent need to reach the most-at-risk black MSM with efficacious culturally appropriate prevention interventions.

Setting: In the Meantime Men’s Group (ITMT) is a well-established grassroots organization in LAC that provides a safe space for BMSM to receive support, empowerment and education.

Project: MyLife MyStyle (MLMS) is a homegrown HIV prevention intervention resulting from ITMT’s years of experience working with young black MSM (YBMSM) in a community setting. The goal of MLMS is to empower YBMSM (ages 18-29 years) to reduce their risk of contracting and transmitting HIV. MLMS combines elements of Social Cognitive and Empowerment Theories into three 1.5 hour, small-group sessions delivered over the course of 3 consecutive days. Short vignettes representing real-life situations are used to inspire facilitator-led discussions on a range of topics including healthy relationships, HIV/STI disclosure, HIV testing, sexual identity, intimacy, HIV/STI transmission, and HIV/STI risk-reduction strategies. The primary outcome measure is condomless sex. Between April 2012 and November 2014, 528 YBMSM enrolled in a Randomized Controlled Trial of the MLMS intervention and completed a baseline survey.

Results: Seventy-three percent of participants attended at least 2 of their scheduled 3 sessions in spite of significant transportation and personal challenges. Baseline data indicate that the mean age of participants was 24 years and 93% identified as gay or bisexual. Eighty-one percent had less than a bachelor’s degree, 70% reported an annual income of less than \$20,000, 34% percent had been homeless in the past year, 47% had a history of incarceration and 55% reported recent binge drinking. With respect to sexual risk taking, 31% reported anonymous sex partners and 52% reported condomless sex in the past 3 months. Sixteen percent were HIV-positive. Among men who were HIV-positive, 37% reported anonymous sex partners, and 59% reported condomless sex in the past 3 months.

Lessons Learned: Grassroots organizations present an effective gateway to access hard to reach most-at-risk populations. While competing priorities and mistrust of research made these men a challenging group to recruit for an HIV research study, utilizing the communication channels previously established by our community partner, such as Facebook, Eztext and niche community events hosted by popular community leaders, enabled us to recruit men from the hard-to-reach core network of most-at-risk YBMSM in LAC. Furthermore, this collaboration of partners with diverse skills, knowledge, and expertise allowed us to package and deliver HIV prevention in a culturally appropriate format that successfully engaged our target population.

BP04

Abstract 1460 - Prevention Research and Implementation Science

Author(s): *Anthony Johnson, Darrell Wheeler, Karlijn Tummers, Trina Williams, Jerris Raiford, Pilgrim Spikes, Arin Freeman, Cleo Manago*

Background: African American men who have sex with men (AAMSM) are disproportionately affected by HIV in the United States. However, the development of more effective interventions to address the epidemic among this population has been hindered by suboptimal levels of recruitment and retention of both AAMSM and African American men who have sex with men and women (AAMSM/W) in clinical research studies. Black Men Evolving (B-ME) is a behavioral research study based on the Critical Thinking and Cultural Affirmation intervention developed to reduce HIV risk behaviors among AAMSM and AAMSM/W in Chicago who are between the ages of 18-55. We describe how, in an effort to reach

and retain men in our trial, we used a comprehensive and holistic approach to recruitment and retention.

Methods: Using mass media (bus/train advertising), street outreach and word-of-mouth recruitment techniques, 1798 AAMSM and AAMSM/W, 18-55 years old, were recruited and screened; 534 (70% of men screened eligible) were enrolled in a randomized HIV risk-reduction trial. A location in downtown Chicago close to public transportation was selected to accommodate a diverse group of AAMSM and AAMSM/W in the metropolitan area (including the city and suburbs). Staff selection and the research space were designed to be culturally affirming (for both race/ethnicity and sexual orientation) to ensure participant engagement. Recruitment and retention activities were monitored and refined throughout the study, including sending bi-monthly health and appointment reminder texts and weekly-targeted call logs to identify participants likely to miss their follow-up appointments. In this study we examine these varied recruitment and retention methods with regards to the yield of diverse AAMSM and AAMSM/W, including characteristics associated with self-reported HIV status across the age continuum, education, employment, income, and history of incarceration.

Results: Recruitment methods yielded a diverse sample at baseline, including age (18-55), self-reported HIV status (42.9% HIV-positive), education (40.4% HS/GED; 41.2% some post-baccalaureate; 16.4% college degree; 2% post-graduate), employment (16.3% full-time; 20.6% part-time; 44.2% unemployed; 18.9% unemployed/not looking for work) and income (62.6% < \$20,000; 22.9% between \$20,000-\$39,999; 13% ≥ \$50,000). While a majority had a high level of education, the employment rate was low and a majority (62%) of men reported having ever been incarcerated. Among men assigned to the intervention arm, we retained 71% for both days of the intervention. Also, 94% of men attending the intervention on day 1 returned on day 2. Overall, we retained 76% of the sample of men at 3-month follow up.

Conclusions/Implications: Comprehensive and holistic recruitment and retention methods were developed to attract and retain a diverse sample of AAMSM and AAMSM/W. Although the research space's location and accessibility to the target population are important, creating a culturally affirming environment which includes culturally competent male and female staff and displays of art and images that highlight gay and black culture may be key to increasing this population's willingness to participate in research. Future studies should plan carefully to incorporate culturally affirming methods to successfully implement HIV risk-reduction interventions that appeal to this disproportionately affected group of MSM.

BP05

Abstract 1554 - Prevention Research and Implementation Science

Author(s): *Darrel Higa, Nicole Crepaz, Sipe Theresa, Adebukola Adegbite*

Background: Men who have sex with men (MSM) have historically been and currently are the most HIV-affected group in the U.S. Consequently, many HIV primary prevention studies have focused on MSM and report information on prevalence of HIV, STD, HIV testing or risk behaviors, correlates of HIV transmission risk behaviors or HIV care continuum outcomes, or evaluation of behavioral and biomedical interventions for this population. Over the years, several systematic reviews (SRs) have been conducted

to synthesize the large number of primary HIV prevention studies on MSM. Analyzing SRs can offer a panoramic view of the HIV prevention research that has been conducted with MSM and highlight research gaps. The objective of this presentation is to describe the portfolio of HIV prevention research on MSM using an overview of reviews approach.

Methods: We systematically searched the CDC's Prevention Research Synthesis (PRS) Project's cumulative database, which is updated annually with automated and manual searches for SRs on HIV prevention focusing on MSM. We included SRs that exclusively focused on MSM, published between 1988 and 2014, and were written in English. Two coders independently coded reports to determine eligibility and collect data on the synthesis method used, population characteristics, topics, and outcomes. Coders met to resolve discrepancies.

Results: The systematic search yielded 312 potentially relevant reports. After eligibility screening, we excluded 190 reports because they were literature reviews, but not SRs (e.g., did not provide systematic search info; n=45), lacked an exclusive focus on MSM (n=161), or were published in a foreign language (n=7) (categories not mutually exclusive). A total of 122 SRs met eligibility criteria. Of these, 75% were published in the past 5 years (between 2009 and 2014) and 42% were meta-analyses. Most SRs focus on non-specific populations of MSM. For SRs that focus on subgroups of MSM, the most frequently researched subgroups were: HIV-positive (22%), young (13%), or black or African American (8%). The most common topics synthesized were sexual behavior (66%), substance use including intravenous drugs (30%), social determinants of health (17%), mental health (16%), and HIV testing (16%). The most common biomedical topics were STI treatment (12%) and male circumcision (8%). The outcomes most frequently reported were related to sexual behaviors (50%), HIV infection (34%), sexually transmitted infections (30%), HIV testing (16%) and substance use (15%).

Conclusions/Implications: HIV prevention research related to MSM has primarily focused on non-specific populations of MSM and their behaviors. Continuing to do research on the general population of MSM is still important, but greater attention is needed on subgroups of MSM who are most affected by HIV. Similarly, behavioral research on MSM remains critical, but with recent advances in the biomedical field such as pre-exposure prophylaxis and treatment as prevention as well as the growing awareness of the importance of social determinants of health, we hope to see more primary studies and SRs focusing on these areas as well.

BP06

Abstract 1631 - Prevention Research and Implementation Science

Author(s): *Nicole Crepaz, Darrel Higa, Theresa Sipe, Mary Mullins, Christina White, Adebukola Adegbite*

Background: As the number of persons living with HIV (PLWH) grows, it is essential that HIV prevention, treatment, care, and services meet their needs in order to improve the health of PLWH and reduce further transmission of HIV. Mapping the body of literature and synthesizing the diverse topics related to this population can facilitate our understanding of the state of science, what works and what the gaps are. A large volume of primary study literature and systematic reviews (SRs) have been conducted on PLWH. We conduct an overview of SRs, describe the portfolio of SRs, and discuss the research gaps in HIV prevention, treatment, care and services for PLWH.

Methods: The Prevention Research Synthesis (PRS) Project's cumulative database on HIV/AIDS/STI prevention (over 72,000 citations as of March, 2015) was searched for relevant citations. Eligible SRs were focused on PLWH and reported prevalence of, correlates of, or interventions that are designed to change the following biologic, biomedical or behavioral outcomes: sexually transmitted infection (STI) or hepatitis infection, disease progression, survival, physical health, linkage to care, retention in care, HIV treatment uptake/status, medication adherence, viral suppression, HIV symptom management, condom use, sexual and reproductive health, or drug and substance use.

Results: Of 3,712 SRs in the PRS database, 326 focusing on PLWH met the inclusion criteria. The publication years range from 1991 to 2014, including 88% published in past 10 years, with an exponential increase in the number of SRs on medication adherence and HIV care engagement in the past 5 years. 49% examined correlates (e.g., patient, provider, care system, structural, sociocultural factors) of biologic or behavioral outcomes, 39% were intervention-related, and 12% focused on prevalence of biologic or behavioral outcomes. 29% targeted subgroups of PLWH, including infants, children, adolescents, women, men who have sex with men (MSM), persons with drug use, racial/ethnic groups, rural residents, inmates, homeless people, persons who were displaced due to conflict, and sex workers. Among the HIV care continuum outcomes, the most examined topic was medication adherence (40%), followed by HIV care engagement (mostly retention in HIV care, 10%) and antiretroviral therapy (ART) access and uptake (5%). Other commonly examined topics were sexual risk behavior, drug or substance use, mental health (e.g., depression, anxiety, coping), disclosure, and efficacy of ART (~10% each topic). Mental disorders, physical abuse, substance and drug abuse, social support, stigma, and text-messaging or a reminder system are the most common factors identified in the correlational studies as barriers or facilitators of HIV care continuum outcomes and as well as components evaluated in interventions.

Conclusions/Implications: Our mapping shows that SRs for PLWH have primarily focused on general populations of PLWH and medication adherence. While diverse topics and subpopulations of PLWH have been synthesized, greater attention is still needed for less-studied HIV care continuum outcomes, such as linkage to care and re-engagement in HIV care, ART uptake, and viral suppression, and subgroups most affected by HIV, particularly MSM of color, transgender and the aging PLWH population.

BP08

Abstract 2137 - Prevention Research and Implementation Science

Author(s): *Rohit Verma*

Issue: CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) provides a national online resource for consumers to find HIV, STD, and Viral Hepatitis testing and vaccination locations in the U.S. In 2012, users could access this resource from two different sites, hivtest.org and findstdtest.org, revealing missed opportunities to provide information to persons with related risks for HIV, STD and Viral Hepatitis. Given increased evidence about co-morbidities and co-mortalities among HIV, STD and Viral Hepatitis, a redesigned and consolidated resource called Get Tested (gettested.cdc.gov) was developed in 2014 to provide consumers with comprehensive education information and tailored testing locations.

Setting: Get Tested was redesigned for individuals searching online for testing and vaccination locations and sexual health information. This project identified several priority audiences with an increased risk for multiple diseases, including people living with HIV/AIDS, men who have sex with men (MSM), and adolescents.

Project: This work demonstrates how user-centered design (UCD) processes from the field of human-computer interaction (HCI) were combined with health communication and marketing approaches in the redesign of this online resource. The objective of the project was to redesign the search locator and results page to more effectively display testing locations, services offered, and integrated testing messages. Several key research activities, such as stakeholder and user interviews, review of the literature, competitive analysis, and usability testing were essential in developing the communication plan, health messaging and site design recommendations.

Results: The redesigned site was developed on an approach that was both user-centered and research-based. The site was designed for both consumers, clinicians and public health partners, supporting a flexible delivery of testing information and linkages to care across multiple channels (including mobile, widgets, SMS, and social media). Additionally, a new tool was developed providing HIV, STD and hepatitis testing suggestions based on a user's age, gender and sexual orientation. This new tool assists individuals in talking to their health care provider about appropriate tests for their needs.

Lessons Learned: The project validated an important model for user-centered design that applied health communication and marketing principles to the design process. The Get Tested project systematically collected several design inputs to synthesize evidence-based design recommendations and create tailored audience-centric content while effectively managing stakeholder expectations. User-centered design methods such as usability studies can provide direction for designing online health information, but these methods alone fail to fully scope design requirements for digital media channel delivery of health messages. Communication science, planning and marketing approaches are critical to creating an effective user experience in providing online health information for varied audience segments. Adding health communication principles, health marketing frameworks and approaches to UCD methods from HCI requires an interdisciplinary approach to bridge the engineering and design practices of UCD with evidence from health behavior studies and marketing frameworks.

BP09

Abstract 1354 - Prevention Research and Implementation Science

Author(s): *Loris Mattox, Braunz Courtney, Jennifer Lorvick*

Issue: HCV treatment access for increased risk populations in Alameda County

Setting: Alameda County, the city of Oakland, urban area

Project: A "cascade of care" for HCV can be identified that begins with screening and diagnosis, moves to linkage to care, and ultimately results in successful treatment. We examine this progression among people recruited by a community-based harm reduction agency in Oakland, CA. HCV antibody testing

and RNA testing (for HCV Ab+) persons were provided at community locations, including a drop-in center, a mobile testing van, syringe exchange program sites and methadone programs between July 1, 2012 - June 30, 2013.

Results: 1,215 individuals were screened for HCV antibody, 760 of whom had a history of injection drug use. HCV antibody prevalence was 32% (391 Ab+ cases). Of these 391, 60% (233/391) received RNA testing. Thirty-five percent (82/233) had active HCV infection. Assertive follow-up by agency staff, combined with provision of transportation and a cash incentive, led to 85% of those with HCV infection (70/82) attending an intake appointment at a public HCV clinic. However, only three HCV infected individuals became engaged in treatment. Major barriers to treatment were the presence of co-morbid health conditions and lack of current MediCal coverage. Many participants reported being disappointed that they were unable to get HCV treatment once linked to the clinic. Another barrier was poor attendance at follow-up appointments, which were not facilitated by harm reduction agency staff.

Lessons Learned: Screening for HCV antibody was successfully accomplished by a community-based harm reduction agency in many venues, and ultimately led to the identification of 82 cases of active HCV infection. Additional efforts are needed to (1) ascertain all HCV Ab+ individuals receive RNA testing; (2) educate patients about the complexities of HCV treatment decisions; (3) facilitate enrollment in MediCal for treatment candidates; (4) provide continuing practical and emotional support throughout the treatment process, not just at the point of linkage.

BP10

Abstract 1236 - Prevention Research and Implementation Science

Author(s): *Megan Hicks, Steve Kogan, Junhan Cho, Assaf Oshri*

Background: African American men who have sex with women (MSW) are an understudied group that has experienced rising HIV infection rates and high rates of other STIs. Heterosexual HIV transmission is facilitated by non-HIV STIs which increase HIV infectivity and susceptibility in both women and men. Thus, risk conferred by STIs acquired in heterosexual relationships affects the spread of HIV in a community and highlights the importance of investigating MSWs' sexual risk behaviors. Engaging in concurrent sexual partnerships (sexual relationships that overlap across time) has been identified as a prominent risk factor contributing to the HIV/STI epidemic in African American communities. This study examines African American men who report a "main" partner as well as a concurrent, "casual" sexual partner and investigates the psychosocial factors that predict inconsistent condom use with their "other" partner. Predictors of casual partner condom use include adverse childhood experiences, intrapersonal risk factors and characteristics of the couple relationship with the main partner. Intrapersonal factors included impulsivity and "street code" a defensive relationship style.

Methods: This data originates from the African American men's Project (AMP; R01DA029488) an investigation of HIV related behavior among 505 rural African American men age 19-22 living in South Georgia. Of the 505 participants, 367 report being in a committed relationship with a woman. Of the men in a committed relationship, 176 (48%) report having one or more casual sexual partners in the past 3 months. Condom use is largely inconsistent with main partners (84.1%); approximately half of men report inconsistent condom use with casual partners (48.9%). Bivariate and multivariate analyses

investigating associations between predictors and casual partner condom use consistency, controlling for use of condoms with the main partner were conducted.

Results: Bivariate analyses indicated that street code, impulsivity, adverse childhood experiences, criticism from the main partner, and supportiveness of the main partner were significantly associated with casual partner condom use. In multivariate analyses, impulsivity, partner support, and partner criticism predicted inconsistent casual partner condom use.

Conclusions/Implications: Little research has addressed psychosocial correlates of condom use with “other partners.” This study acknowledges the complexity of condom use decisions in the context of sexual concurrency and will allow intervention developers to pinpoint the focus of their activities, better to match these men’s needs. Interventions using our model can address casual partner condom use by taking a systemic approach. Focusing on condom use alone may not reduce sexual risk behavior, however taking into account intrapersonal and relationship factors may create a clearer picture.

BP11

Abstract 1250 - Prevention Research and Implementation Science

Author(s): *Jinxiang Hu, Julianne Serovich, Yi-Hsin Chen, Monique Brown, Judy Kimberly*

Background: The purpose of this study was to provide psychometric assessment as validity evidence to a HIV disclosure attitude measure among men who have sex with men (MSM).

Methods: This study used sexual behavior baseline data from a clinical trial evaluating the effectiveness of an HIV serostatus disclosure intervention. The Rasch model was used to examine the psychometric properties of the disclosure attitude instrument with 14 items. Unidimensionality and local independence assumption was tested through confirmatory factor analysis, examining the residual correlation matrix. Evidence of validity was provided by Messick’s conceptualization of unified validity theory. Scale content validity was investigated via expert opinion, item-total correlations, and item fit statistics. The substantive aspect of validity was addressed by interpreting the meaning of continuum of the item difficulties and person fit statistics. The structural aspect of validity was assessed using item fit statistics, principle component analysis of the standardized residuals. The generalizability aspect of validity was examined through internal consistency reliability of both items and persons. Aspects of external validity were assessed by examining between group differences on the disclosure attitude measure.

Results: The average age of participants (N = 340) was 42.1 years (SD = 11.03 years). The average time since diagnosis was 163.77 months (SD = 99.20). Most participants identified their race as either White/Caucasian (n = 171, 50.3%) or Black/African American (N = 127, 37.4%). Only 9.1% (n = 31) of participants identified their ethnicity as Hispanic. Self-reported sexual orientation was mostly gay (n = 267, 78.5%), and 74.4% (n = 253) indicated that they had sex only with men. Most participants reported being single (N = 238, 70%). More than half of participants (n = 224, 65.8%) reported having completed at least some college, but most were currently unemployed (n = 235, 69.1%) with monthly incomes at or below \$1000/month (n = 198, 58.2%). Confirmatory factor analysis and principal component analysis of standardized residuals showed that the items met the unidimensionality and local independence

assumption. There was only one item that did not fit the model well (item 14 addressing disclosing serostatus when partner specifically asked). There were only 4 persons that did not fit the model. Item reliability after removing item 14 was high (.89). There was no between group difference based on age and race.

Conclusions/Implications: The findings suggest that the disclosure attitude instrument is suitable to inform, design and evaluate HIV serostatus disclosure interventions.

BP12

Abstract 1383 - Prevention Research and Implementation Science

Author(s): *Anna Satcher Johnson, Zanetta Gant, Xiaohong Hu*

Background: Reducing disparities in diagnoses and treatment are central goals of the National HIV/AIDS Strategy for the United States. Addressing the social determinants of health (SDH) that adversely affect persons infected with HIV from progressing along the HIV care continuum may advance efforts in reducing disparities in diagnosis rates between populations. Mandated reporting of HIV-related laboratory tests provides surveillance systems with the capacity to monitor utilization of care, identify deficits, and evaluate progress in programs designed to facilitate linkage to care. Previous studies have found that markers of social marginalization and lack of health insurance and housing are associated with poor utilization of care. We examined the relationship between SDH and linkage to HIV medical care.

Methods: Using data from the National HIV Surveillance System and the U.S. Census Bureau's American Community Survey, disparities in timely linkage to care (≥ 1 CD4 or VL test within 3 months of diagnosis) were measured for adults (≥ 18 years) with HIV infection diagnosed in 2010 in 6 U.S. jurisdictions with complete reporting of HIV-related lab results. Percentages of persons linked to care and their associated census-tract level SDH indicators (poverty status, education level, median household income, and employment status) were calculated for the total population, by sex, and for blacks, whites, and Hispanics/Latinos.

Results: Of the 2,503 adults in 6 U.S. jurisdictions whose HIV infection was diagnosed during 2010, 83.5% were linked to care ≤ 3 months after diagnosis. By race/ethnicity, linkage to care was highest for whites (85.2%) followed by Hispanics/Latinos (84.9%) and blacks (82.0%). Among males overall, linkage to care was lowest among males who lived in census tracts with the highest percentage of persons living below federal poverty level (80.7%), the lowest median household income (80.5%), and the highest percentage unemployed (80.6%). By race/ethnicity, linkage was lowest among black/African American males living in census tracts with the highest poverty (77.6%), lowest income (77.9%), and the lowest unemployment (77.6%). Among white males, linkage was lowest in census tracts with the lowest poverty (83.0%), the highest education (82.8%), the highest income (81.5%), and the highest unemployment (81.5%). No patterns of association between SDH and lower linkage were observed for Hispanic/Latino males. Among females overall, linkage to care was lowest among females living in census tracts with the lowest education (83.8%), the highest income (83.0%), and the lowest unemployment (77.8%). By race/ethnicity, linkage was lowest among black/African American females who lived in census tracts with the lowest education (84.4%), the highest income (82.9%), and the

lowest unemployment (74.2%). White females living in census tracts with the highest poverty and the lowest income had the lowest linkage (70.0 % and 70.0%, respectively). Numbers for Hispanic/Latino females were too small for investigation.

Conclusions/Implications: We observed potential patterns of association between select SDH and lower linkage to HIV medical care for blacks/African American males and white females. Further investigation of potential associations between SDH and linkage to HIV care among these populations are warranted as addressing them may improve patient outcomes and decrease HIV transmission.

BP14

Abstract 1798 - Prevention Research and Implementation Science

Author(s): *Heidi Reukauf, James Tesoriero, Denis Nash, Kelly Piersanti, Robert Remien, Katherine Elkington, Carl Koenigsmann, Bethsabet de León-Justiniano*

Background: Approximately 2,000 HIV positive inmates were held in a New York State (NYS) prison in 2013. Less than half that number was receiving HIV treatment, despite evidence that 90% were aware of their status. Concerns about confidentiality, stigma, and the quality of medical care are primary reasons for non-disclosure to medical staff. NYS's Positive Pathways Project was implemented to reduce HIV-related stigma, increase HIV knowledge and improve perceptions of medical care. This study established baseline and post-intervention levels of HIV knowledge, HIV-related stigma, and perceptions of medical care in NYS's prison system.

Methods: Voluntary and anonymous surveys were conducted with medical staff, correction officers and inmates in 17 prisons in 2012/2013 and again in 2014. The surveys targeted all medical staff (n = 436) and correction officers (n = 4076), and a random sample of inmates (n = 1207). Structured scales were used to assess HIV knowledge, HIV-related stigma, and perceptions of medical care. Post-intervention surveys are currently being analyzed and will be compared to baseline results to assess changes in the levels of HIV knowledge, HIV-related stigma and perceptions of medical care.

Results: (Baseline surveys only)

Prior to the intervention 42% of inmates (n = 1041) answered all HIV knowledge questions correctly. Thirty seven percent of correction officers (n = 804) answered all HIV knowledge questions correctly. Mean stigma scores were 1.5, 1.4 and 1.2 out of 3 for correction officers, inmates and medical staff respectively (the higher the number the higher the stigma). Inmates exhibited poor perceptions regarding the quality of medical care in prison with a mean perception of medical care score of 2.27 out of 4 (the higher the number the more positive the perception). Post intervention results are under analysis and will reveal whether Positive Pathways resulted in changes in the levels of HIV knowledge, HIV-related stigma or the perception of medical care.

Conclusions/Implications: Baseline survey results revealed high levels of HIV knowledge and HIV-related stigma and poor perceptions of medical care. Post-intervention surveys will determine if the Positive Pathways project impacted levels of HIV knowledge, HIV-related stigma and perceptions of medical care in NYS's prisons. Post intervention results will be available for presentation at the 2015 National HIV Prevention Conference.

BP15

Abstract 1921 - Prevention Research and Implementation Science

Author(s): *Katya Corado, Sonia Jain, Jill Blumenthal, Deborah Collins, Shelly Sun, Michael Dube, Michael Menchine, Sheldon Morris, Kathleen Jacobson*

Background: Willingness to use pre-exposure prophylaxis (PrEP) for HIV varies by demographic factors and perceived risk of HIV infection. Less studied are reasons for PrEP refusal. We examined recently tested HIV-negative individuals who declined referral/linkage to PrEP evaluation (hereafter known as PrEP-refusers) to determine reasons for PrEP refusal.

Methods: Participants who tested HIV negative at a Southern California local health department testing site and a university-based testing site were asked to complete an anonymous survey that recorded demographics, PrEP awareness and reasons for refusal. Reasons for refusals were divided into risk-behavior concerns, medication-related concerns, and logistical concerns. Comparisons between groups were done by Chi-square test.

Results: A total of 1033 survey forms were collected. Mean age was 33 years, 41% were male, 22% Black and 42% Hispanic. Greater awareness of PrEP (overall 45%) was associated with being male (62% vs 35% female, $p<0.001$), White (59 vs 46% Black vs 40% other, $p<0.001$), non-Hispanic (50 vs 39%, $p<0.001$) and men who have sex with men (MSM) (78 vs 36%, $p<0.001$). Twenty four percent of Black men (20/82) and 83% (124/147) of White men self reported as MSM.

Overall, 64% (512/798) reported being interested in PrEP with similar rates by sexual orientation. PrEP refusal differed by race, with Blacks having lower refusal rates (25 vs 34% white, vs 41% other, both $p<0.001$), and Hispanics higher than white men (42 vs 34%, $p=0.002$). Refusers were less aware of PrEP (44 vs 59%, $p<0.001$). Of PrEP refusers, 76% marked refusal reasons, including: perceived lack of HIV risk (36%), in a monogamous relationship (18%), lack of doctor recommendation (32%), and side effects concerns (24%). MSM refusers ($n=85$) were concerned with side effects (47%); not wanting pills (26%) or perceived a lack of HIV risk (20%). Women chose lack of risk-behavioral concerns (64 vs 40% men, $p<0.001$), and men medication-related concerns (62 vs 21% women, $p<0.001$).

Conclusions/Implications: Understanding awareness and reasons for PrEP refusal is essential to better educate high-risk groups about HIV prevention strategies. Our findings suggest that women need to understand their HIV risk, heterosexual men and MSM need to be better educated about PrEP medication. Awareness within culturally distinct groups appear to be different suggesting a need to reach out especially to Hispanic populations.

BP17

Abstract 2062 - Prevention Research and Implementation Science

Author(s): *Leigh Bukowski, Steven Meanley, Amy Herrick, Derrick Matthews, Lisa Eaton, Patrick Wilson, Ronald Stall, The Power Study Team*

Background: Despite the disproportionate burden of HIV experienced by Black transgender women (BTW) in the United States, little is known about how HIV care continuum outcomes manifest among this vulnerable community. As far as we know, there have been no attempts to develop an HIV care continuum among BTW. We sought to determine the prevalence of HIV care continuum outcomes in a sample of BTW.

Methods: Cross-sectional data for our analysis came from the first year of the ongoing study, Promoting Our Worth Equality and Resilience (POWER). In 2014, the POWER study employed time-location sampling to recruit a community-based sample of Black men who have sex with men (BMSM) and BTW who attended Black Pride events in Philadelphia, PA, Houston, TX, Washington, D.C., Detroit, MI, and Atlanta, GA.

A total of 111 BTW provided complete data for our measures on HIV care continuum outcomes. HIV-positive participants were identified for analysis if they reported a prior HIV diagnosis in the POWER survey and/or received a positive result from an on-site HIV test. To determine care continuum outcomes among BTW, we defined linkage to care as having ever been seen for HIV-related care, retention in care as current engagement in HIV-related care, antiretroviral treatment (ARV) initiation as currently prescribed HIV medication, and viral suppression as a report of <200 copies/mL at the participant's most recent lab test. For HIV-positive participants on ARVs, we examined individual-level factors that explicate our BTW sample's difficulty with adherence.

Results: Among BTW in our study sample, we observed an HIV prevalence of 42% (n=47). Of the positive BTW participants, 53% were previously diagnosed and linked to care, 49% were retained in care and prescribed ARVs, and 28% reported an undetectable viral load at most recent lab test. Roughly two-thirds (68%) of the BTW who were aware of their HIV status and currently taking ARVs reported having had difficulty taking HIV medication on time during the previous month for reasons at the individual level (e.g., felt depressed and overwhelmed). Lastly, 76% of unknown HIV-positive participants reported a prior HIV test in their lifetime and only 57% reported receiving an HIV test within the past six months.

Conclusions/Implications: Developing and implementing interventions that address routine HIV testing uptake and promising approaches such as treatment as prevention (TasP) may assist in informing the HIV disparity among BTW in the United States. Given the alarming prevalence rates across the HIV Care continuum, more research is needed to identify and understand the structural, community, and individual-level barriers and facilitators that shape BTW's engagement to health promotion services.

BP18

Abstract 2111 - Prevention Research and Implementation Science

Author(s): *Robin Lanzi, Elysia Jordan, Tony Ma, Katie Chang, Loral Patchen*

Background: Our research team developed Sexually Active Adolescent Focused Education (SAAFE), via a user-centered approach (UCD), to deliver an interactive theory-driven, evidence-based sexual health mobile-based game that paired HIV/STI education with information on local health centers that offer comprehensive STI testing.

Methods: Our UCD approach leveraged feedback from a product advisory group of African American males and females ages 15-21 to guide the concept, design, and development. The game concept, a dating simulation game, was selected by the product advisory group for design and development. Using the UCD approach, we successfully developed, implemented, and pilot tested usability and acceptance of this interactive sexual health mobile simulation game with African American males and females age 15-21.

Results: Focus Group Findings:

Gaming Habits: Participants reported daily video game play and were more likely to purchase a game if it was popular among their friends. Participants typically played mobile games for 15-20 minutes; however, they would play up to two hours in order to win or finish a game. Young men were more likely to play games for longer periods of time.

Sexual health topics: Participants reported that peers engaged in sexual activity at a variety of locations including parties and playgrounds. Oral sex and casual sex were commonly identified sexual activities performed in those locations. Participants reported their friends were aware of the risk of STIs when engaging in sexual activities, but did not care, especially when under the influence of drugs and alcohol. Participants also identified local slang terms for sexual behaviors to aid in the authenticity of game language.

Game Concept; Character and Scenario Design: Participants selected the dating simulator game from four possible game concepts. They wanted to create a character drawn realistically that offered a range of different body types, skin tones, and ages. Participants also selected mini games to be embedded within the dating simulation game play from proposed concepts. Game dialogue was suggested by participants.

Game Testing

Twenty-three participants completed responses to the System Usability Scale (SUS), one of the most commonly used measures of perceived usability, with an average score of 77.7. This score is at the 82nd percentile with error bars of 90% confidence intervals, which means that if we were able to measure 1000 users, this is where the expected score would fall. Additionally, twenty-five users responded to the following statements on a five point Likert scale, with a score of 4 or higher that they: 1) learned from SAAFE, 2) they would recommend it to a friend, and 3) would consider downloading it to play with a confidence level of 90%. For each item, the goal was to obtain a score of 4 or higher.

Conclusions/Implications: We believe SAAFE has potential to significantly impact acquisition of HIV by leveraging a theory-driven, evidence-based gaming approach. It may also have the potential to affect other related areas, such as decreasing rates of other STIs and unintended pregnancy.

BP19

Abstract 2183 - Prevention Research and Implementation Science

Author(s): *Angulique Outlaw, Monique Jones*

Background: African American YMSM continue to be at high risk for acquiring HIV as evidenced by the increased incidence of HIV infection in recent years (CDC, 2013). Nonetheless, adequate prevention programming for this population is lacking. Many proposed prevention interventions have failed to address the unique aspects of and important to

African American YMSM. For example, difficulties with ethnic and sexual identity may be a precursor to the psychological distress, substance use, and lack of perceived social support often associated with sexual risk behavior for this population. Therefore, a culturally and developmentally appropriate intervention is needed to address these issues and to reduce associated risk behaviors. Brothers Saving Brothers (BSB) (guided by social cognitive theory and behavioral skills acquisition) was adapted from a hybrid of Brother to Brother (formerly the African American Men's Health Study) and Many Men, Many Voices (3MV). Objectives include: (1) Decrease HIV/STI risk behavior; (2) Decrease condomless sex; and (3) Increase pride in ethnic and sexual identity.

Methods: This single-session (6 hours), group-level prevention intervention focuses on ethnic and sexual identity, HIV risk and vulnerability, partner negotiation, risk reduction, and health relationships. Participants' gain mastery through role-play, group discussion, and skill building activities. African American YMSM were recruited through traditional and non-traditional outreach and venues (e.g., youth serving agencies, social media, field outreach events, colleges and universities) by peer outreach representatives who were also the group facilitators. The evaluation measures focus on satisfaction with the intervention (content and facilitators) and pre- and post-test to evaluate specific intervention components (HIV/STI knowledge, risk behavior, ethnic and sexual identity).

Results: From August 2007 – March 2014, 267 African American YMSM have participated in the intervention to date (ages 16 – 26; M=20.71; SD=2.26). Participants really liked the intervention (97%) and the facilitators (96%), and felt there was a good balance between the discussions and activities (96%). Participants felt they could express themselves without fear of criticism (98%) and 95% of participants reported having a better understanding of the behaviors that put them at risk for HIV. Thirty-one percent of the participants reported having had a STI and 96% had been tested for HIV. There were significant changes, from pre-test to post-test, with regard to HIV/STI knowledge (M=4.07; SD=.86) and (M=4.34; SD=.77), $t(254)=-5.28$, $p=.000$); ready to change condom use for oral sex (M=5.21; SD=3.41) and (M=5.52; SD=3.35), $t(260)=-2.09$, $p=.038$); avoiding alcohol (M=5.15; SD=3.48) and (M=5.78; SD=3.41), $t(258)=-4.10$, $p=.000$), and avoiding marijuana (M=6.14; SD=3.81) and (M=6.66; SD=3.70), $t(261)=-3.70$, $p=.000$).

Conclusions/Implications: Providing a culturally and developmentally appropriate group-level prevention intervention appears to be appropriate for meeting the prevention needs of African American YMSM. The use of peer outreach staff (i.e., who are representative of the population of interest) appears to be a critical component in implementing a successful prevention intervention for this population. While these results are promising, more data is needed to determine how efficacious this intervention will be for the population of interest.

BP20

Abstract 2317 - Prevention Research and Implementation Science

Author(s): *Lisa Hightow-Weidman, Kathryn Muessig, Karina Soni, Emily Pike, Helene Kirschke-Schwartz, Sara LeGrand*

Background: HIV disproportionately impacts young Black men who have sex with men (YBMSM). Once diagnosed these men experience disparities along all stages of the HIV care continuum. A more nuanced

understanding of individual, institutional and structural barriers experienced by YBMSM along the continuum would provide information to more effectively improve provision of care and the design of interventions.

Methods: healthMpowerment.org (HMP) is a mobile-phone-optimized, Internet-based intervention for both HIV-positive and negative YBMSM (age 18-30) that provides information, resources, tailored feedback, game-based elements and a social networking platform to offer and receive social support from peers. A randomized controlled trial comparing HMP to a control website that provides HIV/STI information began enrolling in December 2013 and 332 (70%) of the planned sample has been enrolled to date. Participants' complete baseline and follow-up surveys at three, six and 12-months post enrollment which includes measures to describe the HIV continuum of care (testing, linkage to care – defined as having an HIV provider, retention in care – defined as < two missed clinic visits in past 12 months, antiretroviral therapy (ART) use, and viral suppression).

Results: Median age is 24 years; most identified as gay (65.4%) or bisexual (17.6%). Seven participants identified as transgender. Almost all participants' (96.1%) had been HIV tested prior to study start. Among those testing negative (n=174), 93 (53.4%) had tested within the past three months, 42 (24.1%) in the past 3-6 months, 24 (13.9%) in the past 6-12 months, and 15 (8.6%) greater than 12 months ago. Of the 144 HIV-positive YBMSM, 131 (91.0%) were receiving HIV care. The most common reasons for not being in care were inconvenient location/transportation issues (69.2%) and cost concerns (53.8%). Among those in care, 64 (48.9%) report no missed visits in the past 12 months, 36 (27.5%) report one missed visit, and 31 (23.7%) report two or more. Most (n=122, 84.7%) had been prescribed ART. Among the 22 YBMSM not prescribed ART, the most common reasons were participants' concerns regarding their ability to adhere (40.9%), fear of side effects (27.3%) and being recently diagnosed (27.3%). Two thirds (63.1%) of men on ART reported an undetectable viral load in the past six months. YBMSM who reported any drug use in past three months were less likely to be undetectable (p=0.03); methamphetamine use was low overall but approached statistical significance (p=0.06) with those using less likely to be undetectable.

Conclusions/Implications: These results from a large sample of YBMSM living in a geographic area highly impacted by HIV revealed multi-level barriers to engagement across the continuum of care. Structural barriers such as transportation and cost limited engagement and retention in care, while individual-level concerns about adherence and side effects impeded ART initiation. An Internet-based intervention has the potential to address these care continuum barriers across multiple levels by: reaching populations not traditionally accessed through clinic based evaluations, helping patients stay connected with providers, and connecting HIV-positive YBMSM with each other to provide reassurance, support and success stories about taking ART and achieving viral suppression.

BP21

Abstract 1580 - Prevention Research and Implementation Science

Author(s): *Greg Rebchook, Susan Kegeles, Judy Tan, Lance Pollack, David Huebner, John Peterson*

Background: Young, African American gay, bisexual, and other MSM (YAAMSM) are at high risk for HIV infection. Since YAAMSM report the same level of condom use as do young MSM of other racial/ethnic

groups, trying to increase condom use to reduce HIV disparities is likely to be a difficult task. Pre-exposure prophylaxis (PrEP) may contribute to the solution, but only if PrEP is available and YAAMSM are aware of PrEP and motivated to use it. The HIV prevention workforce needs more data to plan appropriately for the continued scale-up of PrEP in the YAAMSM community, especially in communities outside of the primary HIV epicenters.

Methods: As part of a multi-year evaluation of an Mpowerment Project (MP) adapted for YAAMSM in Texas, we collected cross-sectional data from YAAMSM annually in Houston and Dallas. In 2013, we surveyed 660 YAAMSM and included questions about their experience with and attitudes towards PrEP. We defined PrEP within the survey, and we also measured a variety of psychosocial variables, HIV risk behaviors, and participation in the MP, a community-level HIV prevention intervention.

Results: Among the 565 self-reported HIV negative men, 26% had ever heard of PrEP prior to the survey, and only 8% reported either current or past PrEP use. Among the men not currently taking PrEP, 43% indicated that they were extremely likely to use PrEP if it were available, and 47% said that they would use it if it were free. Men who were most likely to have heard of PrEP had a primary healthcare provider (PHP) ($p=.05$) or had participated in MP ($p<.001$). Factors related to ever taking PrEP included high self-perceived SES ($p<.01$), having a PHP ($p<.001$), willing to disclose sexual history to a PHP ($p<.01$), and intervention participation ($p<.001$). Compared to men who had not used PrEP, men who had used PrEP perceived that community norms were less supportive of safer sex and HIV testing ($p<.05$), were less depressed ($p<.01$), less resilient ($p<.01$), expressed lower levels of gay pride ($p<.05$), received less social support from other YAAMSM ($p<.05$), and perceived less HIV stigma in the community ($p<.001$).

Conclusions/Implications: In 2013, use of PrEP among Texan YAAMSM was low (i.e., under 10%). We found that over a quarter of the men sampled had at least heard about PrEP, which suggests that information about PrEP has been diffusing through the community. We also found PrEP awareness and use to be higher among men who reported participation in MP. This suggests that incorporating PrEP messages and PrEP access programs into MP and other interventions may be a worthwhile strategy to increase PrEP uptake. HIV prevention professionals can also learn from the characteristics, perceptions, and attitudes of the early PrEP adopters when crafting and positioning messages to expand the use of PrEP throughout the community (e.g., reaching men of lower SES, emphasizing that PrEP use need not depend on partner cooperation, personal resilience, or community norms).

BP22

Abstract 2432 - Prevention Research and Implementation Science

Author(s): *Susan Kegeles, Emily Arnold, Robert Williams, Gregory Rebchook, Scott Tebbetts, David Huebner, Wilson Vincent, Judy Tan, John Peterson*

Background: HIV+ YBMSM engage in the HIV care continuum and have suppressed viral loads at lower rates than most other US groups. To develop a CLI to help HIV+ YBMSM engage in care and adhere to treatment regimens, we conducted focus groups of HIV+ YBMSM to explore different aspects of being HIV+, obtaining care, and receiving social support for being positive.

Methods: Four 3-hour focus groups (FGs, total N=28) were conducted in 2012-2013 with HIV+ YBMSM (ages 18-29) in a large Texas city. Men were recruited through social networks. FGs were recorded, transcribed and entered into a qualitative software program. Themes were derived through an iterative process involving regular discussions within a team of analysts, and then used as a basis for a codebook.

Results: Five major themes emerged: There was considerable discussion about HIV-Related Stigma and gossip about HIV-status. Gossip is used as a form of interpersonal aggression (“used as a weapon”), or to protect a friend (“don’t sleep with him, he has ‘it’”), and takes place online and during in-person social situations. Stigma is situated both within the YBMSM and the broader Black community. There was tension concerning HIV-Disclosure, with some men applauded for being out about their serostatus, but others stating they cannot risk disclosure to friends or family. Participants reported that Medication Myths are rampant among negatives and positives not in care, with many believing that medications cause appearance changes, are toxic, and have severe side-effects. However, participants themselves recognized that current medications are effective and well tolerated after a few weeks. Participants believed that Resilience (“mental strength”) was required to deal with the many challenges of having HIV and to avoid depression, fear, and denial. Men felt that Social Support was key to coping with HIV and that support for engaging in care and adhering to medication would be enormously helpful, though had to be expressed differently depending upon the relationship. Many expressed enthusiasm for intervention activities that focused on HIV+ YBMSM, where they can be themselves; socialize with, obtain and give support to each other; discuss challenges; and share information. Some were already doing this, but others did not have such opportunities. Participants expressed that they did not, however, want a program solely for positives since they also wanted to interact with, receive support from, and educate HIV-negatives about these issues, and also so that they would not become identified as being part of an HIV+ group.

Conclusions/Implications: HIV+ YBMSM face enormous challenges, and interventions for them should seek to increase social support for engaging in the continuum of care and living with HIV, to reduce HIV-stigma, and to increase community-wide HIV treatment literacy. Issues beyond good clinical care affect them since they remain a part of the YBMSM community that is not always supportive. HIV-stigma remains prevalent in the South and is a disincentive to obtaining care, receiving support, and disclosure. It is important to mobilize HIV+ and HIV- YBMSM to support HIV+ men to engage in care and take their medications regularly.

BP23

Abstract 1993 - Prevention Research and Implementation Science

Author(s): *Judy Tan, Susan Kegeles, Lance Pollack, Greg Rebchook, David Huebner, John Peterson, Wayne Johnson, Agatha Eke*

Background: There is a dearth of research that examines engagement in the HIV care continuum (CC) among couples, and even less among couples of young black men who have sex with men (YBMSM), a population that is disproportionately impact by HIV and AIDS. Despite the potential of antiretroviral therapy (ART) to lower HIV transmission rates, the efficacy of treatment-for-prevention approaches for HIV-positive (HIV+) YBMSM with serodiscordant partners may be limited due to poor engagement in the CC, and developing efficacious interventions for improving their care engagement is paramount. The

present study aimed to examine differences in engagement in care outcomes among HIV+ YBMSM with and without primary partners (i.e., boyfriends), and partnered HIV+ YBMSM in HIV-seroconcordant versus serodiscordant relationships.

Methods: The present analysis was limited to all self-reported HIV+ young (ages 18-29) HIV+ BMSM from five annual cross-sectional samples (2009-2013) in Dallas and Houston, TX, recruited via respondent driven sampling. Participants completed a questionnaire that included items about linkage to care (have a primary health care provider), any care in past 6 months, adherence to ART (any skipped doses in past 30 days), and demographic information.

Results: Data across single and partnered men (N=290) were compared on engagement in the CC variables. Chi-square difference tests showed that men with a primary partner reported being more engaged in HIV care than single men in terms of receiving HIV treatment in past 6 months ($\chi^2[1]=6.68$, $p=.01$), and in having a primary health care provider ($\chi^2[1]=7.01$, $p=.01$). No statistically significant differences were found between partnered and single men on ART adherence. However, chi-square difference tests comparing men with seroconcordant positive partners with those with serodiscordant partners showed that men with seroconcordant partners reported worse adherence in the last 30 days than men with serodiscordant partners ($\chi^2[1]=6.65$, $p=.01$), while engagement in the CC did not vary by partner serostatus.

Conclusions/Implications: These data suggest that partners may play an integral role in engagement in the HIV CC and adherence to treatment, and that optimizing care and treatment outcomes may be improved through intervention strategies that incorporate a couples approach. Further, interventions to improve HIV care engagement and ART adherence for partnered HIV+ BMSM should be tailored to whether their partner is HIV- or HIV+.

BP24

Abstract 1109 - Prevention Research and Implementation Science

Author(s): *Richard Lechtenberg, Nicholas Moss, Neena Murgai*

Background: In Oakland and the surrounding communities of Alameda County, California, both race/ethnicity and neighborhood poverty are associated with engagement in HIV care. In 2013, only 40.6% of African Americans living with HIV infection (PLHIV) were retained in continuous HIV care (2 or more visits at least 90 days apart within the calendar year), compared to 48.8% of whites. Also, retention in continuous HIV care increased as census tract poverty rate decreased, ranging from 38.7% among PLHIV in the poorest areas to 49.8% in the wealthiest areas. We assessed whether the association between neighborhood poverty and retention in HIV care differed by racial/ethnic group among PLHIV in Alameda County.

Methods: Persons 18 years or older living with HIV infection in Alameda County on January 1, 2013 were selected for analysis from the county's Enhanced HIV/AIDS Reporting System (eHARS) data. Those known to have died or believed to have moved out of the county in 2013 were excluded. Those diagnosed after January 1, 2012 and those without a care visit in 2011 or 2012 were also excluded. Dates of HIV viral load or CD4 count laboratory tests were taken to reflect HIV care visits. Data were

geocoded to census tract of residence. Neighborhood poverty was defined as the percentage of census tract residents living below the federal poverty level based on the American Community Survey. Log binomial regression models were fit in order to estimate adjusted relative risks (RR) of retention in continuous HIV care in 2013 per 10% change in neighborhood poverty, controlling for race/ethnicity, age, gender and sexual orientation.

Results: Of 5,585 estimated PLHIV on January 1, 2013, 3,783 cases were eligible for analysis. Overall, 55.6% were retained in continuous care. The association between neighborhood poverty and retention in HIV care varied by race/ethnicity. Neighborhood poverty rate was inversely associated with retention in continuous care in 2013 only among African American PLHIV. For every 10% increase in neighborhood poverty, the relative probability of having been engaged in continuous HIV care among African American PLHIV declined by 8% (RR: 0.92; 95% confidence interval (CI): 0.88-0.97; $p = 0.001$).

Conclusions/Implications: We found that associations of retention in HIV care with poverty differed by race/ethnicity in Alameda County. Neighborhood poverty was only found to be significantly associated with retention in continuous care among African American PLHIV, possibly reflecting differential prevalence or impact of specific poverty-associated barriers to HIV care in this population. These results support the importance of examining the role of contextual factors in shaping outcomes along the continuum of HIV care. They also suggest the potential for prevention strategies aimed at reducing structural barriers to improve retention in HIV care among African Americans.

BP25

Abstract 2092 - Prevention Research and Implementation Science

Author(s): *Jenne Massie, Anita Raj, Jennifer Yore, Lianne Urada, Sidney Holt, Lisa Bowleg*

Background: Although Black men in the U.S. accounted for 68% of new HIV cases due to heterosexual exposure among men in 2011, HIV prevention research and community-based interventions for Black heterosexual men (BHM) are rare. Research has documented the challenges in recruiting Black men, yet our understanding of the challenges associated with recruiting BHM is limited. The REPRESENT Study and MEN (Making Employment Needs) Count are two of the first community-based HIV prevention/intervention research studies to focus on BHM. The purpose of this study is to evaluate the process for establishing effective recruitment strategies to reach BHM in HIV prevention and intervention research in urban areas.

Methods: This study utilized two large NIH studies: The REPRESENT Study (REP) in Philadelphia, PA (N = 578, completed in 2012) and the MEN Count (MC) Study in Washington, DC (N = 504, in process; current n=197). Participants were BHM aged 18 years or older, reporting past year vaginal sex. Qualitative data involved interviews with potentially eligible Black males regarding reasons for study decline or participation (MC n=10). Quantitative data were taken from study screening reports (REP n=964, MC n=418) to assess recruitment and enrollment rates by recruitment methods and venue.

Results: Results from both studies document the process of establishing effective recruitment methods to reach BHM. This process included weekly monitoring of recruitment data and collaboration with community partners to address recruitment challenges.

The REP study utilized venue-based recruitment strategies. During formative research we randomly selected 53 Census block groups with a population of at least 50% African American. Using an enumeration process, we enlisted the participation of 88 viable venues (e.g. barber shops, corner stores, etc.) within these block groups. We completed 179 sampling events.

The MC study was initiated in a workforce development program, and then in a faith-based healthcare venue. These venues offered little resultant yield. The study shifted to recruitment from community sites (i.e. homeless shelters), but this yielded predominantly older and lower risk clients. The study then shifted to an STD clinic pursuant to information from clinicians of greater access to BHM in this venue. Enrollment data document the MC study recruited men using Craigslist (4%), flyer distribution (3%), friend/participant referrals (17.2%), outreach at community-based organizations (2.5%), local STD clinic (59.9%), and from other/unidentified means (14.4%). Both studies completed on-going analysis of recruitment methods throughout the course of the study to determine the effectiveness of the method and quickly adapt to challenges related to staff, weather, venues, establishing relationships with community-based organizations and reaching a high-risk population.

Conclusions/Implications: Successful recruitment plans must be nimble and allocate time and resources for testing multiple strategies to accommodate the challenges of recruiting BHM for research. Recruitment plans should also consider alternate recruitment strategies (i.e. changing recruitment sites to target specific populations) if the primary method proves ineffective during interim recruitment strategy analysis.

BP26

Abstract 1349 - Prevention Research and Implementation Science

Author(s): *Yue Pan, Lisa Metsch, Lauren Gooden, Allan Rodriguez, George Woody, Antoine Douaihy, Raul Mandler, Carlos del Rio, Eric Daar, Daniel Feaster*

Background: The risk behavior profiles for those who are HIV virally unsuppressed are of interest for HIV prevention. The aims of the present study are to 1) describe the prevalence of sexual risk and injection drug use (IDU) behaviors, and 2) examine the associations of viral suppression (<200 copies/ml) with these HIV risky behaviors among hospitalized HIV-positive patients.

Methods: Cross-sectional analysis was conducted on data from 2,289 HIV-infected patients from 11 hospitals in the U.S. screened for study inclusion in CTN-0049, Hospital Visit as Opportunity for Prevention and Engagement for HIV-Infected Drug Users (HOPE), a trial conducted within the National Institute on Drug Abuse Clinical Trials Network (NIDA CTN) from July 2012 to January 2014. Chi-square tests and multiple logistic regression were used.

Results: Among the HIV-infected patients screened in the hospital, 1116 (48.8%) were men who have sex with women, 765 (33.4%) were women and 408 (17.8%) were men who have sex with men. The overall rate of HIV viral suppression was 25.2%. The prevalence of ever being an IDU was 40.4% for virally suppressed and 27.2% for virally unsuppressed patients (chisq=23.0, df=1, p<0.0001), while the prevalence of IDU in the past 12 months was 8.1 and 8.3% for virally suppressed and unsuppressed

patients, respectively (chisq=0.02, df=1, p=0.9). Patients who were virally suppressed showed no differences in sharing needles or injection paraphernalia from those who were unsuppressed. The two groups were not significantly different in the percentage reporting condomless sex acts in the past 12 months: 23.3% among virally suppressed and 25.7% among virally unsuppressed patients (chisq=0.38, df=1, p=0.4). However, virally suppressed patients were less likely to engage in sex acts while high on drugs or alcohol (15.7% vs 22.1%, OR=0.64, 95% CI=0.46-0.88, p=0.007), and were less likely to have sex with HIV uninfected or unknown HIV status partners (19.6% vs 26.3%, OR=0.67, 95% CI=0.49-0.90, p=0.008) compared to those virally unsuppressed.

Conclusions/Implications: Although significantly more HIV virally suppressed patients reported ever being an IDU compared to virally unsuppressed, IDU in the past 12 months was relatively low and not significantly different between the groups. Patients who were virally unsuppressed exhibited more sexual behavioral risk for HIV transmission than those who were suppressed. Hospital settings are potentially appropriate for future targeted interventions focusing on sexual risk behaviors for virally unsuppressed patients in the U.S.

BP27

Abstract 2197 - Prevention Research and Implementation Science

Author(s): *Lisa Hightow-Weidman, Kathryn Muessig, Karina Soni, Emily Pike, Helene Kirschke-Schwartz, Sara LeGrand*

Background: Young black men who have sex with men (YBMSM) are disproportionately affected by HIV. While social networking sites can facilitate opportunities for YBMSM to meet sex partners, they also provide connections to others around health-related issues including HIV prevention, testing and care services. To our knowledge, no social networking websites have been designed explicitly to build community and create positive norms around sexual health and HIV prevention and care for YBMSM.

Methods: healthMpowerment.org (HMP) is a mobile-phone-optimized Internet-based intervention for HIV-positive and negative YBMSM (age 18-30) that provides information, resources, tailored feedback, game-based elements and a social networking platform to offer and receive social support. Two unique social networking features (Getting Real and the Forum) within HMP aim to stimulate dialogue among YBMSM thereby promoting positive norms around sexual behaviors and health. A randomized controlled trial comparing HMP to a control website that provides HIV/STI information began enrollment in December 2013. Participants' complete extensive baseline and follow-up surveys and a qualitative thematic analysis was conducted on user posts.

Results: 322 (68%) of the planned sample have been enrolled. Median age is 24 years. Most are HIV-negative or status unknown (n=188, 58%). Two hundred-seventeen (67.4%) identified as gay, 59 (18.3%) bisexual, six (1.9%) straight and 43 (13.4%) queer, questioning or other. Seven participants (2.2%) identified as transgender. Use of social and sexual networking sites was pervasive; 98.8% had an account on one or more sites. Users spent a median of six hours a day online. For those who used the Internet to search for sex partners (n=232), 42 (18.1%) did so several times a day, 32 (13.8%) about once a day, 80 (34.5%) weekly, and 78 (24.2%) once every few weeks or less often. One hundred seventy-three participants have been randomized to the intervention arm. There have been 1023 user text-based

posts in the two social engagement areas of HMP, Getting Real (n=160) and the Forum (n=863). The most common topics (with a sample post title) include: maintaining healthy friendships (#friendzoned) and sexual relationships (THOT [That Hoe Over There] Life), sexual health and self-care (Manscaping), navigating online hook-up sites (I finally deleted my Jack'd (for good)), sexual positioning (Bottom bashing), gender identity (MASC vs. FEM and everything in between) and HIV stigma (Men that brag about being HIV-negative).

Conclusions/Implications: HMP capitalizes on social network characteristics as a means through which YBMSM are provided with information, experience social norms and reflective appraisals, and feel a sense of connectedness to peers. Formative work identified a lack of spaces, both virtual and real, for YBMSM to converse about intimate topics without these conversations devolving into sexually charged interactions. HMP was deliberately designed to provide anonymity (e.g. customizable avatars, pseudonyms) and to foster communication within a semi-public space (e.g. HMP does not allow private messaging between participants). These social networking features provide individual privacy but also group accountability so that YBMSM can feel comfortable discussing sexually explicit topics or expressing their own thoughts or experiences within the safety of a respectful, affirming online environment.

BP28

Abstract 1279 - Prevention Research and Implementation Science

Author(s): *Jamie Hart, Cynthia Klein, Alejandra Mijares, Theresa Spitzer, Clarke Erickson, James Carey, Monique Carry, Deborah Gelaude, Nicole Pitts, Damian Denson*

Background: Undiagnosed, untreated, and uncontrolled HIV infections remain critical challenges in efforts to control HIV in the United States. Individuals who are undiagnosed and those who are diagnosed but not retained in care account for most of the HIV transmissions. In contrast, those who are virally suppressed are estimated to be 94% less likely, compared to HIV-infected undiagnosed persons, to transmit HIV (Skarbinski et al., 2015). HIV care providers and healthcare systems play a critical role in engaging individuals into testing, linkage to, and retention in continuous HIV care. Understanding the barriers and facilitators experienced by HIV care providers working to engage and retain their patients in HIV care is a key to achieving higher levels of viral suppression, and thus reducing the number of new HIV infections in the United States.

Methods: Our presentation describes results from in-depth, semi-structured interviews conducted with 30 HIV care providers in three major metropolitan statistical areas reporting high prevalence of HIV (Atlanta, GA; Baltimore, MD; Washington, DC). Qualitative data were collected regarding perceived barriers and facilitators to providing HIV care, with a specific focus on engagement and retention. Interviewees included staff in various roles providing HIV care: eleven physicians, five nurse practitioners, one physician assistant, four registered nurses, and nine case managers/social workers. All interviews were audio-recorded with permission from the interviewee and transcribed. Qualitative data were analyzed for emerging themes across facility and provider types using NVivo 10.0.

Results: Key facilitators of engagement in care included the availability of a broad range of providers and support services (ideally in one location), flexibility of clinic procedures and providers, and reputation

and trust between providers and patients. Key barriers of engagement included the lack of capacity to connect patients to needed services; difficulty navigating insurance- and medication-related policies; difficulty managing appointments and follow-up; and continuing stigma and misconception about HIV. The ability to successfully retain patients was augmented by access to other trusted providers as well as access to a wide range of support and social services, and use of patient education and empowerment principles. Barriers to retaining patients included the lack of provider or system capacity to routinely and accurately monitor and follow-up with patients. Retention was further hindered by patient personal barriers to staying in care, such as unstable housing, unemployment and lack of transportation.

Conclusions/Implications: Our findings suggest that an orientation toward understanding and treating the “whole patient” – while improving the systems that support patients and their ability to navigate them – enhances engagement in care. Additionally, improved infrastructure and procedures to monitor patients across the HIV care continuum may be instrumental in providing and retaining those patients in optimal care.

BP30

Abstract 2379 - Prevention Research and Implementation Science

Author(s): *Carlos Rodriguez-Diaz, Edda Santiago-Rodriguez, Ricardo Vargas-Molina, Edgardo Ortiz-Sanchez*

Background: While there is significant evidence of the role of behavioral risks affecting the health status of HIV+ gay men and other men who have sex with men (MSM), there are limited studies addressing the social determinants of health of this group. Social determinants of health are the economic or social conditions that influence differences in health status. Understanding the role of social determinants of health among disenfranchised groups is a key element for the development of combined interventions and therefore a comprehensive response to the HIV epidemic.

Methods: As part of an ongoing health promotion research being conducted in Puerto Rico (PR), 19 qualitative interviews with HIV+ gay men and other MSM were completed in Spanish following a life-history approach. Interviews were recorded, transcribed, and content and discourse analyses were completed using a grounded theory approach and supported by the use of NVivo for data management. For dissemination purposes, quotes from participants will be translated to English.

Results: Participants shared events such as experiencing violence in school and from relatives, receiving and disclosing a diagnosis of HIV+, receiving health care services, and disclosing sexual practices/orientation to friends, family, co-workers and healthcare providers. These experiences have shaped health outcomes such as adherence, retention in care, and disclosure of HIV status or sexual practices/orientation to providers. Among the social determinants of health associated with the negative health outcomes of these men are included gender-based discrimination, limited sexuality education and limited access to efficient public transportation. They also reported social exclusion due to a lack of laws or policies to protect from discrimination at work and the absence of legal protection from systemic or interpersonal violence based on sexual orientation. Different sources of stigma were reported by the participants, including stigma associated with sexuality, stigma related to drug use, stigma associated with socioeconomic status, and HIV-related stigma.

Conclusions/Implications: These preliminary findings suggest that HIV+ gay men and other MSM in PR experience major health inequities caused by social determinants of health. Future interventions should consider a systemic approach in combination with other behavioral interventions in order to improve the health status of these men who are otherwise socially vulnerable.

BP31

Abstract 1588 - Prevention Research and Implementation Science

Author(s): Leigh Willis, Dan Baden, Peter Jenkins

Background: Games have tremendous potential as a vehicle for health communication and education. According to the Entertainment Software Association, 58% of Americans play video games. They are popular among persons of both genders and across a wide range of ages. Games with a health education theme have been shown to increase knowledge, change behavioral intent, and improve adherence to medical treatment (healthgamesresearch.org).

Game development challenge events (also known as “game jams”) are a proven, fast, and relatively inexpensive way to produce new prototype games. These jams bring game developers together in a particular location over a short time frame (i.e., single venue and 48-hour duration), to address a specific theme in a collaborative, yet competitive, atmosphere.

Interactive health education tools such as health education games have demonstrated the ability to induce statistically significant changes in knowledge, attitudes, behavioral intentions, and behaviors consistent with HIV prevention. In an effort to create new game prototypes related to HIV awareness and prevention and to increase game designers interest in public health, we decided to hold an HIV-focused game jam with support from the Department of Health and Human Services (HHS) Ventures fund.

Methods: The 2014 HHS Health Game Jam took place at Southern Polytechnic State University in Marietta, Georgia. The event began at 6 p.m. on Friday, September 26, and ran until 6 p.m. on Sunday, September 28. We partnered with several different organizations, including the Georgia Game Developers Association, who served as hosts. The goal of the event was to have designers create games which focused on the primary and secondary prevention of HIV. We solicited 25 colleagues from CDC as well as our sister HHS (HHS) agencies, Health Resources Services Administration (HRSA) and National Institutes of Health (NIH), to be subject matter experts. These experts provided educational sessions about HIV for the game jam teams prior to the start of the jam and helped to guide the development of the games.

Results: Forty-one games were produced in the 48-hour period. A total of 291 people and 25 subject matter experts participated in the event. Our event attracted many first time participants (56.6%), with most being enrolled at a university (79.4%) and under the age of 25 (73.7%). More importantly, only 16.6% had considered a career in public health prior to the event, rising to 65% after the event. Similarly, of the 43.4% who had ever participated in a game jam before, only 23.4% had ever created a health-related game.

Conclusions/Implications: Results of this event were encouraging. Both attendance and the number of game prototypes produced exceeded expectations. Also encouraging was the robust growth of interest in public health among the participants. The event demonstrated that game jams can be used to build inexpensive demos of HIV-related games as well as to improve awareness of and interest in public health careers. We plan to build on our success and host a similar event in 2015, utilizing the lessons learned from 2014.

BP32

Abstract 1226 - Prevention Research and Implementation Science

Author(s): Michele Andrasik, Michael Arnold, Matthew Mimiaga, Rachel Clad, Emily Leickly, Rita Ismail, Erik Schwab, Ya-Fen Chan, Gail Broder

Background: Prior quantitative and qualitative research among men who have sex with men (MSM) and male-to-female (MTF) transgender women who have not participated in an HIV vaccine trial highlights numerous barriers and facilitators to participation. To address these participation hurdles, efforts have focused on improving community engagement, particularly among marginalized communities who are most at-risk for HIV infection and could benefit the most from an effective HIV vaccine. The goal of this project was to facilitate discussions with Clinical Research Site (CRS) staff to identify methods to enhance and accelerate the recruitment of MSM and transwomen who have sex with men into preventive HIV vaccine clinical trials conducted by the HIV Vaccine Trials Network (HVTN). This project focused on improving recruitment into a Phase 2b HIV vaccine efficacy trial (HVTN 505) in the United States, seeking to facilitate enrollment of eligible members from priority populations and increase the pool of candidates for study screening.

Methods: In order to better understand the perspectives of CRS staff in addressing recruitment and enrollment challenges, we conducted a series of 13 focus groups with a total of 74 staff at CRSs in 6 U.S. cities: Boston, Chicago, Denver, Houston, Los Angeles, and New York (38% of study sites). At each site one focus group was held for principal investigators, clinic managers and supervisors (N=24) while another was convened for clinicians, recruiters, educators and Community Advisory Board (CAB) members (N=50). Semi-structured focus group questions explored staff training needs at each CRS, methods used for obtaining participant feedback and incorporating it into site operations, and strategies to enhance participants' experiences in HVTN clinical trials. A team of six researchers analyzed the data thematically to yield a detailed and complex account, including categorizing data into themes (e.g., training needs, participant recruitment). The team refined the thematic framework throughout the analytic process by identifying emerging themes and expanding existing ones.

Results: Four areas of need were identified in the data: (1) Improving communication and interactions among staff to improve staff collaboration and community engagement effectiveness; (2), Enhancing community relationships; (3) Implementing mechanisms to obtain ongoing participant feedback; and (4) Identifying processes to address ongoing training needs. The data also pointed to six areas that require direct action in order to enhance site capacity and improve participant recruitment and retention: (1) Focused and structured training in specific areas (i.e., cross training to learn different jobs/roles among staff, enhancing relationships and capacity of the Community Advisory Board; cultural responsiveness

training for working with transgender and MSM communities); (2) Implementation of participant feedback surveys; (3) Guidelines and procedures for participant navigation at the clinic; (4) Tools to build relationships and trust with the community; (5) Increased opportunities for CAB and community feedback; and (6) Increased opportunities for sites to share best practices and strategies for overcoming recruitment and retention challenges.

Conclusions/Implications: Attention to these areas is needed for improved community engagement at the local and national level. Recommendations will be discussed.

BP33

Abstract 1212 - Prevention Research and Implementation Science

Author(s): *Monique Brown, Julianne Serovich, Jinxiang Hu, Judy Kimberly*

Background: Vengeance is the extent to which individuals may inflict punishment or retaliate for a perceived wrong. For some men who have sex with men (MSM), contracting HIV could be seen as an intentional purposeful act against them, which could incite vengefulness. Research findings have been inconsistent showing associations (and a lack thereof) between vengefulness, and condom use and disclosure. However, studies examining the extent to which vengeance is associated with varying levels of risky sexual behavior (unprotected anal sex, unprotected insertive sex, and unprotected receptive sex) and different measures of disclosure (behaviors, attitudes and intentions) among men who have sex with men (MSM) are extremely lacking. The aim of this study was to explore the association of vengeance, and risky sexual behavior (unprotected anal sex, unprotected insertive sex, and unprotected receptive sex), and disclosure outcomes (behaviors, attitudes and intentions) among MSM living with HIV.

Methods: Data were obtained from 271 MSM living with HIV from an HIV disclosure intervention study. Vengeance was operationalized into a three-level categorical variable based on percentiles (most vengeful, more vengeful vs. least vengeful). Crude and multivariable logistic regression models were used to examine the association between vengeance and risky sexual behavior (unprotected anal sex, unprotected insertive sex, and unprotected receptive sex) in the past 30 days. Simple and multiple linear regression models were used to determine the association between vengeance and disclosure behavior, attitudes and intention scores. Pseudo R-squared values were obtained for logistic regression models, and R-squared and adjusted R-squared values were obtained for linear regression models to determine the amount of variance in risky sexual behavior and disclosure outcomes explained by vengeance.

Results: The mean vengeance score was 56.8 (SD=20.7) with a range of 20 to 130. After adjusting for age, and knowing source of infection, being more vengeful was positively associated with unprotected anal sex (OR: 2.89; 95% CI: 1.43 – 5.85), unprotected insertive sex (OR: 2.17; 95% CI: 1.09 – 4.31), and unprotected receptive sex (OR: 2.45; 95%CI: 1.23 – 4.85). However, there was a negative association between being more vengeful and disclosure attitudes (β=-2.03; 95% CI: -3.94, -0.11). There were no statistically significant associations found between vengeance and disclosure behavior and intentions or between having high levels of vengeance (being most vengeful) and risky sexual behavior and disclosure outcomes. Vengeance explained a small amount of variance in risky sexual behavior and

disclosure outcomes. For example, being more vengeful explained 6% of the variance in having unprotected anal sexual intercourse in the past 30 days, and 3% of the variance in disclosure attitudes.

Conclusions/Implications: Vengeance is an important trait that should be considered as a focal point and should be addressed in interventions geared towards reducing risky sexual behavior and improving disclosure outcomes among MSM living with HIV. Future studies could examine the association between vengeance and other risky behaviors, such as number of sexual partners and exchange sex.

BP35

Abstract 1855 - Prevention Research and Implementation Science

Author(s): *Perlita Carrillo, Lilia Espinoza, Jenica Ryu*

Background: Incarceration and recidivism interrupts the continuity of HIV care for persons living with HIV, and housing instability post-incarceration often compounds it. The Skid Row area of Downtown Los Angeles is home to a highly vulnerable homeless population with high rates of incarceration and has consistently reported the highest HIV incidence in Los Angeles County. One component of the study was to understand the barriers and facilitators to linking and engaging in HIV care after incarceration among a sample of HIV-infected persons in HIV care at a Skid Row clinic.

Methods: Formerly incarcerated, HIV-positive patients in HIV care at a homeless health care agency in Los Angeles completed an interviewer-administered structured interview between July 2014 and February 2015. Participants with a self-identified history of incarceration and who received care within the last 12 months were randomly selected from the clinic patient database. The questionnaire included standardized questions regarding incarceration history, discharge preparation, barriers and facilitators to accessing care post-incarceration, and sociodemographics. Descriptive statistics were conducted in SPSS.

Results: Forty patients (57.5% male, 15% transgender; 70% African American) were enrolled and completed the questionnaire. The majority self-identified as heterosexual (72.5%), and the average age of the study population was 49.6 years (SD = 8.9 years). The average length of time living with HIV at time of interview was 13.3 years (SD = 7.3 years). Seventy percent reported having been incarcerated in both a jail and prison setting in their lifetime; 20% were incarcerated in jail only; and 10% had been incarcerated in prison only. Upon a participant's most recent release from incarceration, 40% lived in a shelter or on the streets and 45% were precariously housed while 15% lived in their own home or apartment. Almost half of participants (47.5%) with a history of prison incarceration recalled having received some form of discharge planning (e.g., medical or social services referrals) upon release; however, only 12.5% of participants with a history of incarceration in jail reported having received discharge planning upon release. The top three barriers to accessing care immediately post-incarceration were not wanting other people to know their HIV status (60%), lack of housing and forgot to go to appointment (each at 50%), and lack of transportation (47.5%). The top three facilitators to accessing care post-incarceration were wanting to be healthy (95%), trusting the doctor and feeling comfortable at the clinic (each at 92.5%), and knowing HIV medications would help (90%).

Conclusions/Implications: There is a need to have more consistent and comprehensive discharge planning in state and local correctional systems to improve linkage to HIV care upon release. Addressing stigma and its impact, as well as provision of supportive services, such as housing and transportation are essential when linking patients to care. Support and trust of providers and knowledge of antiretroviral's impact on health can positively influence linkage and future retention in care.

BP36

Abstract 1490 - Prevention Research and Implementation Science

Author(s): *Agatha Eke, Wayne Johnson, Ann O'Leary, Greg Rebchook, David Huebner, John Peterson, Susan Kegeles*

Background: BACKGROUND: Several studies have shown that mental health and psychosocial problems are correlated with high-risk sexual behavior and HIV infection among MSM. Other studies have also seen an association between psychosocial indicators such as anxiety and depression with HIV medication adherence. These factors are often not the primary focus of intervention studies and are not often reported as outcomes of effective HIV risk-reduction. We assessed the extent to which a community-level intervention developed for young black MSM impacted their psychosocial health problems.

Methods: METHODS: The community-level intervention was based on the empowerment principles emphasizing community-building and sex-positive affirmation of all orientations, and was delivered through various activities, including peer-led group discussions on HIV prevention, volunteer activities, and core groups. Approximately 330 YBMSM were surveyed annually for four years in each of two sites. The original intervention site received the intervention in waves 2 through 4; the delayed intervention site received the intervention in wave 4 only. We used general linear models to examine change across time in the intervention condition compared to the control condition (intervention effects), and to examine differences in the original intervention site between respondents who reported participation in the intervention activities versus those who did not (participation effects). Psychosocial outcomes included five scores: depression symptoms (potential range 0-21), experience of racism (11-55), comfort with being gay (including reverse-scored items on internalized homophobia) (6 to 30), experiences of external homophobia (7-35), and HIV treatment optimism (4-16). Spearman correlations were measured between variables with significant intervention effects or participation effects and number of non-main partners for condomless anal sex.

Results: RESULTS: The intervention effect was statistically significant and favorable for one outcome, comfort with being gay ($P=0.02$). The mean value increased from 22.0 to 22.6 in the original intervention site. In the delayed intervention site, the mean decreased from 21.9 to 21.1 during the 3 control years, and then increased to 21.6 when the intervention was introduced in the final wave. Participation effects were statistically significant for three outcomes. Intervention participants reported fewer depression symptoms (3.9 vs 4.7, $P=0.03$), more experiences of external homophobia (17.0 vs 16.0, $P=0.03$), and greater treatment optimism (7.5 vs 6.8, $P=0.003$) than non-participants. Comfort with being gay significantly correlated ($P<0.01$) with lower numbers of non-main partners for both receptive and insertive anal sex without condoms, while depression symptoms, external homophobia, and treatment optimism all correlated with greater numbers of both.

Conclusions/Implications: CONCLUSIONS/IMPLICATIONS: Although the ultimate goal of HIV interventions is to reduce risk of transmission, the findings support also focusing on the broader health issues of MSM. The improved comfort with being gay and reduced depressive symptoms positively correlated with reduced sexual risk. On the other hand, increased experiences of external homophobia may have resulted from increased sensitization from intervention participation. Treatment optimism is justifiably increasing among MSM. Perhaps PrEP may be appropriate for MSM who have the most partners for condomless sex.

BP37

Abstract 2041 - Prevention Research and Implementation Science

Author(s): *Jennifer Hecht, Jessica Lin, Albert Plenty, Edwin Charlebois*

Background: MSM have high rates of binge drinking (>50% in San Francisco), which can lead to increased sexual risk and other negative outcomes. Heavy alcohol use has been identified by the local HIV Prevention Planning Council as a driver of the HIV epidemic in San Francisco. MSM are more likely than the general population to meet new sexual partners in bars, making bars an important venue for interventions related to addressing alcohol-related HIV risk. The PACE study aimed to describe patterns of alcohol use and sexual risk among gay bar patrons in San Francisco. The study also aimed to assess the feasibility of several interventions, including normative feedback about level of intoxication, educational messaging in bars, and improved accessibility of free water.

Methods: From September 2013 to August 2014, study participants were recruited outside of 4 gay bars in San Francisco. All individuals exiting the bar were invited to participate. Individuals were eligible if they were over 18 and had consumed at least one alcoholic drink that evening. Upon verbal consent, participants answered a brief survey including questions regarding alcohol intake and sexual history. Participants completed a breathalyzer to measure their blood alcohol concentration (BAC). Breathalyzer results were inputted into a tablet app to display the participant's BAC relative to other study participants.

Results: Participants (n=1013) had consumed just over 4 drinks on average at exit. About a third of participants had BAC levels over the legal driving limit (.08g/dL). Eighty-four percent scored ≥ 4 on the AUDIT-C, a standardized 3-question screener for alcohol dependence. Nine percent scored 10 or higher, corresponding to a 75% likelihood of alcohol dependence. Forty-two percent reported transmission risk at last sex (condomless sex with a potentially serodiscordant partner). Controlling for relationship status and recent condom use, there was a 2.3-fold increase in transmission risk among participants who reported being under the influence of alcohol at last sex ($p < .0001$). Regarding the normative feedback intervention, half of the participants reported finding normative feedback 'quite a bit' or 'extremely' helpful, and 10% reported intending to reduce drinking upon seeing their normative feedback data. Those with highest BAC levels ($\geq .08$ g/dL) were more likely to report that normative feedback would lead them to reduce drinking ($p = .04$). Twenty-two percent reported having seen media promoting pacing drink consumption. Thirty percent reported seeing a water dispenser providing free water; among those, 25% (7% overall) used the dispenser.

Conclusions/Implications: We found very high levels of sexual risk and risk of alcohol dependence among participants. HIV transmission risk was greater among participants under the influence of alcohol at last sex. Working with bar owners to promote healthier drinking through structural-level interventions is feasible. In order to be effective, messages must be prominently displayed. Normative feedback of BAC levels or AUDIT-C scores has potential for increasing uptake of treatment services for those in greatest need. ASOs and Departments of Public Health should consider the importance of addressing alcohol use through partnering with bar owners, screening for alcohol dependence, and sharing harm reduction information in bars and social settings.

BP38

Abstract 2366 - Prevention Research and Implementation Science

Author(s): *Chadwick Campbell, Colleen Hoff, Jessica Kolber, Deepalika Chakravarty, Torsten Neilands, Kirk Grisham, Patrick Wilson, Shari Dworkin*

Background: In 2012, the Food and Drug Administration (FDA) announced the immediate release of Pre-Exposure Prophylaxis (PrEP) to the public. Studies have shown that the majority of MSM have generally high levels of knowledge about PrEP, though lower levels of awareness have been documented among some MSM of color. Most studies have also documented a willingness to use it and positive attitudes about the drug. Condoms and PrEP are both tools in the HIV and STI prevention toolkit, each with its own strengths and weaknesses. However, the actual impact of PrEP on condom use among MSM outside of the context of a clinical trial is not well studied. Further, few studies have examined attitudes of same-sex male (SSM) couples regarding PrEP since it became available for public use, and the dyadic nature of decision-making around PrEP among SSM couples had not been adequately explored.

Methods: Cross-sectional data were collected from 217 Black, White, and Interracial (B/W) SSM couples in San Francisco and New York. Approximately one-third of the couples were HIV-discordant, and approximately two-thirds were concordant negative. The current analysis, includes HIV-negative partners' (n=379) responses to questions focused on PrEP awareness, uptake, dyadic-level decision-making, and condom use.

Results: The majority of men were aware of PrEP, while only 6% of those in concordant negative relationships, and 12% of those in discordant relationships reported being on PrEP. Half of those on PrEP reported that it was a joint decision with their partner, while 44% reported that it was solely their own decision and that they had communicated their PrEP use to their partner. Three quarters of those using PrEP reported that if they wanted to stop taking PrEP, it would be their individual-level decision, while the remaining 25% reported that it would be a joint couple-level decision. The majority of those not on PrEP reported that they would consider taking PrEP, and more than three quarters reported that, it would be a joint decision making process with their partner. Finally, among men who were not on PrEP, 70% reported that if they were on PrEP, they would use condoms with the same frequency, or more often, than they currently do. However, only half of those on PrEP reported using condoms at the same frequency as prior to PrEP use, while 44% reported using condoms less than before or not at all.

Conclusions/Implications: Our findings suggest that, despite being aware of PrEP, only a small proportion reported that they were currently using it as a prevention strategy. Further, that, among SSM

couples, there is variability in PrEP use decision making, revealing that there is a continuum from sole to joint decision making. Finally, actual condom use frequency among men on PrEP may be lower than the intentions of men who are not yet on PrEP. As the use of PrEP increases among MSM, future interventions need to ensure that SSM couples are equipped to support each other in the decision making process around PrEP, and make informed decisions about their condom use.

BP40

Abstract 1566 - Prevention Research and Implementation Science

Author(s): *Celia Fisher, Miriam Arbeit, Brian Mustanski, Kathryn Macapagal*

Background: LGBT youth ages 14 – 17 (LGBTY) are disproportionately affected by HIV, yet there is a paucity of HIV prevention research involving this population because of their legal status as minors. The recent success of adult PrEP trials and CDC recommendations for its use means that health care providers may begin to prescribe PrEP to sexually active LGBTY in the absence of feasibility and effectiveness data. This study drew on the voices of LGBTY to identify barriers and facilitators for youth recruitment and retention in PrEP adherence research.

Methods: Four asynchronous online focus groups were conducted with 37 LGBTY stratified by age (14-15 and 16-17) and gender identity. Youth were shown a video of a PrEP adherence study in which participants would be randomly assigned to receive daily text message medication reminders or to standard treatment. Questions addressed issues relevant to recruitment and retention including agreement to participate with or without guardian permission, attitudes toward random assignment, and barriers to treatment adherence and mandatory 3-month clinic visits.

Results: Although some youth felt parents could provide helpful insight into the participation decision and in considering side effects, most youth indicated guardian permission would pose a potential barrier to recruitment because they were not “out” to parents, or because of negative parental reactions to their sexual orientation or sexual behavior. Most youth felt comfortable asking informed consent questions and refusing participation if needed — although some youth preferred group or text message informed consent procedures. LGBTY comments indicated good consent comprehension including medical risks and potential benefits of PrEP, HIV testing and adherence requirements, and random assignment, and they demonstrated an ability to weigh these factors in making an informed participation decision. Describing their own vulnerability to forgetting to take medication, many youth preferred assignment to the text reminder condition, but some youth also identified strategies to use if they were assigned to the control. Adherence was a major participation problem for youth who were not out to parents. Most youth said they would return for the required 3-month HIV testing even if they had not used the pill consistently, although time and transportation would pose challenges to retention. The majority did not believe researchers have an obligation to provide PrEP post-trial, but did want post-trial referrals for continued PrEP access.

Conclusions/Implications: Guardian permission for LGBTY under age 18 remains a significant barrier to recruitment for PrEP research. Our participants indicated a capacity to understand the nature of the research and their research rights, especially when the researcher has established a trusting relationship. This finding suggests IRBs should be more willing to approve guardian permission waivers

for research so critical to youth health. Our data also suggest that a respectful and trusting research climate will improve research retention for youth who have difficulty adhering to the medication regimen. Finally, although post-trial provision of medication was not seen as a research responsibility, youth did feel investigators had an obligation to provide adequate referral sources for continued access to PrEP.

BP42

Abstract 1336 - Prevention Research and Implementation Science

Author(s): *Aisha Wilkes, Kirk Henny, Christina White, Mary Neumann, Damian Denson*

Background: The National HIV/AIDS Strategy has called for more attention to people who are living with HIV (PLWH) (CDC, 2014). The challenge with this approach is how best to get PLWH linked to care, remain in care, re-engage if they leave care, adhere to antiretroviral therapy, and ultimately achieve viral suppression. Since the introduction of the present-day smartphone in 2007, mobile technological advances have changed how health communication is delivered. In 2013, more than half of US adults reported looking up health information online (Pew Research Center, 2013). In a 2014 poll, two-thirds of internet users reported that they are better informed about their health than they were five years ago because of their internet and cell phone use (Pew Research Center, 2014). Thus, technology should be considered in the solution to improving HIV care and treatment. The purpose of this presentation is to present results from a review of technology-based interventions that address the HIV Care Continuum currently being reported in the literature, identify gaps, and provide recommendations for future direction of technology-based HIV prevention and care tools.

Methods: We searched the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Prevention Research Synthesis (PRS) project cumulative database of HIV/AIDS behavioral prevention research literature. Articles were considered in-scope if they reported technology-based interventions focusing on linkage, retention, or re-engagement of PLWH in care or adherence to HIV medications. Only articles published between January 2007 and December 2014 were included to ensure they focused on current technology. A keyword search yielded 68 unique publications. Pairs of coders screened abstracts to determine if articles were in-scope. In-scope publications were coded by pairs using standardized coding forms. Data were extracted on type of technology used, study characteristics (e.g., location, comparison condition), participant demographics, and intervention characteristics (e.g., main focus, mechanism of behavior change, intervention delivery method).

Results: A total of 25 unique studies were determined eligible for this review and coded. Black or African Americans were 50% or greater of study participants in half of the US-based studies. Only two interventions targeted youth. More than 75% of the studies focused on medication adherence. In particular, nearly half of the interventions (48%) were delivered via cell phones, providing medication reminders. The interventions mostly aimed to address barriers or facilitators to medication adherence (40%) or increase knowledge (36%). Two interventions meet PRS criteria for effectiveness.

Conclusions/Implications: The direction of interventions in this review is promising as half of the US-based studies are reaching the population most affected by HIV, Black/African Americans. However, the interventions were heavily focused on medication adherence; more studies are needed on technology-

based tools that link and retain PLWH in care. Additionally, though we found SMS reminders to be the most frequent form of technology used, technological advances allow for more novel intervention approaches (e.g., mobile applications, interactive web-based modules). Finally, since more youth are online (Pew Research Center, 2013) and are less engaged in HIV care (Zanoni & Mayer, 2014), more technology-based interventions are needed for young PLWH.

BP43

Abstract 1175 - Prevention Research and Implementation Science

Author(s): *Randolph Hubach, Michael Li, Brian Dodge*

Background: Studies have indicated that stigma, discrimination, and loneliness may be higher for men who have sex with men (MSM) in rural areas; however, few studies have addressed the potential connection to sexual behavior among those living with HIV. The overarching literature on HIV-positive MSM has analyzed sexual behavior within the context of risk, thus ignoring the social context for which sexual behaviors occur. On the whole, researchers have not identified the situational and contextual factors associated with sexual risk for rural HIV-positive MSM. Event-level measures evaluating sexual interactions have been called for to inform discussions of risk within sexual health promotion efforts.

Methods: In collaboration with community partners and consumers of HIV-related services, study protocols were developed. Using an internet-based questionnaire, we assessed HIV-related stigma, loneliness, safer sex attitudes, and event-level sexual behaviors in a sample of HIV positive MSM (n = 100) residing within a largely rural area in the Midwestern United States.

Results: Negative attitudes towards safer sex was positively correlated with total HIV stigma ($r = 0.255$, $p < .05$), and HIV stigma was highly correlated with loneliness ($r = 0.619$, $p < 0.01$). Loneliness negatively predicted condom use with the most recent partner, such that 1-unit increase in the loneliness score was met with a 10.3% (exponentiated coefficient (exp B) = 0.897, 95% CI [0.807, 0.998], $p < 0.05$) decrease in odds of condom use with the most recent partner. Negative attitudes toward safer sex negatively predicted condom usage with HIV-positive partners (exp B = 0.949, 95% CI [0.905, 0.996], $P < 0.05$). Specifically a 1-unit increase in negative attitudes towards safer sex in HIV-positive MSM was associated with a 5.1% decrease in odds of using condoms with HIV-positive partners.

Conclusions/Implications: Our study provides novel data on HIV-related stigma, loneliness, safer sex attitudes of HIV of HIV-positive MSM, and sexual behavior by illuminating possible pathways linking sexual beliefs and condom use among HIV-positive MSM. Findings accounted for the differing effects of loneliness across partners of different HIV serostatuses, shedding light on the role of partner status and disclosure on condom use decision-making in rural HIV-positive MSM. More refined data will inform clinical and social service practice, as they provide much-needed information on sexual health outcomes and experiences of an often underserved and under studied population. A more comprehensive perspective on sexual health, in general, would acknowledge a broad range of physical, mental, social and other health-related issues that may facilitate or inhibit behavior.

BP45

Abstract 1648 - Prevention Research and Implementation Science

Author(s): *Cathy Reback, Jesse Fletcher, Mitchael Metzner, Dallas Swendeman*

Background: Methamphetamine use among men who have sex with men (MSM) is deeply integrated into socio-sexual networks including digital spaces such as cell phone applications, websites, and digital chat rooms where MSM “hook up” for sex encounters and methamphetamine use. Project Tech Support is a gay-specific, theory-based simple messaging system (SMS; i.e., text-messaging) intervention that capitalizes on the use of such digital spaces among methamphetamine-using MSM to intervene in real time when high-risk behaviors are most likely to occur. Text-messaging is a feasible and sustainable means of providing targeted, tailored, and personalized intervention content to methamphetamine-using MSM; particularly, those who are less likely to attend face-to-face or site-based interventions.

Methods: Between March 2014 and December 2015, 285 methamphetamine-using MSM will be enrolled in an 8-week, gay-specific, theory-based text-messaging intervention designed to decrease methamphetamine use and HIV sexual risk behavior and, for the HIV-infected participants, simultaneously increase HIV antiretroviral treatment/adherence. Participants are randomized into 1 of 3 conditions: Group 1: five gay-specific, theory-based text messages sent by automation each day in addition to unlimited messages interactively transmitted by Peer Health Educators (TXT-PHE) plus a weekly text-message assessment; or, Group 2: the same five automated text messages but no interaction with PHEs (TXT-Auto) plus a weekly text-message assessment; or, Group 3: a weekly text-message assessment-only control (AO) with no gay-specific, theory-based text messages. All participants receive follow-up assessments at 8-weeks and at 3-, 6-, and 9-months post-enrollment. 616 pre-written text messages were developed according to the theoretical principles of Social Support Theory, Social Cognitive Theory, or the Health Belief Model.

Results: As of March 31, 2015, 175 participants enrolled in the study and enrollment should reach 270 by December 2015. Most participants identified as gay (77%) or bisexual (22%); the most commonly reported racial/ethnic identities were African American/black (40%), Hispanic/Latino (29%), and Caucasian/white (18%). Participants ranged from 18-64 years of age (Mean=41; SD=11), and most reported having graduated high school (62%) or college (20%). Biomarker evidence of sexual risk-taking among participants prior to enrollment included high prevalence of unknown chlamydia (8%), syphilis (14%), and/or gonorrhea (6%) infection at intake. Biomarker confirmed HIV infection was detected in 85/175 participants at baseline (HIV prevalence = 49%). Additionally, three new cases of HIV infection were discovered during baseline testing (prevalence of unknown HIV infection = 1.7%). From baseline to 3-month follow-up (92%; n=128), participants reported reductions in average days of methamphetamine use (10.3 [9.4] vs. 6.1 [7.9]), number of male sex partners (9.5 [14.8] vs. 4.3 [9.1]), engagement in/episodes of methamphetamine use during sex (n = 151 [86%], 7.1 [7.2] vs. n = 67 [52%], 5.3 [7.0]), and unprotected anal intercourse with male partners (15.7 [29.6] vs. 7.2 [36.0]) in the past 30 days.

Conclusions/Implications: Preliminary data indicate significant reductions in methamphetamine use and HIV sexual risk behaviors and demonstrate the effectiveness of the gay-specific, theory-based text-messaging intervention for methamphetamine-using MSM. Distal follow-up evaluations will determine differential and sustained effects and cost effectiveness by condition.

BP46

Abstract 2241 - Prevention Research and Implementation Science

Author(s): *Lisa Parker, Jeffrey Long, Sr.*

Issue: Research conducted by the Johns Hopkins Bloomberg School of Public Health reports that injection drug use in Baltimore City accounts for almost one-third (36%) of HIV/AIDS cases in Baltimore City. Among those who are disproportionately impacted is African American at 36% and Hispanic/Latinos at 19%, whites also counted to 19% of HIV/AIDS infections related to injection drug use. Women also represented a disproportionate number of HIV infection with nearly 63% attributing injection drug use and sex with and IDU partner as the mode of transmission. Injection drug use also increases risk for other drug related infections including hepatitis C which accounted for 64% of hepatitis infections in Baltimore City.

Setting:

The Baltimore City Syringe Exchange Program operates from 2 mobile vans that travel throughout Baltimore City in areas with high-incidence and prevalence of injection drug use, HIV and Hepatitis-C infections. High rates of substance use, drug related crime and violence, poverty and homelessness.

Project: The Baltimore City Health Department's Mobile Syringe Exchange Program (SEP) began in August of 1994 in response to the escalating HIV incidence rate attributable to injection drug use within the city. The program currently operates operating from 2 mobile units(recreational vehicle) and operates at 14 different sites through Baltimore City, Baltimore. Other programs/interventions currently being operated under SEP include: mobile Wound Care Clinic, mobile Vaccine Clinic, and a mobile Women's Reproductive Health program.

Results: From August of 1994 through July of 2014, there have been 9.5 million syringes exchanged and 285,410 visits to the SEP. More than 20,000 client registrations have been conducted, and more than 6,200 HIV tests administered. In addition, more than 3,850 referrals to drug treatment have been made, and has provided overdose prevention training to 11,582 individuals. In addition, there have been 5,200 units of naloxone dispensed, and more than 250 overdose reversals reported.

Lessons Learned: It is imperative that Community Risk Reduction Services have a coordinated focus to help take a creative and collaborative approach towards HIV prevention and harm reduction services. Key activities include the following: Community Engagement – Capacity building through informing, educating and developing working relationships with community stakeholders to address issues concerning HIV among injection drug users and their partners, substance abuse, opioid-related overdose, and health disparities within the City of Baltimore, Prevention and access to services – Increased prevention through awareness and implementation of programming based on public health models that promote high-quality health service delivery and access to care, Policy Development and Advocacy – Proposal and advocacy of policies and legislation needed to improve the services delivered by the department through CRRS in order to significantly decrease the rates of HIV, substance abuse, opioid-related overdose, and health disparities affecting those that live, work, or visit the City of Baltimore, Goals and Objectives – Guides the strategies, activities, and performance metrics of the programs to ensure a high level of effectiveness in its deliverables and outcomes.

BP47

Abstract 1642 - Prevention Research and Implementation Science

Author(s): *Brooke EE Montgomery, Nickolas Zaller, Amy Jones, Sharon Sanders, Songthip Ounpraseuth*

Background: One in five women has been sexually assaulted in her lifetime and one in three has experienced physical violence by an intimate partner. Among rural women, these rates are even higher while access to support services is lower. Female survivors of violence are more likely to report personal and partner HIV risk characteristics. Few sexual-risk reduction (SRR) interventions have been designed or tested to reduce sexual risk among female survivors of violence with unknown or negative HIV status. This leaves community-based agencies that serve this population without tailored cost-effective evidence-based interventions for their clientele. Following the ADAPT-ITT model our team developed a community advisory board and in collaboration with this board selected and adapted evidence-based SRR interventions (“Project: The Future Is Ours (FIO)” with content from “Living in the Face of Trauma (LIFT)”. The resulting adapted sexual risk reduction intervention was piloted among a diverse group of female survivors of violence from rural and metropolitan areas of Arkansas.

Methods: Using venue-based and social network recruitment, 23 female survivors of violence participated in this adapted eight-weekly session, two-hour, small-group cognitive behavioral intervention to reduce sexual risk and revictimization and to improve coping skills. Eligible participants reported unprotected vaginal or anal sex in the past six months with a male sex partner and at least one additional personal or perceived partner HIV-risk characteristic including substance abuse, incarceration, and multiple sexual partners. Baseline, immediate post-intervention, and three-month follow-up assessments were conducted to assess pre/post behavioral outcome changes and the feasibility and acceptability of the intervention. Quantitative data were collected using audio computer-assisted self-interviewing and analyses were conducted using SAS.

Results: At baseline, more than 75% of the sample were residing in transitional housing facilities, had at least a high school degree, and screened positive for PTSD. HIV risk characteristics were high; 43% reported not using a condom the last time they had vaginal or anal sex, 52% reported multiple sexual partners in the last 6 months, 26% reported monthly binge drinking, and 26% reported monthly substance use. However, only 13% perceived themselves as having at least a high chance of acquiring an STI. At post-intervention, rates of PTSD and unprotected sex were significantly lower ($p=0.008$ and $p=0.014$, respectively) while rates of emotional and physical violence trended towards reduction ($p=0.096$ and 0.059 , respectively).

Conclusions/Implications: Research with the female survivors of violence is needed to broaden the impact of evidence-based HIV prevention efforts, unlink violence and sexual risk among this population, and equip under-resourced community-based agencies, such as domestic violence shelters, with evidence-based, theory-driven interventions that have been adapted for this vulnerable population. Future research should build on these preliminary data and test the efficacy of the adapted intervention.

BP48

Abstract 2341 - Prevention Research and Implementation Science

Author(s): *Edgardo Ortiz-Sanchez, Carlos Rodriguez-Diaz, Gerardo Jovet-Toledo, Iliá Otero-Cruz, Jose Martinez-Velez, Veronica Tirado-Mercado*

Background: HIV has historically affected sexual minorities and particularly men who have sex with men (MSM). In 2014, MSM in Puerto Rico (PR) accounted for a third (67.7%) of all new infections. HIV diagnosis has been associated with manifestations of stigma that can limit the willingness of people with HIV to carry out health promoting practices, such as engagement in care, adherence to treatment and HIV-status disclosure. However, very limited interventions have been developed to address the impact of stigma in the well-being of HIV+ MSM. The objective of this analysis is to assess the experiences of implementing Contacto; a stigma management intervention for Spanish-speaking HIV+ MSM.

Methods: The intervention, targeted to HIV+ MSM and delivered in Spanish, consists of three sessions with a health educator. Guided by Motivational Interviewing (MI) techniques, the goal of the intervention is to support participants' management of the negative impact of stigma related to HIV-status, sexual orientation, and the interconnection between them. Delivered with the support of culturally appropriate printed materials, the intervention helps participants self-assess changes needed to improve their health-seeking practices and well-being. Participants' charts were systematically reviewed using content for common topics.

Results: Participants (N=58) expressed a variety of issues throughout the intervention. Different manifestations of stigma were documented based on HIV-status and sexual orientation, such as discrimination by family members and co-workers. Fear to reveal HIV-status and sexual practices to relatives, at work, and in healthcare settings was also reported. During the sessions, most participants have articulated the need to make changes related to disclosure of HIV-status and sexual orientation (to family, friends and employers), improve practices in seeking mental health services, and cigarette smoking cessation. Most participants also established a plan in order to achieve their goals.

Conclusions/Implications: Initial findings suggest participants recognize the impact of stigma and the need to make changes in order to improve their health status and to make better use of available health services. Implementing the intervention has validated the need to incorporate culturally appropriate approaches to address the various sources of stigma and its diverse manifestations. Findings also suggest the need to conduct further research, create programs to support family members and support the development of social policies to eradicate discrimination against HIV-status and sexual identity.

BP50

Abstract 1734 - Prevention Research and Implementation Science

Author(s): *Paula Frew, Marcia Holstad, Julie Zuniga, Nikia Braxton, Eleanor Sarokodie, Hayley Robinett, Igho Ofotokun, Gina Wingood*

Background: Women living with HIV face unique barriers to HIV treatment, affecting their ability to reach HIV continuum of care (CC) outcomes. 2011 estimates indicate that less than half (45%) of women living with HIV in the US receive routine care. Nationally women's overall HIV viral suppression rate in 2012 was estimated at 32%. Georgia reflects these statistics with 55% of women receiving early routine HIV care, yet retention drops to 37% by 4-15 months from diagnosis and 38% achieve viral suppression

by 12 months. This study explored the obstacles to women's HIV care to improve understanding of multilevel factors impacting both successes and challenges in the HIV CC.

Methods: We conducted purposive sampling and interviews with 34 women who retrospectively experienced challenges at different CC milestones prior to enrollment in the Atlanta Women's Interagency HIV Study (WIHS). We conducted constant comparative analyses linking sociobehavioral and biomedical data to cases that resulted in a three group behavioral typology. Group 1, "Care-Engaged" women, reported strong long-term compliance with routine provider visits, labs, and adherence to ARVs. "Care-Inconsistent" women (group 2) experienced consistent intermittent challenges attending routine appointments, obtaining labs, and were inconsistent with ARV use. "Care-Detached" women (group 3) reported general nonadherence with provider visits and labs following diagnosis and short and long-term intentional delays or refusal of ARVs. Illustrative quotes are presented for common and unique themes.

Results: Preliminary analyses with a subsample (N=21) included a majority Black/African American/non-Hispanic (95%) women who were ≥ 46 years (75%). Most had a high school education (57%), were not legally married (95%), had a mean monthly household income of \$1,500 or less (86%), and possessed at least one form of health insurance (81%). "Care-Engaged" women (N=10) described positive healthcare experience, prompt linkage to care, strong social and healthcare provider relationships, and high CD4 (≥ 800) and suppressed viral load value post-diagnosis as care facilitators. "Care-Inconsistent" women (N=7) described challenges related to housing, unsupportive healthcare institutions, and perceived HIV stigma as barriers to care. Supportive healthcare providers and institutions, social and emotional support, and viral suppression within 6 months of treatment were cited as care facilitators, with healthcare provider insistence as a frequently cited intervention for entering treatment. "Care-Detached" women (N=4) described unstable housing, unsupportive healthcare institutions, and drug and alcohol abuse as challenges to care. Supportive social groups and healthcare providers, community-based programs, support groups and mental health services, and knowledge of HIV and HIV treatment were cited as care facilitators.

Conclusions/Implications: This study identified unique factors that influence women's HIV treatment and care-seeking behaviors; however, each group face common challenges that threaten HIV CC. There is consistency among healthcare experience and strong social support. Inconsistencies identified among other factors suggest a need for interventions targeting specific subgroups. Through in-depth interviews linked with quantitative data, we developed a typology that can enhance the ability of providers, case managers, and community-based services to develop targeted interventions. Findings from this study will inform tailored programming to more effectively address unique factors contributing to women's HIV continuum of care.

BP51

Abstract 2479 - Prevention Research and Implementation Science

Author(s): *Nancy Glick, Monique Rucker, Audra Tobin*

Background: In June 2014, the Centers for Disease Control and Prevention released Updated Recommendations for Laboratory Testing for the Diagnosis of HIV Infection. We review the experience

of a safety-net provider in (1) transitioning to the new algorithm and (2) engaging patients with acute HIV infection (AHI) and their partners.

Methods: In November 2012, Sinai Health System, located in Chicago, Illinois, began using an Antigen/Antibody (Ag/Ab) immunoassay for the preliminary diagnosis of HIV and in January 2014, began using an immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies (HIV-1/HIV-2) for patients whose results were preliminary positive with the Ag/Ab immunoassay. Patients with nonreactive or indeterminate results on the HIV-1/HIV-2 antibody differentiation immunoassay have acute HIV infection confirmed with an HIV-1 RNA. Patients who screen reactive for HIV are post-test counseled by a clinician and navigated to care by a patient navigator. Patients who are diagnosed with AHI are fast tracked to medical appointments and patients are referred for partner elicitation to an external agency with experience in engaging the social networks of persons diagnosed with HIV.

Results: As part of routine screening, 15,537 patients were screened from December 2012 to March 2015, 64 patients were newly diagnosed with chronic HIV infection and 9 patients were diagnosed with AHI (Ag/Ab reactive, HIV-1/HIV-2 nonreactive, HIV-1 RNA detectable). AHI patients were Latino (n=1), black (n=6), and white (n=2); 17 to 56 years old; male (n=6), female (n=2), and male to female transgender (n=1). The mean CD4 count for 8 patients was 467; 1 patient had labs drawn outside of Sinai. Initial viral loads ranged from 84,403 to over 10,000,000 copies per ml. Patients were diagnosed in the Emergency Department and 100% were linked to care. Viral suppression within 6 months of their diagnosis was <400 copies per ml (n=4) and <2,000 copies per ml (n=4) and 88.9% initiated treatment (one patient was diagnosed in March 2015). Patients were heterosexual 55.5% (n=5) and men who had sex with men 45.5% (n=4). Regarding sexual partners: those who were unaware of their HIV status and for whom the partner could be reached were tested for HIV (n=5), initiated Pre-Exposure Prophylaxis (n=2), were living with HIV infection but the AHI was unaware (n=1), and reinitiated antiretroviral therapy when HIV infection was known (n=1). The two patients with AHI diagnosed since December 2014 were referred for social network engagement and are in the process of having partners elicited, interviewed, tested, and evaluated for PrEP.

Conclusions/Implications: Patients with AHI were identified because of the use of the recommended testing algorithm. In the absence of this algorithm these patients may have been classified as false positives. All patients achieved high rates of viral suppression because they were post-test counseled on the day of diagnosis, linked to care, and started treatment. Most of the patient's recent partners were immediately engaged, tested, and either linked to care or started on PrEP. An effective system has to be in place to quickly engage the social networks of persons with AHI if new infections are to be prevented.

BP52

Abstract 2307 - Prevention Research and Implementation Science

Author(s): *Edda Santiago-Rodriguez, Gerardo Jovet-Toledo, Carlos Rodriguez-Diaz, Ricardo Vargas-Molina*

Background: Experiences of stigma have a negative impact in the health status of people with HIV/AIDS. For a person with HIV/AIDS, receiving appropriate social support from family, friends, and health care providers is determinant for their proper adherence to treatment and care. Yet, disclosure of HIV status

seems to be a challenge for many people with HIV/AIDS in Puerto Rico (PR). Fear of being rejected or stigmatized limits a person's willingness to communicate their HIV status and, for that matter, the social support they receive. Further, there is very limited research on how the different sources of stigma affect the level of social support people with HIV/AIDS receive, particularly gay men and other men who have sex with men (MSM).

Methods: We conducted a mixed method study with 149 structured interviews and 18 qualitative life history interviews. Participation in the study was limited to HIV-positive gay men and other MSM. The survey interview included culturally appropriate measures of HIV felt stigma, perceived gay stigma, internalized homophobia, and quality of life. The in-depth interviews included topics of life experiences related to stigma, disclosure of HIV status and sexual identity/practices, and social support, among others. Experiences of stigma and its aftermath were identified using descriptive and bivariate analysis and by conducting content analysis informed by grounded theory.

Results: The mean age for the sample (N=149) was 38.8 (SD=11.0) and they had been living with HIV for an average of 9.6 years (SD=7.9). The vast majority was born in PR (89.3%) and lived in the San Juan Metropolitan Area (83.2%). The vast majority also (88.6%) reported having received some kind of social support during the 3 months prior to the interview, mainly from friends (39.6%) and family (37.6%). All levels of stigma were generally high. Those who did not receive any kind of social support obtained higher scores in the stigma scales (gay-related and felt HIV stigma), and hence were more frequently exposed to experiences of stigma. However, these differences did not reach statistical significance. Through the qualitative interviews, participants reported that HIV status disclosure has been a challenge with family, friends, partners and healthcare providers. HIV related stigma was identified in the form of rejection and violence from family and community members, discrimination by healthcare providers, delays in engagement/retention in care, difficulties in disclosing HIV-status and sexual identity, and the perception of HIV-diagnosis as a death sentence

Conclusions/Implications: No statistically significant differences were observed probably due to the fact that most of the sample reported having received social support. Further, levels of HIV felt stigma and gay-related stigma were generally high across the sample. Qualitative analysis supports that participants have experienced stigma and that these experiences have significantly affected the willingness to seek social support and the presence, type and quality of social support they received from family, friends, partners, and healthcare providers. Findings highlight the need to understand stigma as a multi-source social expression, eliminate the sources of stigma, and develop efficient targeted support services for this population.

BP53

Abstract 1310 - Prevention Research and Implementation Science

Author(s): *Bertram Johnson, Harlan Pruden, Russell Campbell, Jeffrey Schouten*

Issue: American Indians and Alaska Natives (AI/AN) comprise less than one percent of HIV/AIDS cases in the United States, yet Native Americans as a cultural group rank third in HIV/AIDS infections. In 2005, the Centers for Disease Control reported AI/AN men who have sex with men, culturally known as "two-spirit," comprised 61 percent of AI/AN HIV/AIDS diagnosis. Socioeconomic factors such as high rates of

poverty, low educational levels, and low HIV prevention literacy also contribute to a high burden of HIV among Native communities. AI/AN have also been reluctant to welcome discussions around HIV/AIDS and sexuality from people outside their community due to deep-seated mistrust from historical traumas like non-consensual sterilization of AI/AN women and AI/AN youth forced into residential boarding schools. These factors underscore the necessity to develop culturally appropriate, relevant, and integrated approaches to present HIV prevention research methodologies to Native communities in various settings.

Setting: The Office of HIV/AIDS Network Coordination's (HANC) Legacy Project, through the National Institute of Allergy and Infectious Diseases funded (NIAID) Be the Generation (BTG) Project, and the NorthEast Two-Spirit Society (NE2SS) collaborated to design a culturally relevant and integrated training to increase understanding of current and developing biomedical HIV prevention research modalities among Native American/Two-Spirit communities across the United States.

Project: In 2014 BTG and NE2SS collaborated around a goal of increasing AI/AN literacy of HIV prevention research. Together they edited BTG's original HIV Prevention Research training module by adding culturally relevant and appropriate AI/AN images and principles alongside current HIV prevention research modalities. The module was presented at three Native/Two-spirit gatherings in Pawhuska, OK, San Francisco, CA, and Buffalo, NY. Participants completed a knowledge assessment of HIV prevention research before and after the presentation of the module to test the effectiveness of the module.

Results: The results of the pre and post-test showed the amended module was statistically significant in raising knowledge of HIV prevention research. The mean score of the Tulsa Two-Spirit Gathering pre-test was 46.6, n=22. The post-test mean was 72.2, n=20. The Bay Area American Indian Two-Spirit service providers presentation showed a higher pre-test mean of 73.2, n=7. The post-test mean rose to 87.5, n=5. The greatest increase was found at the NorthEast Two-Spirit Society Gathering. The pre-test mean there was 48.8, n=31. The post-test score was 80.2, n=28.

Lessons Learned: The culturally enhanced module was effective for engaging AI/AN communities and proved statistically significant in increasing knowledge of HIV prevention pre-exposure prophylaxis (PrEP), microbicide, and vaccine research among community members and HIV health providers. AI/AN were also more receptive to messaging around prevention research that recognized and honored their images and culture. This joint project provides an excellent example of highlighting that more culturally relevant approaches should be employed to improve knowledge of HIV research literacy in AI/AN communities.

BP54

Abstract 1704 - Prevention Research and Implementation Science

Author(s): *Jaime Martin, Shruti Ramachandran, Nana Mensah, Jonny Andia, Tracey Griffith, Michelle Melendez, Jameela Yusuff, Julie Myers*

Issue: Persons living with HIV/AIDS often adopt healthier behaviors after initial diagnosis, but some may return to less healthy behaviors over time. Implementation of an evidence-based, community level intervention within the clinical setting could play a role in reversing this trend and reducing risk

behaviors among this population. One such intervention, PROMISE, is effective in reducing risk in diverse urban communities; less is known about its ability to affect change in a clinic population.

Setting: As part of a larger Prevention with Positives initiative involving behavioral screening coupled with provider risk reduction counseling, NYC Department of Health is piloting an adaptation of PROMISE in collaboration with a HIV primary care clinic in Brooklyn. Primary objectives of the initial evaluation are to assess feasibility and uptake to inform scale up.

Project: PROMISE was carefully adapted to a clinic-based intervention while maintaining fidelity to core elements: community identification (CID), role model (“success”) stories, peer advocates, and evaluation. CID assesses the community’s current knowledge, attitudes, and behaviors related to HIV risk via surveys with stakeholders. Clinic-based CID was optimized to focus primarily on clinic staff as system-level stakeholders and patients as key participants (as opposed to the usual focus on four levels, including interviews with gatekeepers to the target population). The CID survey was modified to contain only questions relevant to the clinic context. Through knowledge of individual patients’ behaviors, providers identified potential role models. Stories were disseminated passively in clinic waiting/exam rooms and by nursing staff following a risk behavior screen during intake (as opposed to the usual approach of peers disseminating stories in targeted neighborhoods). Evaluation elements of community-based PROMISE were limited to process and outcomes monitoring focusing on feasibility, uptake, and behavior change.

Results: Clinic-based PROMISE CID was implemented February–May, 2014. 25 patient interviews and 18 clinical staff interviews were conducted. Less healthy behaviors identified through CID were condomless sex, multiple partners, and alcohol/drug use. By June 2014, a patient success story was developed and three peers were recruited. During July–December, 2014, 869 patients were screened (approximately 80% of the clinic population) and distribution of success stories was initiated by clinic personnel. Only 10 peer-to-peer engagements were reported during the timeframe. Future evaluation will assess the impact of clinic-based PROMISE on patient outcomes.

Lessons Learned: Preliminary data on implementation of clinically-adapted PROMISE indicated feasibility, especially for the CID and success story elements. Several core elements were easily streamlined and integrated into the clinic by leveraging provider knowledge of patient behavior and regular clinic visits. However, engagement between patients and on-site peers was low. More intensive peer training and greater emphasis on linkage from nurses to peers may be required, alongside improvement of stories based on patient feedback. We experienced early challenges to accurately track success story exposure and mode of engagement, and subsequently added data elements to the nursing intake to enhance monitoring. The feasibility shown for clinic-based PROMISE suggests that it can be implemented successfully in a clinical setting with modification to suit the population’s needs and the resource capacity of the practice.

BP55

Abstract 1437 - Prevention Research and Implementation Science

Author(s): *Rob Stephenson, Tamar Goldenberg*

Background: Men who have sex with men (MSM) account for a disproportionate burden of HIV incidence in the United States. This paper examines how relationship definitions shape sexual risk taking among MSM.

Methods: In this qualitative longitudinal study in Atlanta, gay and bisexual men completed three web-based quantitative diaries to track experiences of anal and/or oral sex. In each diary, men elaborated on up to three partners, explaining how they met the partner, how long they knew each other, the type of sex they had, condom use, and ranking of perceptions of HIV risk. Participants also chose applicable statements to describe emotional relationship states. Diaries were discussed in timeline-based interviews at the end of the study period.

Results: 25 men completed a total of 75 diaries. The number of sex partners in each diary varied from 0-11. 77 partners were discussed in more depth; 43 of them were partners who were met online, 17 were committed relationships, 54 were anal sex partners, and 29 were partners with whom the participant had condomless anal sex. We categorized partners into five groups: 1) Formal and committed monogamous relationships; 2) Formal and committed non-monogamous relationships; 3) Casual, non-monogamous, and uncommitted relationships; 4) Developing relationships where the status of formality and monogamy were not yet established; and 5) One-time sexual partners. Decisions about condom use varied depending on the formality of the relationship and agreements regarding monogamy.

Conclusions/Implications: These findings indicate that relationship definitions and agreements shape sexual decision-making and condom use among MSM. More nuanced messages for HIV prevention are needed that move away from merely describing HIV risk as coming from casual sex

BP57

Abstract 1286 - Prevention Research and Implementation Science

Author(s): *Camilla Harshbarger, Olivia Taylor, Jennifer Uhrig, Carla Galindo, Megan Lewis*

Issue: HIV antiretroviral therapy (ART) can durably suppress the plasma HIV viral load which improves individual survival and dramatically reduces further HIV transmission. Achieving HIV viral suppression is a primary goal when initiating ART. Unfortunately, only 30% of all people with HIV achieve HIV viral suppression. There is a need for innovative, web-based and scalable digital strategies that focus on enhancing prevention and care to improve the health of, and to reduce HIV transmission risk among people living with HIV (PLWH). Formative work to inform the development of these interventions increases the likelihood of clinics' uptake of these interventions.

Setting: Positive Health Check is a 15-20 minute web-based video behavioral counseling intervention designed to improve clinical health outcomes among PLWH. English-language video messages and behavior-change tips to practice are individually-tailored for each patient. Currently, the intervention is designed for laptops, desktops and tablet computers. One of the first web-based interventions for PLWH attending HIV primary care clinics, the digital format is relatively low-cost for clinics to adopt and implement, and enables rapid content updates.

Project: Formative inquiries were conducted to develop a web-based video counseling intervention that is appealing and acceptable to people living with HIV in clinical care and their clinicians. A panel of 14 technical consultants (TCs) comprising 7 HIV-positive patients and 7 HIV primary care providers gave feedback on the development of Positive Health Check over a 15-month period. TCs answered series of questions in seven individual and two group webinars providing feedback on script content, intervention design, and implementation processes. Finally, TCs logged on to Positive Health Check and provided feedback on their user experience, the tool's content, and the planned implementation protocol. TC feedback was analyzed with descriptive statistics and qualitative analysis.

Results: TCs' feedback resulted in revising draft content of scripts to be more motivational (e.g. protect your partners), and improving the usability of handouts generated from patients' interactions with PHC (e.g. ratings on the provider handout improved between versions 1 and 2 from 3 to 6 out of 7 providers reporting they would use it with patients). Tailoring of messages included the addition of Hepatitis C and STD screening for men who have sex with men. Design input included selection of 4 video doctors, layout of the user interface, and creation of the clinic filmset. A final session demonstrated that overall, TCs were pleased with the look and feel, functionality, and content of Positive Health Check, but recommended adding additional content on understanding blood tests, PrEP, and services provided by local agencies. Patient TCs would be comfortable using the tool in their clinic waiting rooms and provider TCs believed the tool could be implemented successfully in their clinics.

Lessons Learned: Gathering and analyzing input from the TCs to inform the content, design, function and usability of Positive Health Check vastly improved the intervention. Positive Health Check responds to the opinions and needs of HIV patients and providers, and so upon dissemination may be more accepted by them and integrated into clinic settings.

BP58

Abstract 2416 - Prevention Research and Implementation Science

Author(s): *Steven Wakefield*

Issue: Since its inception, the HIV Vaccine Trials Network (HVTN) has worked to build a strong foundation of community support for vaccine clinical trials. Five operating principles have ensured successful recruit and retention by committing resources to community education, development of special population focused outreach programs and academic level theoretical models to guide partnerships.

Setting: Nationally and internationally, key population stakeholder engagement proved essential for HVTN to remain a leader in community engagement, increased HIV science literacy and understanding the decisions regarding continuing the Step and HVTN 505 studies and what could be learned from following participants even longer than originally planned. It was also important to make new linkages with civil society leadership in southern Africa to ensure understanding of outreach to participants of HVTN 503. We were able to reach out to HVTN's durable partnerships with key stakeholders; continue maintaining the highest standard of good participatory practices; engaging community advisory boards at the site level regarding leadership voices; while maintaining the depth, breadth and quality of

community education for which the HVTN has set a standard we rapidly disseminated trial findings to all health and HIV community stakeholders.

Project: A literature review and planning process with external advisors guided HVTN to utilize 5 operating principles: a) an academic theoretical basis, b) responsiveness to what you find in each community, c) appropriate resources, d) value people – invest in them and they invest in the science, e) ensure stakeholder input at every level.

Results: The HVTN has high levels of retention in clinical trials because of a commitment to remain a leader in community engagement and participation throughout all stages of the HIV vaccine development process by forging durable partnerships with key stakeholders; maintaining the highest standard of good participatory practices; engaging community advisory boards at the site level; maintaining the depth, breadth and quality of community education for which the HVTN has set a standard; and rapidly disseminating clinical research findings to all community stakeholders. Inclusion of community input in the protocol development process has been challenged by dynamics that are part of that very process such as the high levels of scientific literacy required, tight time lines, and the unequal power dynamics that may occur when researchers and lay community members work closely on highly technical documents. VMMC and PrEP implementation programs have been incorporated into clinical trial conduct while high retention rates have been maintained despite unwanted trial results.

Lessons Learned: Ongoing dialogue is an important component of building engagement and removing obstacles to participation. However to build true partnerships there must be a commitment of resources and constant attention to issues of politics and power. Ethical research demands critical approaches to understand and overcome the barriers that exist for support and participation in HIV vaccine research.

BP60

Abstract 1244 - Prevention Research and Implementation Science

Author(s): *Sam-mosley Ayuk, Sindy Jaramillo, JoNell Potter*

Background: Many HIV discordant couples in the United States want children (Lampe 2011). Individuals living with HIV do not understand how to reduce the risk of HIV transmission to their HIV negative partners during conception (Steiner, 2013). Reproductive technologies such as sperm washing are not always affordable. Other strategies such as pre-exposure prophylaxis (PrEP) may provide additional options (Semprini, 2013). Understanding risk behavior among discordant couples is important for designing risk reduction interventions that couples can successfully use to conceive and to reduce the risk of transmission to their HIV negative partner. The purpose of this study was to discover what the HIV negative partner knew about HIV risk during conception. Methods used to conceive, safe conception practices and risk reduction strategies used during conception were also explored.

Methods: HIV infected pregnant women and their HIV negative partners were interviewed. Audio computer assisted self-interviews (ACSI) were used to collect demographic data. Interviews were then conducted with each couple to explore knowledge regarding fertility, desire for pregnancy, understanding of reproductive technologies (sperm washing), medical/pharmacological prevention strategies (PrEP) and reproductive decision-making practices. All interviews were tape recorded and

transcribed by two investigators for conceptual categories and emergent themes. This study was approved by the Institutional Review Board.

Results: None of the male partners were on PrEP. The HIV negative partners reported very little (if any) access to health care. HIV risk information for the men came from their HIV positive partners, which was limited and inaccurate. Most did not know about safe conception methods, or if they did (such as assisted reproductive technologies) most were not open to exploring this technology. Knowledge on fertility and the female menstrual cycle was often inaccurate.

Conclusions/Implications: Our findings demonstrated that this cohort of HIV negative partners had limited knowledge on fertility and strategies to promote safer conception and prevent HIV transmission. The HIV negative male partners lack access to health care and education regarding safe conception methods for HIV discordant couples. Stigma remains a serious concern for this population. Work must continue to reduce the effects of stigma so there can be conversation between couples and providers regarding planning pregnancy and safe conception strategies. Access to health care, HIV testing and PrEP for HIV negative partners is needed.

BP61

Abstract 1317 - Prevention Research and Implementation Science

Author(s): *Shikha Garg, Linda Beer, John Weiser*

Background: Non-occupational post-exposure prophylaxis (nPEP) with antiretroviral therapy immediately after high-risk exposures is an important bio-medical tool for HIV prevention. Because successful implementation of nPEP requires patients to present for treatment within 72 hours of exposure, take a two- or three-drug regimen for 28 days, and report for serial HIV testing, providers may face multiple challenges when prescribing nPEP, including delayed patient presentation, poor treatment adherence and loss to follow-up. Obtaining national estimates of nPEP prescription and better understanding barriers to nPEP prescription may help identify opportunities to increase use of nPEP as an HIV prevention tool.

Methods: U.S. HIV care providers were surveyed during June 2013–January 2014 to estimate the weighted prevalence of ever prescribing nPEP and to describe patients for whom nPEP was prescribed. Physicians, nurse practitioners, or physician assistants who had completed training, provided care to both HIV-infected and HIV-uninfected patients, and who answered questions regarding nPEP were included in the analysis (n=932). We used adjusted prevalence ratios (aPR) estimated from multivariable logistic regression to investigate the association between provider characteristics, including demographic factors and HIV care experience, and nPEP prescription. Analyses accounted for clustering, unequal selection probabilities, and non-response.

Results: Surveys were completed by 1234 of 2023 eligible providers (adjusted response rate 64%). In all, 57% (95% confidence interval (CI): 51–63) of providers ever prescribed nPEP. Among providers prescribing nPEP, 69% prescribed to men who have sex with men (MSM), 33% to men who have sex with women, 51% to women who have sex with men, 13% to uninfected partners in serodiscordant couples trying to conceive, and 11% to persons who inject drugs (PWID). Other types of individuals for

whom nPEP was prescribed included sexual assault victims and persons accidentally exposed to needle sticks. Provider characteristics independently associated with nPEP prescription included gay/lesbian/bisexual orientation (aPR 1.3; CI 1.1–1.6), being a board-certified infectious diseases physician (aPR 1.7; CI 1.1–2.5) or a physician assistant (aPR 1.7; CI 1.1–2.7), providing care for HIV-infected patients for >20 years (aPR 1.3; CI 1.1–1.6), providing care to > 200 HIV-infected patients (aPR 1.37; CI 1.1–1.8), obtaining a minimum of 40 hours continuing medication education (CME) in the past 3 years (aPR 1.2; CI 1.1–1.4) and providing care to patients of whom >50% were MSM (aPR 1.3; CI 1.0–1.6).

Conclusions/Implications: Over half of providers who care for HIV-infected and HIV-uninfected patients have ever prescribed nPEP for HIV prevention. Prescribers of nPEP tended to have greater training and experience related to the care of HIV-infected patients, and likely more opportunities to prescribe nPEP, than non-prescribers of nPEP. Qualitative research may help elucidate why heterosexual providers are less likely than their gay/lesbian/bisexual colleagues to prescribe nPEP. Enhancing awareness of clinical guidelines and continuing education may increase nPEP prescription by providers who deliver immediate care to patients with high-risk exposures to HIV.

BP62

Abstract 1391 - Prevention Research and Implementation Science

Author(s): *Alexander Morse, Guadalupe Dominguez Plummer, Graham Harriman*

Background: Two evidence-based interventions (EBIs) for reducing drug use, increasing medication adherence, and improving viral suppression among HIV-positive substance abuse users were implemented by agencies that received Ryan White Part A funding from the New York City Department of Health and Mental Hygiene (DOHMH). The DOHMH supports program EBI fidelity to ensure EBI core elements are maintained and quality interventions are conducted. Differences in EBI fidelity scores can be attributed to a number of key differences between the clients' demographic breakdown, staff training and expertise, and agency organizational structure. This study examines the perceived barriers and challenges that frontline staff encounter when implementing the EBIs among factors affecting clients, staff, and agencies with differing fidelity levels.

Methods: Frontline staff from agencies that implement Healthy Living Project (HLP) and/or Seeking Safety (SS) were asked to complete an online survey to determine specific barriers and challenges, identified from the literature, such as clients' attendance and attitudes, staffs' education and skills, and agency's' resources and capacity. Semi-structured interviews were conducted to determine additional factors that frontline staff encountered and to expand upon survey responses. Interviews were recorded, transcribed, and analyzed using NVivo. EBI fidelity scores were taken from DOHMH agency reports during the 2014-2015 contract year and then categorized into high and medium fidelity levels.

Results: There was an 85% response rate to the online survey among frontline staff and several semi-structured interviews were conducted. The most common barriers that prevented staff from properly implementing the EBIs were: clients' poor attendance during the beginning and end of each month when the allocation of public assistance benefits and entitlements occur (68.8%); clients' poor attendance affected by factors other than incarceration, hospitalization, and short term rehab (73.3%);

clients' poor mental health (66.7%); clients' current substance use (66.7%); staff fulfillment of contract requirements (56.3%); and high staff workload, leading to the feeling of "burnout" (53.3%). HLP staff identified homelessness of clients (57.1%), whereas SS staff identified the clients' low literacy level (54.5%), as an additional barrier. Among medium fidelity level agencies, contract requirements and high workloads were identified as larger barriers compared to high fidelity level agencies. Staff of medium fidelity level agencies that implement HLP identified: clients' poor attendance; clients' poor physical and mental health; homelessness; and clients' negative attitude towards HLP as greater barriers than high fidelity level agencies. Staff of medium fidelity level agencies that implement SS group sessions indicated: clients not trusting other clients during sessions; clients' negative attitude towards SS; and clients' reporting that sessions were too long as additional barriers compared to high fidelity level agencies.

Conclusions/Implications: By comparing the barriers and challenges that clients, staff, and agencies encounter to properly implement the EBIs between the agencies with high and medium fidelity level, we identified the specific factors that disproportionately affect agencies with medium fidelity scores. By engaging and utilizing clients and frontline staff, the identified barriers and challenges to these EBIs will lead to tailored interventions to minimize the barriers and challenges of these programs, thus improving health outcomes.

BP63

Abstract 1403 - Prevention Research and Implementation Science

Author(s): *Martha Kapaya, Helen Ding, Leslie Harrison*

Background: Intimate partner violence (IPV) may increase a woman's susceptibility to HIV infection through forced sexual contact and limited ability to negotiate safer sexual practices with partners. Clinical guidelines recommend universal screening for HIV among pregnant women and screening for IPV among all women of childbearing age. The purpose of this study is to assess the prevalence and predictors of receipt of HIV test counseling among women reporting IPV before or during pregnancy.

Methods: We used 2009–2011 data from 26 PRAMS states (N=111,162 women) to calculate prevalence and 95% confidence intervals (CI) of prenatal HIV test counseling among women with self-reported IPV by selected socio-demographic characteristics. Multivariable logistic regression and predictive marginal analyses were used to calculate adjusted prevalence ratios (aPR) and determine factors associated with receipt of HIV test counseling among women who reported any IPV before or during pregnancy.

Results: Overall, 5% (n=5,522) of women reported experiencing IPV before or during pregnancy. Among women reporting any IPV and any prenatal care (N=5,333), 81.1% (95% CI: 79.1, 82.9) reported that their provider discussed HIV testing. In adjusted analyses, women who were non-Hispanic black (adjusted prevalence ratio [aPR]= 1.11, 95% CI: 1.05, 1.17) classified as "other" race (aPR=1.07, 95% CI: 1.01, 1.14), younger than age 20 (aPR=1.08, 95% CI: 1.01, 1.16), greater than age 30 (aPR=1.07, 95% CI: 1.01, 1.13) and received provider counseling on IPV during prenatal care (aPR=1.33, 95% CI: 1.26, 1.41), had a higher prevalence of receipt of HIV test counseling compared with their counterparts.

Conclusions/Implications: Nearly four in five women reporting IPV before or during pregnancy received counseling on HIV testing during prenatal care. Receipt of counseling on IPV is a significant predictor of being counseled for HIV testing. Therefore, prenatal care providers should establish each woman's IPV profile through screening as recommended by clinical guidelines to thus ensure they appropriately receive counseling on HIV testing.

BP64

Abstract 1407 - Prevention Research and Implementation Science

Author(s): *Jinxiang Hu, Julianne Serovich, Yi-Hsin Chen, Monique Brown, Judy Kimberly*

Background: Women living with HIV may experience elevated levels of stress due to psychosocial and physical challenges. The purpose of this study was to investigate the change of stress level among women living with HIV and the potential influence of demographic characteristics and seeking social support on stress.

Methods: Data for this study were gathered from 125 HIV-positive women as part of a larger research study addressing disclosure. The stress subscale in the stress arousal checklist (SACL) was used to obtain the stress score ($\alpha = .94$). The original 5-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) was recoded to create a binary variable: 3 to 5 representing stress vs. 1 and 2 representing no stress. The stress subscale included 18 SACL items and scores were summed (range = 0 - 18) with higher scores reflecting more stress . Different latent growth models were fit to the data (unconditional linear growth model with only the stress scale at different time points, unconditional growth curve model with a quadratic term, and conditional growth curve model with covariates).

Results: The growth curve model with a quadratic term, time invariant covariates (age, race, number of children, education level, employment, annual income, time since diagnosis, and size of network), and one time varying covariate (seeking social support) showed the best model fit ($\chi^2 = 23.09$, $p = .34$; RMSEA = .04; CFI = .98; TLI = .95; SRMR = .05). Analysis of the model showed the stress level of women living with HIV in the study decreased and the rate of decrease slowed over time. The initial status of the stress level was 8.447 ($li=1.44$, $p = .01$) indicating all participants experienced stress when all the covariates were at zero. The variance of the initial status and the decrease of the stress level was significant (Vari= 31.83, $p < .01$; Vars = 18.99, $p = .02$) indicating participants had significantly different initial status of stress level and experienced significantly different degrees of decrease of stress over time. The decrease of the stress level and the rate of decreasing were significantly related to the initial status ($ris = -25.83$, $p < .01$; $riq = 6.30$, $p < .01$), with women who had higher levels of stress initially decreasing faster in stress levels . Also, education level and employment status predicted the decrease of the stress level significantly ($\gamma = -3.14$, $p < .01$; $\gamma = 3.40$, $p = .01$). Other covariates in the model were not significantly associated with the level of stress over time.

Conclusions/Implications: The level of stress of women living with HIV decreased over time. The rate of stress decrease varied significantly across participants, with women of higher education levels and without jobs experiencing more reduction in stress. Therefore, efforts to improve education and encouragement to take a leave of absence from employment after HIV diagnosis may help to reduce stress levels among women living with HIV.

BP65

Abstract 1590 - Prevention Research and Implementation Science

Author(s): *Christina White, Mary Mullins, Nicole Crepaz*

Background: The US state and federal correctional systems have a prevalence of HIV infections that is at least four times that of the general population (Marushak et al, 2009). Although research suggests jails and prisons improve the health of PLWH while incarcerated, there is a substantial drop off in engagement with HIV care after release to community. Examining factors associated with and developing interventions for engagement in the HIV care continuum for recently released detainees with HIV, is an essential part of improving the health of this population and preventing new HIV infections. We conducted a systematic review to identify barriers and facilitators of HIV care continuum outcomes and interventions designed for improving these outcomes among previously incarcerated persons with HIV.

Methods: As part of CDC's HIV/AIDS Prevention Research Synthesis (PRS) Project, we performed a systematic search of the scientific literature using automated (e.g., MEDLINE, PsycINFO and CINAHL) and manual search methods to identify published reports on correlates and barriers to HIV care outcomes among persons with HIV. We also searched the PRS database, consisting of over 70,000 HIV prevention research papers, for relevant intervention studies. Studies are eligible for this review if they: target persons with HIV recently released from detention (jail, prison); provide data on barriers or facilitators of HIV care outcomes or evaluate intervention effects on HIV care outcomes; are published between 2001 to 2014.

Results: Fourteen studies met the eligibility criteria: 8 examined barriers/facilitators and 6 evaluated interventions. Correlational studies showed that substance use and housing status were significantly associated with linkage to care, retention, medication adherence, and viral suppression, by at least one of the articles examining that outcome. Similarly age and mental health were significantly associated with all outcomes except medication adherence. Three of the four studies examining HIV care engagement post-release found a significant correlation between having completed a discharge plan pre-release and being engaged in HIV care. Intervention studies provided a variety of case management services (e.g., referrals to housing assistance, substance abuse, and mental health treatment). Most included an element of pre-release discharge planning and one randomized control trial found that pre-release discharge planning was no less effective than intensive case management at increasing engagement in care post-release.

Conclusions/Implications: There appears to be good agreement between correlates of HIV care engagement and interventions designed to improve HIV care outcomes. Evidence from correlational and intervention studies suggests that post-release interventions that focus on providing housing assistance and substance abuse and mental health treatment may be able to increase engagement. Case management referrals offered through the majority of interventions included access to these services. Pre-release discharge planning was an important component associated with HIV care engagement post release, and was also an element in the interventions. As case management programs require

manpower to implement and follow up with individual participants, more research is needed on the type and extent of discharge planning that has the greatest impact on HIV care engagement.

BP68

Abstract 1756 - Prevention Research and Implementation Science

Author(s): *Christine Borges, Sarah Braunstein, Selam Seyoum, Preeti Pathela, Kate Washburn*

Background: Diagnosing HIV in the acute phase enables persons to adopt safer behaviors and initiate treatment, which may improve individual health and reduce HIV transmission. Knowing the behavioral and risk characteristics of people recently infected with HIV can help public health authorities identify ways to prevent HIV.

We surveyed persons with AHI in New York City (NYC) to understand risk behaviors immediately preceding diagnosis.

Methods: Eligibility for this study included AHI case-persons > 13 years in NYC who received partner services and spoke English or Spanish. The self-administered survey asked about risk behavior, HIV testing, and sexual partnerships.

AHI was defined by (1) a negative/indeterminate Western Blot test (WB), OR a negative enzyme immunoassay (EIA), or negative rapid test, and a detectable viral load (>5,000 copies/mL) within one month of the WB or EIA/rapid specimen; or, (2) serial HIV antibody tests within 3 months that are consistent with recent HIV infection; or, (3) a rapid negative test followed by a detectable nucleic acid amplification test performed on a specimen collected the same day.

Using the HIV surveillance registry, we determined the number of AHI cases diagnosed citywide.

Results: During the study period, 564 AHI cases were diagnosed; 278 (49%) were eligible to participate, and 113 (41%) completed the survey.

Most respondents were male (89%;101/113), Black race or Hispanic ethnicity (69%;78/113), and aged 20-29 years (58%;65/113). Men who have sex with men (MSM) represented 81% (91/113) of the sample; 4% (5/113) reported injection drug use. Of all respondents, 30% (34/113) reported having an STD in the three months before the first positive HIV test. Almost all (99%) survey respondents had previously tested for HIV; 73% (83/113) reported three or more HIV tests in the two years before testing positive, and 78% (88/113) reported that their most recent HIV test was less than six months before diagnosis.

When asked about reasons for condomless sex, 43% (36/113) of respondents said “[I] didn’t feel I was at risk” and 42% (35/113) reported they got “caught up in the moment.”

When asked about sexual partnerships in the three months before HIV diagnosis, the majority reported steady and/or casual rather than anonymous partners; 55% (62/113) reported at least one steady partner, 54% (61/113) reported at least one casual partner, and 12% (13/113) reported at least one anonymous partner. Males reported a total of 183 sexual partners, 85/183 (46%) of whom had an

unknown HIV serostatus. Of those 85 partners, 72 (85%) were characterized as steady or casual partners.

Conclusions/Implications: Persons diagnosed with AHI reported frequent testing in the two years leading up to their diagnosis. Testing encounters provide an opportunity to deliver high impact prevention services, including pre- and post-exposure prophylaxis or behavioral interventions, particularly given reported ongoing risk behavior. The relative infrequency of anonymous partners and lack of knowledge of HIV status of steady and casual partners suggests that interventions and health messages should also focus on sexual behavior with steady and casual sex partners.

BP69

Abstract 1775 - Prevention Research and Implementation Science

Author(s): *Wen Lin, Supriya Rao, George Han, Pamela Stoddard*

Background: Hispanics are disproportionately affected by HIV infection and are more likely to be diagnosed late and less likely to receive prompt care after diagnosis than non-Hispanic whites. However, little literature is available concerning disparities among Hispanic subgroups, particularly by country of origin and nativity. This study examined the differences in early linkage to care among Mexico-born Hispanics, U.S.-born Hispanics, and U.S.-born non-Hispanic whites in Santa Clara County, California, where Hispanics accounted for 39% of newly diagnosed HIV cases in 2013.

Methods: We studied Hispanics (Mexico- and U.S.-born) and U.S.-born non-Hispanic whites aged 13 years and older newly diagnosed with HIV in 2004–2014. Foreign-born Hispanics born in countries other than Mexico were excluded due to small numbers and diverse countries of origin. Our primary outcome was early linkage to care: having a CD4 count or viral load performed within three months of HIV diagnosis. We analyzed associations with gender, age at diagnosis, mode of transmission, year of diagnosis, CD4 count at diagnosis, race/ethnicity and nativity, and type of facility where HIV was diagnosed using multivariate logistic regression.

Results: Of 1,067 individuals with HIV, 293 were Mexico-born Hispanics, 273 were U.S.-born Hispanics, and 501 were U.S.-born non-Hispanic whites. Mexico-born Hispanics were more likely to have a CD4 count below 200 at diagnosis (44%), compared to 34% of U.S.-born Hispanics and 30% of U.S.-born whites ($p=0.002$). However, Mexico-born Hispanics were least likely to experience delays in receiving HIV care (11%), compared to 21% of U.S.-born Hispanics and 17% of U.S.-born whites ($p=0.011$). After controlling for other variables, both U.S.-born Hispanics and U.S.-born non-Hispanic whites had higher odds of late linkage to care than Mexico-born Hispanics (U.S.-born Hispanics: adjusted odds ratio (AOR)=2.08, 95% confidence interval (CI): 1.27–3.43; U.S.-born whites: AOR=1.90, 95% 1.17–3.08). Overall, individuals <40 years were significantly more likely to experience delays in receiving care than those aged ≥ 50 years (ages 13–29: AOR=1.98, 95% CI: 1.05–3.71; ages 30–39: AOR=2.14, 95% CI: 1.16–3.93; ages 40–49: AOR=1.65, 95% CI: 0.89–3.03). Also, individuals diagnosed in 2004–2008 were more likely to be linked to care late than those diagnosed in 2009–2014 (AOR=2.09, 95% CI: 1.43–3.05). Gender, mode of transmission, CD4 count at diagnosis, and type of facility where diagnosed were not associated with delays in linkage to care.

Conclusions/Implications: In a large, diverse county in Northern California, U.S.-born Hispanics were more likely to experience delays in receiving care after HIV diagnosis than their Mexico-born counterparts, as were non-Hispanic whites. Younger age at diagnosis and diagnosis in the earlier part of the decade were also associated with delays in receiving care. In order to address disparities in linkage to care and improve key health outcomes, further studies are necessary to understand associations with other factors not routinely reported in HIV surveillance such as healthcare access, health insurance, and participation in safety net programs including the Ryan White program, as well as potential reporting bias by nativity.

BP70

Abstract 1782 - Prevention Research and Implementation Science

Author(s): *Larry Brown, Beth Kennard, Graham Emslie, Taryn Mayes, Jiahong Xu, Laura Whiteley, Laura Stoff, Linda Hawkins, Patricia Garvie, Mary Tanney*

Background: Depression is prevalent in individuals with HIV, and is 2-3 times higher than in the general population. Depression interferes with adherence to HIV treatment, increases caregiver burden, increases healthcare costs, and decreases quality of life for those infected. While psychosocial and psychopharmacological studies have shown improvements in depression among adults with HIV, no studies have been conducted with adolescents.

Methods: Youth were recruited through the Adolescent Trials Network for HIV/AIDS Interventions. Four sites were randomly assigned to either a 24-week, manualized combination CBT and medication management algorithm (COMB) tailored for youth living with HIV or to treatment as usual (TAU). Youth at TAU sites had access to therapists and medication management as needed. COMB site clinicians were trained in the manualized intervention and participated in supervision calls to monitor intervention fidelity. Depression severity was rated using the Quick Inventory of Depression Symptomatology for Adolescents [QIDS-A] self-report and clinician rating. Participants were re-evaluated at 24 and 48 weeks.

Results: Participants (n=44) were predominantly male (69%) and African American (83%), with a mean age of 18.6 years. Approximately half (48%) of the participants had CD4 counts >500 and 50% had nondetectable viral loads. All had depressive symptoms warranting treatment. There were no differences between groups at baseline in level of depressive symptoms, CD4, or HIV levels. Over 24 weeks, those in COMB reported fewer depressive symptoms than those in TAU ($p<0.01$). COMB participants were also more likely to be in remission at week 24 (65% vs.10%; $p<.001$) and week 48 (71% vs. 7%; $p<.001$). In the entire sample, reductions in depressive symptoms were associated with reductions in viral load ($p<0.05$). A greater proportion of COMB participants received psychotherapy (95% vs. 45%, $p<0.001$) and attended more sessions (12.6 vs. 5, $p<0.001$) than those in TAU. The use of antidepressants did not differ between the groups over time, with 48% of both groups taking antidepressants at week 12.

Conclusions/Implications: A 24-week manualized, measurement-guided psychotherapy and medication management algorithm tailored for youth living with HIV was more effective in achieving and sustaining remission from depression than treatment as usual at HIV care clinic sites. Given observed treatment

efficacy in this small sample, this structured combination treatment might be able to successfully treat youth living with HIV, who are at particular risk for depression.

BP71

Abstract 1849 - Prevention Research and Implementation Science

Author(s): *William Johnson*

Issue: High-risk sexual behavior has continued to perpetuate the spread of the HIV pandemic at a disproportionate rate among minorities, especially in the African-American community. Reports published by CDC indicate African-Americans face a higher risk of exposure to HIV infection with each sexual encounter than other racial/ethnic groups. This disparity may be related to various factors, however, knowledge regarding safer sexual practices and correct condom usage could prove vital to the prevention of HIV spread. Utilizing CDC evidence-based interventions has shown to be a necessary element in reducing HIV risk associated with drug use and sexual behavior. The Self-Help in Eliminating Life-threatening Diseases (SHIELD) intervention is an approach to HIV prevention at the group level, based on several theories: Social Cognitive Theory, Social Identity Theory, Cognitive Dissonance Theory, and Social Influence Theory. The intervention trains individuals in strategies to reduce HIV-risk associated with sexual behavior and correct condom usage, while exposing myths and educating them on routes of transmission, which are critical in the reducing HIV spread.

Setting: Throughout 2014, SHIELD was implemented in Jackson, MS among African-American men-who-have-sex-with-men (AAMSM). Intervention sessions were conducted over 3 days in casual settings which encouraged unity and discussion. Participants also completed a follow-up survey within 3-6 months of completion.

Project: Intervention sessions were conducted in small-group settings focusing on core elements: 1) Sharing experiences and gaining social support from peers; 2) HIV-learning, problem solving, and situational role play. Initial & post assessment survey tools assessed changes in knowledge, attitudes, and behaviors, with a 3-6 month online follow-up survey.

Results: During 2014, a total of 100 AAMSM living in Jackson, MS completed the SHIELD intervention. Assessments gauged community connectedness, attitude towards condom use, and HIV risk knowledge with statistically significant changes seen. Comparison independent-sample t-test analyses of pre & post surveys revealed the most significant were increases in gay community connectedness ($p < .001$) and feeling part of the black-gay community ($p < .001$). Attitudes shifted towards more condom usage, with an increase in confidence and planning of participants to get new partners to use condoms ($p < .05$). Knowledge gains were observed regarding risk of transmission, specifically in participants correctly identifying which cell HIV invades ($p < .001$). The analysis of 51 6-month follow-up surveys revealed participants were committed to utilizing the knowledge acquired in the SHIELD intervention, specifically condom use and decreasing number of sexual partners. Over 96% of participants (96.1%) agreed/strongly agreed they were fully confident in their ability and planned to get new partners to use condoms. Similarly, the majority agreed/strongly agreed they knew how to correctly use condoms, (94.1%) due to the intervention. When discussing number of partners, majority indicated that they were having sex with fewer partners, with majority not having unprotected sex (56.9%).

Lessons Learned: Knowledge provided to high-risk individuals who completed SHIELD could prove to be substantial in combating HIV spread among AAMSM. Participants are still applying the knowledge after having completed the intervention 3-6 months later. This report provides evidence of sustained safer habits due to SHIELD. A thorough report is planned for the future using a larger sample.

BP72

Abstract 1860 - Prevention Research and Implementation Science

Author(s): *Brittani Saafir-Callaway, Adam Allston, Garret Lum, Michael Kharfen*

Background: The HIV Care Continuum suggests that people diagnosed with HIV follow the pattern of diagnosis, linkage into care, and retention in care to achieve viral suppression. In practice, variations from this ideal occur with similar outcomes. This analysis uses surveillance data to assess demographic and clinical differences between people with multiple preliminary and diagnostic tests and those with only a single diagnostic test.

Methods: People over the age of 12, diagnosed with HIV and reported to the DC surveillance system in 2012 and 2013, and alive at the end of 2014 were considered eligible for this analysis. People with multiple tests were defined as having any HIV-1 or HIV1/2 antibody tests conducted on different days following the first Western Blot test to confirm diagnosis. People with only the first Western Blot test to confirm diagnosis were defined as having a singular test. The independent variables considered in this analysis include, HIV/AIDS status, age, sex, race/ethnicity, residential ward at diagnosis, and transmission mode. Retention in care and viral suppression assessed in 2014 were included as clinical outcomes. Statistical differences were assessed using logistic regression.

Results: Of the 959 eligible diagnoses from 2012-2013, 583 (60.79%) had multiple tests. Among those with multiple tests, on average there were 36 days between tests (range: 1-551 days) and 2 different facilities (range 1-6 facilities). Overall, those with multiple tests do not differ demographically from those with a single test. However, compared with all other racial/ethnic groups, whites were found to have a 1.588 increased odds of having multiple tests than those with a single diagnostic test. (95% CI: 1.057-2.385)

Through the end of 2014, there were 616 (64.23%) were found to be in care. After adjusting for the independent variables, those with multiple tests were found have a 1.388 increased odds of being retained in care when compared to those with a single test. (95% CI: 1.052- 1.831). Among those in care, 71.90% of those tested multiple times were found to be in continuous care (greater than two CD4 or viral load test results at least 90 days apart) compared with 58.37% of those with a single test. Conversely, 41.63% were retained in sporadic care (at least one CD4 or VL during 2014) compared with 28.10% of people with multiple tests. Those with multiple tests, compared to those with a single test, were found have a 1.793 increased odds of being retained in continuous care as opposed to sporadic care. (95% CI: 1.266- 2.539). Among those in care, viral suppression did not differ between those with multiple tests and those with a singular test.

Conclusions/Implications: This analysis suggests that multiple preliminary and diagnostic tests may be an avenue for greater retention in care. Future research should be conducted to better understand the reasons multiple tests are conducted at both the provider and individual levels.

BP73

Abstract 1925 - Prevention Research and Implementation Science

Author(s): *Diana Rowan, Darrin Johnson, Jeffrey Shears*

Background: Use of water or silicone based lubricants is recommended for anal sex in MSM because they help minimize risk of condom breakage, reduce damage to rectal tissues during sex, and therefore reduce chances of HIV/STI transmission. Use of oil-based products can weaken latex condoms. Use of saliva as a lubricant is not recommended because oral fluids can contain HIV. Therefore knowledge of and promotion of proper use of a variety of lubricants are important behavioral interventions for HIV prevention in MSM and transwomen. While perceptions of and use of condoms is well-studied, there is little known about use of lubricants for anal sex in MSM and transwomen.

Methods: As part of a brand new culturally-based HIV prevention intervention that involves online social networking, an online survey of young (aged 18 to 30) MSM and transgender women in North and South Carolina (USA) is underway. Data on demographics and perceptions and behaviors related to sexual risk are collected via Qualtrics and analyzed using SPSS. Specific information regarding frequency of use of lubricants, types of anal lubricant use, and barriers to lubricant use are collected.

Results: Currently, N = 68 young Black MSM and transwomen have been surveyed. To date, 86.2% of these have been tested for HIV, and 25.0% have tested HIV positive. All respondents report some amount of lubricant use when engaging in receptive or insertive anal sex. Of those surveyed, 39.0% report anal bleeding when not enough lubricant was used. 54.2% report that they carry lubricant in case they have sex. 50.9% will use saliva for lubricant if nothing else is available. 67.8% reported they believe the anal-receptive partner has to use lubricant for safety. And 17.0% reported that lubricant is not necessary during insertive sex. 33.9% reported that it is expensive for them to purchase both condoms and lubricant. Respondents reported the following lubricant use for insertive and/or receptive anal sex: 61.1% water-based; 64.7% silicone-based; 23.6% oil-based and 20.6% use of saliva.

Conclusions/Implications: There appear to be barriers to carrying lubricants, including cost, even though their use was common and seen as essential for safe sex. Further, there is a need for better education about the negative implications for HIV prevention of the use of oil-based lubricants with latex condoms and of the introduction to the anal cavity of saliva that could contain HIV. Descriptive information on the use of and perceptions of lubricant use in this behaviorally high-risk sample is of interest to developers of behavioral risk-reduction interventions involving lubricant use and for study of lubricant-based anal microbicides.

BP75

Abstract 2084 - Prevention Research and Implementation Science

Author(s): *Nicholas Perry, Jared Staheli, David Huebner*

Background: Young black men who have sex with men (YBMSM) are disproportionately burdened with HIV (CDC, 2013), despite their comparable levels of use of behavioral prevention strategies (Millett, et al. 2012). Recent evidence has suggested that older sexual partners may drive HIV incidence among YBMSM, given that older partners are more likely to be HIV infected and often have greater power or control in sexual situations (Bingham, et al. 2003). Early sexual debut has also been cited as an important developmental factor promoting condomless sex among YBMSM (Outlaw, et al. 2011). However, no studies to date have examined the intersection of these sexual dynamics among YBMSM in relation to condomless sex.

Methods: 51 YBMSM ages 15-19 (M=17.81, SD=1.21) were recruited from a youth organization as part of a larger study. 64.7% identified as gay/homosexual, 31.4% as bisexual, and 4% as queer/other. 96% identified as Black and 4% identified as Black-mixed.

Youth completed self-report questionnaires using audio computer-assisted self-interview (ACASI). Adolescents reported on sexual debut (own age and partner's age), as well as recent sexual behavior in the past six months, including condom use and age of most recent partner. Partner age differences were categorized as "5 years or older" (1) and "less than 5 years" (0). Early sexual debut was categorized as before age 16 (1) or at age 16 or later (0). These categorizations were based on prior research on early sexual dynamics among adolescents (Bingham, et al. 2003; Lohman & Billings, 2003). Condomless sex in the past 6 months was dichotomized as having occurred (1) or not (0).

We used logistic regressions to predict whether: 1) early sexual debut predicted recent condomless sex, 2) age difference with partner at sexual debut predicted recent condomless sex, 3) age difference with partner at sexual debut predicted age difference with most recent partner.

Results: Same-sex sexual debut occurred on average at age 13 (SD=2.6) and the mean age difference with their partner at debut was 3 years (SD=5). Early sexual debut was not significantly associated with recent condomless sex (OR=.42; 95% CI: [.06, 2.78]). Greater age difference at debut was significantly associated with recent condomless sex (OR=1.26; 95% CI: [1.01, 1.590]). Greater age difference at debut was also significantly associated with greater age difference at most recent sexual episode (OR=1.35; 95%CI: [1.05, 1.73]).

Conclusions/Implications: Early sexual debut was not predictive of recent condomless sex among the young men in our sample. However, having a much older first sexual partner predicted both recent condomless sex and having had a much older recent sexual partner. Early sexual encounters with older partners may influence the ways in which YBMSM engage in sex later in adolescence, as well as the sexual partners they select. Interventions to promote healthy sexual development among YBMSM must reach the very youngest adolescents and attend to important partner dynamics that shape sexual safety. Finally, our results suggest the importance of evaluating partner-level characteristics (e.g., partner age), beyond individual-level characteristics (e.g., participant age), to fully understand the interpersonal mechanisms that shape sexual health decisions.

BP76

Abstract 2098 - Prevention Research and Implementation Science

Author(s): Tyler Tulloch, Syed Noor, David Brennan, Winston Husbands, Trevor Hart

Background: The prevalence of anxiety disorders is higher among gay, bisexual and other men who have sex with men (GBM) relative to heterosexual men (41.2% vs. 18.6%). Higher levels of anxiety have been associated with substance use among GBM. Further, substance use before/during sex has been associated with increased risk for HIV transmission, including unprotected receptive anal intercourse. There are two types of emotion regulation strategies used to down-regulate emotion that may explain how anxiety impacts substance use before and during sex: cognitive reappraisal, which involves re-evaluating a potentially emotion-soliciting situation in a way that reduces its emotional impact, and expressive suppression, which involves inhibiting the expression of emotions once they are experienced. Research suggests that reappraisal is a more effective emotion regulation strategy than suppression. The current study examines the mediating role of these two types of emotion regulation styles on the impact of anxiety on substance use before/during sex among a sample of GBM.

Methods: The sample was comprised of 470 HIV-negative sexually active GBM in Toronto. Trait anxiety was measured using the State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA), which contains subscales measuring cognitive and somatic anxiety. Substance use included any recreational drugs, excluding alcohol and marijuana, within 2 hours before or during sexual activity. Multiple mediation models were fit using MPlus 6.1 following the Preacher and Hayes approach in order to examine direct and indirect associations between three types of anxiety (total, cognitive, and somatic) and substance use via cognitive reappraisal and expressive suppression as well as the contrast between the two mediators.

Results: The majority of participants were younger (mean age=35, SD=12), White (59%), born in Canada (60%), and self-identified as gay (86%). Anxiety was negatively correlated with cognitive reappraisal ($r = -.24, p < .001$), and positively correlated with expressive suppression ($r = .16, p < .01$). A similar pattern was observed for cognitive and somatic anxiety subscales. Substance use was positively correlated with somatic anxiety ($r = .10, p < .05$) and negatively correlated with cognitive reappraisal ($r = -.13, p < .01$). Multiple mediation analyses revealed statistically significant indirect associations via reappraisal between anxiety (total) and substance use ($\beta = .014, 95\% \text{ CI}: 0.003, 0.034$), between cognitive anxiety and substance use ($\beta = .012, 95\% \text{ CI}: 0.004, 0.029$), and between somatic anxiety and substance use ($\beta = .009, 95\% \text{ CI}: 0.002, 0.026$). No statistically significant indirect associations via suppression were observed.

Conclusions/Implications: Low use of cognitive reappraisal for coping with mood may be a key mechanism explaining why higher anxiety is associated with recreational drug use before and during sex. Counselling-based interventions aimed at increasing the use of cognitive reappraisal as an emotion regulation strategy may result in less substance use before/during sex. For GBM with high anxiety, cognitive-behavioral therapy may be used not only to address anxiety but also to reduce risks for HIV via decreasing the use of maladaptive substance use before and during sexual situations.

BP77

Abstract 2156 - Prevention Research and Implementation Science

Author(s): Todd Sabato

Background: Although total HIV cases and estimated HIV prevalence for Pacific Islanders are relatively low, there are alarming indicators of a rapid increase in HIV infection in this group. CDC analyses, based on a review of HIV data, show that of all racial groups, Pacific Islanders had the highest estimated annual percentage change in annual HIV diagnosis rates. In fact, Pacific Islanders were the only racial group with statistically significant percentage increases in annual HIV/AIDS diagnosis rates, with Pacific Islander women having the largest increase of all. Antibody testing among is integral, as women who test HIV-positive report reductions in risky behaviors, minimizing mother-to-child transmission during pregnancy. Routine gynecologic care is also vital in promoting antibody testing. Gynecologic care can act as the front line of HIV testing, diagnosis, and implementing strategies for treatment and prevention. The purpose of the present study was to describe the proportion of HIV testing in the prior 12 months among sexually active Pacific Islander women, and to examine the extent to which routine gynecologic care impacted HIV testing among Pacific Islander women.

Methods: Data were derived from Wave III of the National Longitudinal Study of Adolescent Health, as well as from clients of the Guam Department of Public Health and Social Services. Analyses were limited to 7,099 sexually active women (Caucasian, n = 4,269 [60.1%]; African American n = 1,645 [23.2%]; Hispanic/Latina n = 909 [12.8%]; Pacific Islander n = 276 [3.9%]) aged 18 to 24 years. Multiple logistic regression analyses were used to estimate the association between routine gynecologic care and HIV testing after controlling for predisposing, need, and enabling factors.

Results: On average, 19.3% (n = 1,370) of sexually experienced women reported HIV testing during the prior year. Pacific Islander women had the lowest proportion of testing (16.4%), whereas African American women has the highest (27.6%). Overall, 58.5% of Pacific Islander women reported receiving routine gynecologic care. However, only 12.2% of Pacific Islander women receiving routine gynecologic care reported a history of HIV testing. After controlling for covariates, significantly positive associations were found for Caucasian, African American, and Hispanic/Latina women between routine gynecologic care and HIV testing. However, there was no evidence that routine gynecologic care was associated with HIV testing among Pacific Islander women.

Conclusions/Implications: The present data suggests that routine gynecologic care does not increase HIV testing among Pacific Islander women. To effectively eliminate disparities in HIV testing service utilization among API women, appropriate efforts must be focused on enhanced understanding of both barriers and facilitators of HIV testing among this population.

BP79

Abstract 1573 - Prevention Research and Implementation Science

Author(s): *Wendasha Hall, Christina Sun, Jason Stowers, Amanda Tanner, Lilli Mann, Scott Rhodes*

Background: Men who have sex with men (MSM) currently carry disproportionate HIV/AIDS burden in the United States. To address this disparity, health professionals have begun to use GPS-based social and sexual networking mobile applications (“apps”) to deliver HIV/AIDS education and prevention programming to this population. Yet, little is known about the outcomes of these efforts. Accordingly, the goal of this study was to understand and describe the nature of the conversations between app

users and the interventionist for MAP'T, an intervention designed by our community-based participatory research partnership to promote HIV testing among MSM using established GPS-based social and sexual networking apps. We sought to gain insight on the sexual health needs of app users and the future utility of app-based interventions.

Methods: Between August 2013 and October 2014, a trained interventionist promoted HIV testing resources in 4 popular apps geared toward MSM. The interventionist created app profiles to spark user interest, provide information about the intervention, and accurately represent his role. He responded to app users only after they contacted him. Conversations between app users and the interventionist were captured through screen-shot images from the interventionist's mobile device and stored on a password-protected computer. Screen-shots allowed us to analyze text as well as photographs and emoticons. All images were uploaded to ATLAS.ti 7.0 for data analysis. Content analysis was used to identify salient themes that emerged from the conversations. A coding structure was developed with research team involvement and then the images were coded by the first author. The results and representative quotes were shared with the research team for validation, refinement, and interpretation. Any discrepancies were resolved via discussion.

Results: The analysis included 673 distinct conversations. The analysis of the transcripts revealed four major characteristics prevalent in the conversations between the interventionist and app users: (1) soliciting sexual encounters (i.e. attempting to engage sexually with the interventionist; e.g., "Let's have safe sex"), (2) relationship development (i.e. establishing the interventionist as a safe and reliable resource for HIV information; e.g., "Do you work at Triad Health [AIDS service organization]? You gave me my first test"), (3) HIV testing inquiries (e.g., locating local testing services: "Hello! Do you know where I can get tested for free?"), and (4) seeking sexual health education (e.g., wanting to know the riskiness of oral sex: "Can you contract HIV by giving/getting head?"). To quickly answer inquiries regarding sexual health, the interventionist compiled digestible, user-friendly responses that linked to resources about various topics such as HIV symptoms, PrEP, and oral sex.

Conclusions/Implications: The results suggest that the intervention's social media based strategy, respect for community culture, and unobtrusive approach was advantageous in establishing credibility and rapport with users (e.g. some users contacted interventionist multiple times for information, referrals, and/or support). These results highlight a need for convenient and discrete methods to access accurate sexual health information and suggest that apps provide an alternative, non-traditional venue for sexual health education in addition to HIV testing promotion.

BP85

Abstract 2057 - Prevention Research and Implementation Science

Author(s): *Lynn Yee, Adina Goldberger, Patricia Garcia, Emily Miller*

Background: Residual cases of mother-to-child-transmission (MTCT) of HIV continue to occur. These cases are often due to seroconversion during pregnancy, rendering early universal HIV screening inadequate to identify all women at risk of transmission. Yet, partner testing for HIV is rarely performed in the U.S. The objective was to assess knowledge of partner HIV status and desire for partner testing among low-income pregnant women in urban Chicago.

Methods: Pregnant women known to be HIV-negative were recruited from a university-based prenatal clinic serving low-income women. No participants in the survey had revealed the serostatus of their partner prior to participation. Participants completed an anonymous survey about knowledge, attitudes, and preferences regarding partner HIV testing. Descriptive statistics were utilized.

Results: 102 obstetric patients (mean age $28.6 \pm SD 5.8$ years, mean gestational age $17.8 \pm SD 8.7$ weeks) participated; all received Medicaid assistance for prenatal care. 56 (55%) women self-identified as African American and 31 (30%) as Hispanic. A majority (61%) reported being married or partnered, and 91% reported having at least one current sexual partner. 61 (62%) women reported their partners had no health insurance or were unaware of his health insurance status. In this population, 38 (38%) women did not know if their partner had been tested for HIV. Of the 63 women who reported knowing their partner previously been tested, 57 (90%) knew the test results but only 16 (25%) partners were tested within the last 6 months. One woman reported an HIV-infected partner. Overall, a majority (69%) of surveyed women desired knowledge of their partner's current status and 78% believed their partners would like testing. Over 70% preferred their partners undergo testing at the prenatal clinic at the time of a routine visit and believed their partners would also prefer this testing location. While 32 (32%) women had never discussed HIV testing with their partners, the majority (93%) of all surveyed women felt comfortable doing so.

Conclusions/Implications: In this urban, high risk community, a majority of pregnant women do not know the results of a HIV test for their sexual partner during the current pregnancy. Patients and their partners must both know their status during the current pregnancy if all cases of seroconversion are to be identified. Moreover, one of the 57 women who knew their partner's test results reported having an HIV-positive partner, representing an unmet need for preexposure prophylaxis counseling. Women desired to know their partner's HIV status and were receptive to partner testing at the site of prenatal care. Given the acceptability of partner testing in this community, future work must investigate the uptake of such resources for male partners in at-risk communities.

DP19

Abstract 2520 - Partnerships, Community, Communication, and Mobilization

Author(s): *Linda Chen, Kirsten Balano*

Background: Under California state law, revised January 1, 2015, community pharmacists can furnish an unlimited number of syringes to individuals 18 and older without a prescription. This is a revision to previous legislation that limited syringe sales to 30 syringes per transaction. The law aims to expand syringe access in the state to reduce the spread of blood-borne illnesses such as HIV/AIDS and Hepatitis C. Despite the allowance for non-prescription syringe sales (NPSS), one study surveying California community pharmacists found that over 30% of pharmacists were unwilling to sell syringes and almost 40% saw no need to sell syringes. The major barriers to NPSS were lack of information about the law, managing difficult patients, and the fear of being seen as a supplier of syringes to intravenous drug users.

Methods: In a collaborative effort among the UCSF School of Pharmacy, Pacific AIDS Education and Training Center, the California Department of Public Health-Office of AIDS, and an independent researcher, an online webinar series titled “What’s the Point?” was designed with the goal to increase the willingness of California community pharmacists to adopt NPSS their into practices by addressing the barriers to NPSS found in prior research.

Results: Two, 1-hour, interactive webinars were developed, advertised, and held on January 12 and February 6, 2015. The first webinar addressed general knowledge about NPSS including the current NPSS legislation, the research explaining the impact of NPSS, and the role of the community pharmacists in increasing syringe access. Each piece was presented by an individual highly experienced in that area. The second webinar addressed the details and logistics of NPSS implementation by inviting a small panel of community pharmacists with varying backgrounds in California who were actively participating in NPSS. Over a hundred individuals attended each webinar. The ability to chat and ask questions was implemented throughout each webinar which allowed the webinar developers to gauge the concerns and barriers to NPSS most relevant those community pharmacists in attendance. In these webinars, a major barrier was syringe disposal options especially in counties where there was little to no financial support for providing sharps containers and disposal costs.

Conclusions/Implications: While these webinars mainly addressed barriers in a pharmacists’ willingness to participate in NPSS, the webinars also revealed new barriers. These new barriers are preventing willing pharmacists from participating in NPSS, which as highlighted in these webinars mainly involved the logistics and economics of implementing NPSS. This information will be used to guide relevant future education campaigns and research to promote widespread adoption of the practice by California community pharmacists to ultimately decrease the spread of HIV and Hepatitis C in the state.

EP01

Abstract 1532 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Martin Hoenigl, Joshua Graff Zivin, Susan Little*

Background: Given the high transmission efficiency that characterizes acute HIV infection (AHI), one might wonder whether routine AHI screening should be the standard of care in field based HIV screening programs. The main deterrents of widespread use of AHI testing algorithms appear to be the elevated costs. The purpose of this study was to develop and evaluate the first economic assessment of a dual HIV field-based screening algorithm [HIV antibody (Ab) plus individual donation HIV nucleic acid amplification testing, i.e. the “Early Test” (ET) algorithm] that identifies both acute (i.e. seronegative) and established HIV infection among men who have sex with men (MSM).

Methods: This represents a cost-analysis of the ET algorithm and comparison to an algorithm using ARCHITECT for HIV Ab/p24 antigen (Ag) detection (AR algorithm). In addition we compared both algorithms to two point-of-care (POC) testing-strategies [using Determine™ HIV Ab/p24 Ag test (DT algorithm) or INSTI™ HIV rapid Ab alone (Ab algorithm)].

The model is based on number of tests per year, and numbers of HIV diagnoses at different stages of infection in MSM who enrolled in the San Diego Primary Infection Consortium between 2006 and 2014 [i.e. 3000 HIV tests performed per year, overall HIV prevalence 2.4%, acute HIV (AHI) prevalence 0.9%].

Incremental cost effectiveness ratios (ICER) per diagnosis of AHI and cost per infection (i.e. transmission) averted (IA) were calculated for comparisons of the four algorithms.

Results: The ET algorithm was cost-saving when compared to the AR algorithm with an ICER of \$1,731 per AHI diagnosis. Estimation of IA by ET when compared to AR ranged between 0.7 - 8.5 HIV transmissions (range of costs per IA: \$1,044 - \$13,451). The ET algorithm was also cost-saving versus the DT algorithm (ICER \$7,490 AB per AHI diagnosis), and the Ab algorithm (ICER \$4,828). The ET algorithm was cost-saving when compared to the three other testing strategies for HIV prevalence rates of .0.8%; DT was cost-saving for prevalence rates between 0.25% and 0.8%, while below 0.25% HIV prevalence none of the three algorithms that detect AHI was cost-saving versus Ab alone.

Conclusions/Implications: The ET algorithm was cost-saving among MSM undergoing field-based HIV screening in San Diego, when compared to the AR, DT and Ab algorithms. The model suggests that field based screening for AHI using the DT POC test may be cost-saving for HIV prevalence rates of . 0.25%, while the more sensitive ET screening algorithm may be the method of choice for prevalence rates . 0.8%.

MONDAY, DECEMBER 7 | ORAL SESSIONS | 1:30 PM – 3:00 PM

Track A

Session A02 - Data to Care: State-based Approaches of Using Routinely Collected Surveillance Data to Facilitate Care

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1507 - “Out of Care” Case Investigations: A Collaborative Analysis among Six States in the Northwest US

Author(s): *Julia Dombrowski, Joanna Bove, J. Clay Roscoe, Jessica Harvill, Caislin Firth, Shireen Khormooji, Jason Carr, Peter Choi, Courtney Smith, Matthew Golden*

Background: Surveillance-based estimates of the HIV care continuum typically assume that absence of CD4 and viral load (VL) reports indicates absence of care. However, cases without recent laboratory data represent a heterogeneous population that includes persons who are out of care and persons who have moved, died, or are in care without laboratory results captured in surveillance.

Methods: We evaluated the impact of individual case investigation on estimates of the percent of “out of care” HIV-diagnosed persons in six states (Alaska, Idaho, Montana, Oregon, Washington, and Wyoming). We defined “out of care” as no evidence of care for ≥ 12 months. In all states but ID, health department staff investigated cases with no CD4 or VL results reported to the health department for ≥ 12 months. Due to the lack of mandatory comprehensive VL reporting, ID staff investigated patients at the state’s two largest HIV clinics without a visit for ≥ 12 months. (These clinics care for $\geq 90\%$ of PLWHA in ID.) Cases were extracted for investigation in 2012-13. Analysis in WA excluded King County because out-of-care investigations in the county started several years earlier. A common case investigation protocol in WA, MT, ID, and WY included queries of HIV/STD surveillance and AIDS Drug Assistance Program data (except in ID), a Lexis Nexis® database, and electronic medical records; if these queries did not define a person’s location or care status, staff attempted to contact the case’s last care provider or directly contact the case. Staff in AK and OR used similar protocols developed locally. We categorized case dispositions into the following categories: 1) moved, 2) died, 3) in care, 4) no evidence of care (i.e. no evidence of relocation, death, or receipt of care, including unlocatable cases), or 5) data error. We calculated the adjusted percentage of cases in each state with no evidence of care during the surveillance period by removing cases that had moved, died or were data errors from the denominator and removing cases found to be in care from the numerator.

Results: 3,866 HIV cases in the 6 states had no labs for ≥ 12 months, representing 19% to 37% of HIV cases in each area. Case dispositions were as follows [overall % (range across sites)]: 1,661 moved [43% (20-67%)]; 325 died [8% (4-14%)]; 792 in-care [20% (10-33%)]; 1082 no evidence of care [28% (11-57%)]; and 7 [$<1\%$ (0-1%)] data errors. Most cases with no evidence of care could not be located (35%) or resumed care after the surveillance period but prior to efforts by outreach staff to contact them (25%).

Adjusting for the results of case investigations, the percent of PLWHA estimated to be out of HIV care decreased by 61% in AK, 35% in ID, 74% in MT, 71% in OR, 65% in WA, and 33% in WY.

Conclusions/Implications: Our results highlight the challenges that Data-to-Care programs are likely to encounter and add to evidence that most surveillance-based HIV care continuum estimates are too pessimistic. Data-to-care programs will need to better prioritize cases for investigation to improve efficiency.

Session A02 - Data to Care: State-based Approaches of Using Routinely Collected Surveillance Data to Facilitate Care

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1910 - Expanding the Use of Surveillance Data to Improve HIV Medical Care Engagement and Viral Suppression

Author(s): *Antoine Brantley, Jessica Fridge, Samuel Burgess, Jacquelyn Bickham*

Issue: Continual engagement in HIV medical care and adherence to HIV treatment leads to viral suppression, optimal health outcomes, and reduced risk of transmitting HIV to others. Despite the availability of HIV medical care and HIV treatment to all persons living with HIV/AIDS (PLWHA) in the state of Louisiana, only 61% were retained in HIV medical care in 2012 and only 49% were virally suppressed.

Setting: Louisiana Links (LA Links) is a linkage/re-engagement and patient navigation intervention under Louisiana's CAPUS demonstration project that is currently implemented in 3 regions with the highest HIV prevalence (New Orleans, Baton Rouge, and Shreveport). LA Links utilizes Louisiana's HIV surveillance data to identify PLWHA who are newly diagnosed with HIV and haven't linked to care within 6 months, PLWHA who haven't been in care for 1-3 years, and PLWHA who have had 2 consecutive viral loads greater than 1,000 copies/mL and could benefit from treatment adherence assistance.

Project: LA Links employs a state-of-the-art, automated program to refer PLWHA to 5 Linkage to Care Coordinators (LCCs) who will provide linkage/re-engagement to HIV medical care and supportive case management services, treatment adherence assistance, and referrals to other supportive services (i.e., mental health, housing, employment). The referral program generates electronic line lists for each target population by applying a set of eligibility criteria to Louisiana's enhanced HIV/AIDS Reporting System (eHARS) and HIV laboratory database and ordering the resulting lists according to a prioritization scheme. The line lists are updated weekly using the above program. LCCs access the line lists through a user-friendly interface and attempt to contact persons using contact information provided by both surveillance databases and LexisNexis. Any new surveillance data collected for a person by the LCCs (i.e., contact data, missing laboratory data, and vital status) is reported back to both surveillance databases.

Results: During Year 1 (September 2013 – September 2014), 3,531 persons were added to the LA Links line lists (79% were black, 67% were male, 34% were men who sex with men, and 24% were under 30

years of age). 36% were removed during subsequent weekly updates due to changes in eligibility status. LCCs attempted to contact 63% (n=2,207) of persons on the line lists. Of persons that had a final contact outcome by the end of Year 1 (n=1194), 25% were enrolled (n=300), 48% were found to be ineligible, 19% refused enrollment, and 7% were ultimately unable to be contacted. The most common reason for becoming ineligible was already being engaged in HIV care. Of those that enrolled, 84% (n=252) were linked to care. Moreover, LCCs contributed updated surveillance data for 342 persons (15% of persons LCCs attempted to contact).

Lessons Learned: HIV surveillance data can be a valuable tool for identifying persons in need of linkage/re-engagement and treatment adherence assistance; however, such a strategy requires timely and near-complete laboratory data reporting to prevent employing resources on persons that are already engaged in HIV care. This strategy can also be utilized to improve the quality of an HIV surveillance database by providing updated surveillance data.

Abstract 2231 - Using HIV Laboratory Surveillance Data to Identify Out-of-Care Patients

Author(s): *Kshema Nagavedu, Rebecca Hawrusik, John Christian Hague, Betsey John, Linda Goldman, Sophie Lewis, Serena Rajabiun, Dawn Fukuda, Kevin Cranston*

Issue: Engagement and retention in HIV care enables individuals living with HIV to achieve viral suppression, leading to improved health outcomes and reducing the probability of onward transmission. Recent CDC, HRSA and NIH recommendations suggest health departments can use CD4+ T-cell count and HIV viral load lab data to identify HIV+ individuals who are out of care and who may benefit from re-engagement interventions.

Setting: Massachusetts Department of Public Health (MDPH) amended its reporting regulations to collect all CD4 and all viral load results beginning in January 2012. MDPH developed a process to generate out-of-care (OOC) patient line lists as part of a US Health Resources and Services Administration (HRSA), Special Projects of National Significance (SPNS) grant. The project aimed to identify and re-engage OOC individuals using HIV surveillance data and clinical information provided by five participating medical facilities, including two large urban hospitals, two community health centers, and one small outpatient clinic.

Project: The intervention focused on a system-level communication and data exchange between MDPH and participating medical facilities. For each facility, MDPH identified individuals whose most recent HIV-related laboratory test took place at that facility. Using HIV laboratory tests as a proxy for an HIV care visit, MDPH identified which of those individuals were suspected to be OOC, defined as the absence of CD4 or viral load testing for ≥ 180 days. Line lists of patients suspected of being OOC were sent to the participating clinical facilities on a monthly basis. The clinical staff reviewed the lists, consulted members of the medical care team, queried electronic health records, and then provided feedback to MDPH regarding each patient's true care status. Feedback indicated if the individual was either truly OOC or had another valid explanation for the gap in HIV laboratory testing. "Truly OOC" patients were those who did not have a lab test for ≥ 180 days, and for whom there was other clinical explanation for the lapse in lab testing.

Results: During June 2013 to May 2014, 1,137 individuals at the participating facilities appeared to be OOC based on HIV surveillance data and were therefore included on OOC line lists sent to the facilities. Of those, 416 (37%) were confirmed to be truly OOC based on feedback from clinical providers. The remaining 63% of individuals were identified as being in care by the facilities based on EHR data unavailable to MHASP. Among individuals identified as truly OOC, 55.0% had a lab reported to MHASP within three months and 71.6% had a lab reported to MHASP within six months of their initial line list appearance.

Lessons Learned: Supplemental information provided by medical facilities was essential in ascertaining an HIV+ individual's true care status. This collaborative method of identifying truly OOC individuals helps to save time and resources, particularly when the OOC information is informing active patient follow-up. The data systems developed through this project have provided the framework to expand the line list communication system to other sites across Massachusetts, to guide targeted reengagement interventions for OOC patients in a more efficient and effective manner.

Abstract 2326 - A Pilot Project to Assess Mechanisms to Identify HIV-Positive Persons out of Care or Never Linked to Care in Texas

Author(s): *Melissa Roach, Jennifer Chase, Miranda Fanning, Karen Surita, Tammy Foskey, Rebecca Filipowicz*

Issue: In 2013 there were almost 20,000 persons living with HIV in Texas that had no evidence of HIV-related medical care in that year. Linkage and retention in care are critical to receiving antiretrovirals, achieving viral suppression, and ultimately improving health outcomes and reducing HIV transmission.

Setting: Texas implemented a pilot project in Austin-Travis County and Dallas County beginning in 2012 to determine the best mechanism for identifying persons out of care and re-engaging them in HIV-related medical care.

Project: The pilot project utilized surveillance data and medical records to identify HIV-positive persons not engaged in care. Surveillance defined out of care as no HIV-related test or HIV prescription in the past 12 months, and never linked to care as no test or prescription within 6 months of diagnosis. Medical providers considered someone out of care if there was no medical appointment in the past 6 months, or 2 or more missed appointments. Each person selected was contacted through telephone calls and home visits, and then assisted with scheduling medical appointments and referrals to other services.

Results: By the end of 2014, 597 persons were selected in Austin-Travis County and Dallas County. There were 244 persons that were ineligible for linkage to care: 46% were already engaged in care, 36% had moved, 9% were incarcerated, 8% were deceased, and 1% was found to be HIV negative. Of the 353 eligible for linkage to care, 21% of those selected by surveillance and 54% of those selected by a medical provider were successfully linked to care. Overall, those selected by surveillance were more likely to have never been engaged in care previously, and be male and younger than those selected by a medical provider. Some groups experienced greater success in linkage to care, including those less than 6 months out of care (68%), black (41%), and female (46%). Once linked to medical care, persons with a

suppressed viral load within 12 months of linkage to care increased from 7% at re-entry to care to 44% if were identified by surveillance, and increased from 14% to 43% if identified by a medical provider.

Lessons Learned: People living with HIV that are out of care can successfully be identified and re-engaged in care. There are advantages to both mechanisms of identifying persons out of care; medical providers are able to identify someone has fallen out of care earlier, while surveillance has access to more information and can identify both persons never linked to care and those that have fallen out of care.

Session A03 - Using Molecular Transmission Networks to Understand the Spread of HIV

Room: Baker (Hyatt Regency Atlanta)

Abstract 1592 - Making it Happen: How We Collect Molecular HIV Surveillance Data

Author(s): *M Cheryl Banez Ocfemia, Alexandra Oster, Tianchi Zhang, Angela Hernandez*

Issue: Antiretroviral (ARV) drug resistance testing conducted as a part of standard HIV care generates HIV nucleotide sequences. To better understand the burden of HIV and guide public health action, CDC funds the collection of HIV sequences and ARV use data through Molecular HIV Surveillance (MHS), a component of the U.S. National HIV Surveillance System (NHSS). These data are used to monitor the prevalence of HIV drug resistance among persons living with HIV, describe the diversity of HIV strains, and study HIV transmission among populations.

Setting: Sixty-five U.S. jurisdictions have the regulatory authority and confidentiality protections to conduct HIV surveillance and report de-identified information on persons diagnosed with HIV to NHSS. These jurisdictions ensure the appropriate use and release of HIV surveillance data. During 2001—2012, CDC funded a series of demonstration and surveillance projects to assess transmitted HIV drug resistance and HIV diversity. In January 2013, CDC implemented MHS, which adds the analysis of transmission networks to the HIV surveillance portfolio and expands data collection to 27 jurisdictions (20 states, 5 cities/counties, the District of Columbia, and Puerto Rico). Of these, 11 (41%) jurisdictions had no prior experience collecting HIV sequences.

Project: The primary MHS objectives include the secure and confidential electronic collection of HIV sequences from laboratories and related ARV use data and the analysis and dissemination of findings to inform HIV care and prevention. MHS jurisdictions collaborate with laboratories, import the sequences into the enhanced HIV/AIDS Reporting System (eHARS), and transfer these sequences to CDC with HIV case surveillance data, including demographic, risk, clinical, and laboratory information. Jurisdictions also collect ARV use data to determine whether persons were exposed to HIV medications before HIV diagnosis. MHS jurisdictions aim to collect an initial HIV sequence (i.e., obtained 3 months after diagnosis) for at least 50% of newly diagnosed persons and ARV use data for at least 85% of newly diagnosed persons with an initial sequence.

Results: By the end of 2013, 17 jurisdictions (63%) submitted a total of 121,617 sequences and, by the end of 2014, 25 jurisdictions (93%) submitted a total of 296,911 sequences. This represented a 47% increase in the number of jurisdictions submitting data and 144% increase in the number of sequences

reported. For diagnoses in 2013, median completeness of initial sequences was 21.5% (interquartile range 6.5% to 42.0%) and median completeness of ARV use data among persons with an initial sequence was 95.6% (interquartile range 84.7% to 99.9%).

Lessons Learned: Integration of MHS activities into routine HIV case reporting relies on jurisdictions having the legal authority to collect all HIV-related laboratory results and requires robust electronic laboratory reporting mechanisms, solid HIV case investigation procedures, and skilled staff. Improved reporting and completeness of HIV sequences and ARV use data will enhance the use of molecular techniques to better characterize the burden of HIV and inform prevention interventions to deter the spread of HIV.

Abstract 1669 - Reconciliation of Named vs. Genetic Partner Networks and Proposal to Use Genetic Network Information for Routine Partner Notification Activities

Author(s): *Lucia Torian, Joel Wertheim, Lisa Forgione, Sharmila Shah, Chi-Chi Udeagu, Sarah Braunstein*

Background: Partner and social network naming, notification and testing are traditional means for ascertainment of undiagnosed infections and interdiction of secondary transmission of sexually transmitted diseases, including HIV. However, a recent analysis of named partners as compared to genetically plausible transmission partners, as determined by analysis of genotype data, showed significant discrepancies that raised questions about the utility of using partner naming alone for prevention intervention.

Methods: Between 2006 and 2012, the New York City Department of Health elicited partners from 770 index cases on whom a genotype was ordered within 3 months of initial diagnosis and subsequently reported to surveillance, as required by law. These cases named 810 HIV+ partners who also had genotypes. Using the pol sequence generated by routine clinical genotyping, we identified index and named partners who were most closely related in a maximum likelihood phylogeny. We estimated the Tamura-Nei 93 (TN-93) genetic distance between each pair of index cases and named partners. We designated sequence pairs that fell below a previously validated distance cutoff of 1.75% as plausible genetic links. We used logistic regression to assess the variables associated with the index case naming at least one genetically linked partner.

Results: 451 of 770 (59%) index cases named partners who were also genetically linked. We observed many different shapes and sizes of genetic networks, most clustering by risk factor but some having mixed risk. Heterosexual female index cases were more likely (77%) to be genetically linked to a named partner than men who have sex with men (42%, OR= 0.21, 95% confidence interval 0.14, 0.31) and male injecting drug users (38%, OR=0.18, 95% confidence interval 0.08, 0.38). Black index cases were less likely than whites and Hispanics to name a genetically linked partner (53%, OR=0.46, 95% confidence interval 0.25, 0.87).

Conclusions/Implications: Construction of genetic transmission networks can supplement partner naming by identifying previously unknown parts of a potential transmission network-- i.e., unnamed partners. New York City will soon perform genotyping at the point of diagnosis, so that genetic transmission networks can supplement named partner networks in the routine disease intervention

activities and partner notification that take place immediately at the time of diagnosis and assume special urgency in the case of a diagnosis of acute HIV infection. This strategy has the potential for improving interdiction of new infections in active transmission chains and clusters, particularly in networks with hub or bridge persons diagnosed during acute or early HIV infection and networks that have public venues or internet sites in common.

Abstract 2047 - Implementation of a Near Real-Time Phylogenetic Monitoring System for Localized HIV Outbreaks in British Columbia, Canada

Author(s): *Art Poon, Conan Woods, Susan Shurgold, Guillaume Colley, Robert Hogg, David Moore, Mel Krajden, Réka Gustafson, Julio Montaner, P. Richard Harrigan*

Background: About 11,700 people in British Columbia (BC) were living with HIV by the end of 2011. Historically, the HIV epidemic in BC has been highly heterogeneous with a disproportionate impact on multiple marginalized populations such as injection drug users, female sex workers, and men who have sex with men. Although the overall incidence of HIV has declined with the expansion of antiretroviral therapy (ART), managing localized outbreaks of HIV transmission continues to pose significant public health challenges. Furthermore, the transmission of drug resistant variants of HIV is a significant public health concern, since the spread of resistant variants can limit treatment options for those newly infected.

Screening for HIV drug resistance by genotyping the virus is standard-of-care for the clinical management of HIV infection. The BC Centre for Excellence in HIV/AIDS (CFE) is a provincial agency responsible for all HIV genotyping and distribution of ART at no cost to all HIV-infected residents of BC. Under current BC treatment guidelines, every new HIV diagnosis undergoes viral load testing and a genotype resistance test. Presently, the CFE database holds over 31,000 HIV genotypes representing over 8,600 individuals — over half the estimated prevalence of HIV in BC. Roughly 10 to 30 new anonymized sequences are deposited in the database every day, and linked in a de-identified fashion with corresponding clinical, demographic, geographic, and risk factor data.

Methods: We have developed a near real-time monitoring system of HIV transmissions in BC. This automated system queries the CFE database on an hourly basis. Whenever new genotype records are uploaded, the system reconstructs phylogenetic trees relating all HIV sequences from the entire database and extracts clusters comprising five or more closely-related infections each. The system generates reports that summarize the growth and characteristics of active de-identified clusters, which are disseminated to select Directors at the CFE, the BC Centre for Disease Control, and medical health officers at the provincial health authorities.

Results: On June 24, 2014, the monitoring system identified 11 new cases in the database within a three month period that formed a cluster with 30 other individuals. The mean viral load among these new cases was 4.9 log₁₀ copies/mL and 9 of the 11 new cases carried a transmitted mutation conferring resistance to non-nucleotide reverse transcriptase inhibitors (NNRTIs, K103N). On the basis of the ensuing report, the provincial health officer deemed this rapid spread of a resistant strain of HIV to be of sufficient public health concern to warrant an enhanced public health followup. As a result of the public health response, the majority of these new cases have achieved a suppressed viral load and only two

new cases carrying transmitted drug resistance have appeared in this cluster since the formal outbreak investigation.

Conclusions/Implications: The CFE database represents one of the most comprehensive population and health research databases in Canada. Systematic application of this molecular epidemiologic-based near real-time monitoring system has significant potential to improve HIV surveillance capacity and enhanced targeting of public health interventions to limit HIV transmission, including transmission of drug resistance.

Abstract 2139 - Using Molecular Transmission Networks to Understand the Spread of HIV in the United States: A Novel Perspective for Focusing Prevention Efforts

Author(s): *Alexandra Oster, Ellsworth Campbell, Ruiguang Song, William Switzer, Joel Wertheim, M. Cheryl Ocfemia, H. Irene Hall, Angela Hernandez*

Background: HIV nucleotide sequence data can be used to identify clusters of infection (persons with genetically related viruses) and develop a nuanced understanding of the spread of HIV among and between populations. Clusters of HIV infection that continue to grow likely represent ongoing transmission and are potential points for intervention with effective prevention methods. Predicting which clusters are likely to grow may help guide the appropriate allocation of limited prevention resources toward maximizing viral suppression and stemming transmission.

Methods: We analyzed HIV-1 polymerase sequences for persons diagnosed through 2012 collected through Molecular HIV Surveillance, an integral component of the National HIV Surveillance System. We identified pairs of sequences that were highly genetically related ($\leq 1.5\%$ genetic distance) and inferred a transmission network that showed connections between closely related pairs of sequences. From that network, we selected large clusters (those with at least 30 persons) for further epidemiological characterization. We first plotted the characteristics (race/ethnicity and transmission category) of the members of each cluster. Next, we fitted a sigmoidal (S-shaped) curve to each cluster to infer potential cluster growth between 2012 and 2020 and estimated whether growth was still rapid or plateauing. Phylogeographic analysis was conducted to describe geographic spread of HIV over space and time.

Results: Of 70,669 sequences collected during 2001–2013, 21,117 clustered with at least one other sequence. There were 46 clusters of at least 30 persons (total size 2,217). The majority of clusters comprised persons with infection attributable to male-to-male sexual contact, although a small number of clusters included predominantly persons with infection attributable to injection drug use or heterosexual contact. By race/ethnicity, the large clusters typically fell into two categories: mostly blacks/African Americans or a mixture of whites and Hispanics/Latinos. Based on our analysis, these 46 large clusters are predicted to grow from a total size of 2,217 in 2012 to a total size of 3,595 in 2020 (increase of 1,382 persons, or 62%). Eight of the 46 clusters were predicted to grow by at least 50 persons each; these 8 clusters represent 50% of the total expected growth for the 46 large clusters. Phylogeographic analysis shows that, of the 8 largest clusters, 5 were localized (>90% within one state), while three clusters spread throughout multiple (6–11) states.

Conclusions/Implications: Detailed molecular analysis can identify clusters that are likely to have substantial potential for growth. This growth may represent persons who are not yet diagnosed or additional transmissions that have not yet occurred. State and local health departments can use results from molecular analyses to prioritize these cluster members with interventions aimed at reducing onward HIV transmission and improving linkage to care, ART use, and viral suppression and can tailor prevention approaches based on the demographic and risk characteristics of persons clustered. Surveillance at the national level is useful for identifying multi-state clusters, and collaboration between jurisdictions to intervene upon these clusters may be important to stemming the spread of HIV.

Session A13 - HIV/AIDS Disparities Among Certain Racial/Ethnic Groups

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1562 - The Role of Social Determinants of Health on Retention and Viral Suppression for Black and White MSM Served by the Ryan White HIV/AIDS Program

Author(s): Stacy Cohen, Antigone Dempsey

Background: Black men who have sex with men (MSM) continue to be disproportionately affected by HIV in the United States. A growing body of research suggests underlying social and environmental determinants may influence the care and treatment outcomes for this population of persons living with HIV. This study examines socio-demographic characteristics among black MSM and white MSM served by the Ryan White HIV/AIDS Program and compares retention in care and viral suppression between these two populations.

Methods: Client-level data from the 2013 Ryan White Services Report were used to identify the populations of black and white MSM aged 13 years and older who received Ryan White HIV/AIDS Program services during 2013. Differences were examined between black and white MSM in the percentage distributions of age group, poverty level, healthcare coverage, housing status, and Census region using chi square tests. Retention in care and viral suppression were then calculated for each subpopulation of black and white MSM; chi square tests were used identify differences in the percentages of retention and viral suppression between black and white MSM in each subpopulation.

Results: The distributions of black and white MSM receiving Ryan White services in 2013 were significantly different for all subpopulations: black MSM were more likely to be aged <35 years, to be living at <100% below poverty, to have multiple types of health care coverage or Medicaid only, to have temporary or unstable housing statuses, and to live in the South; white MSM were more likely to be aged ≥45 years, to be living at or above 100% poverty level, to have Medicare only or to be uninsured, to be stably housed, and to live in the West. The percentages of persons retained in care differed significantly between black MSM and white MSM for some categories of poverty level, healthcare coverage, housing stability, and region, but not by age group. The percentages of persons who achieved viral suppression differed significantly between black MSM and white MSM across all subpopulations, with black MSM having lower levels of viral suppression than whites.

Conclusions/Implications: In this cohort of black and white MSM who received Ryan White HIV/AIDS Program services during 2013, black MSM had significantly lower levels of viral suppression compared to

white MSM, regardless of age, poverty level, housing status, or healthcare coverage. Clear health disparities between black and white MSM have been demonstrated. More research is needed to understand how social determinants of health and other environmental factors intersect and affect the health outcomes of black MSM living with HIV.

Abstract 2167 - Trends in Racial/Ethnic Disparities of New AIDS Diagnoses in the United States and Puerto Rico, 1984-2013

Author(s): *Johanna Chapin-Bardales, Patrick Sullivan, Eli Rosenberg*

Background: In the United States, HIV disproportionately impacts racial/ethnic minorities. The US National HIV/AIDS Strategy (NHAS) aims to reduce these disparities. Trends in HIV and AIDS cases by race/ethnicity are commonly reported, but disparity is rarely considered as an outcome. Furthermore, previous analyses have assessed trends over relatively short durations of time. Analyses are needed to understand whether disparities have grown, declined, or been sustained since the beginning of the epidemic. To fill this gap, we described and tested the trends in the non-Hispanic black vs. non-Hispanic white and Hispanic vs. non-Hispanic white disparities of new AIDS diagnoses from 1984 to 2013 over 30 years of the epidemic in the United States and Puerto Rico.

Methods: AIDS diagnosis rates by race/ethnicity for adults and adolescents ≥ 13 years were calculated using publicly available national HIV surveillance reports and US Census Bureau data. Black-white and Hispanic-white disparities in new AIDS diagnoses were measured as rate ratios. Joinpoint Regression was used to identify time periods across which to estimate rate-ratio trends. We calculated and tested the estimated annual percent change (EAPC) in the trends of the disparity measures for each indicated time period using a log-transformed linear regression model.

Results: The black-white disparity increased from 1984 to the end of 1990 (EAPC = 5.6, 95% confidence interval (CI): 3.8, 7.5), followed by the largest increase from 1991-1996 (EAPC = 11.6, 95% CI: 9.1, 14.1) and a continued but more gradual increase from 1997-2001 (EAPC = 3.2, 95% CI: 0.2, 6.3). The black-white disparity then moderated from 2002-2005 (EAPC = -3.0, 95% CI: -7.0, 1.2) and began to rise again from 2006-2013 (EAPC = 1.9, 95% CI: 0.4, 3.4). The Hispanic-white disparity also increased from 1984 to 1997 (EAPC = 4.5, 95% CI: 3.4, 5.6), but has gradually declined since 1998 (EAPC = -1.2, 95% CI: -2.0, -0.3).

Conclusions/Implications: Because AIDS diagnoses is a downstream indicator capturing multiple levels of the HIV care continuum simultaneously, increases in the disparity of AIDS diagnoses are likely due to existing and emerging inequalities across various components of the continuum. From the mid-1980s through the early 2000s, growing disparities were likely a result of racial/ethnic differences in access to HIV testing and HIV care services in the absence of widespread use of combination antiretroviral therapy. The more recent increase in the black-white disparity from 2006-2013 might represent persistent inequalities in the care continuum – particularly linkage to care, retention in care, and viral suppression. Alternatively, a part of this increasing trend may also be related to the growing number of HIV diagnoses among young black men who have sex with men if these men are diagnosed with or quickly progressing to AIDS. To monitor goals of the NHAS, disparities in new AIDS diagnoses may be useful as a high-level measure to capture changes at multiple levels of the care continuum collectively.

Future research should also examine indicators of disparities at each step of the continuum in order to better identify which components drive racial/ethnic disparities and require targeted interventions.

Abstract 2171 - HIV Rates among Heterosexuals: Quantifying Burden of Disease and Disparities among Groups

Author(s): Amy Lansky, Christopher Johnson, Emeka Oraka, Catlainn Sionean, M. Patricia Joyce, Elizabeth DiNenno, Nicole Crepaz

Background: This study estimated the proportions and numbers of heterosexuals in the United States to calculate rates of heterosexually acquired HIV infection. Quantifying the burden of disease and disparities among subgroups can inform effective prevention planning and resource allocation.

Methods: Our definition of heterosexual was created to best correspond to the HIV transmission category used for surveillance in order to calculate disease rates. Heterosexuals were defined as males and females who ever had sex with an opposite-sex partner and excluded those with other HIV risks: persons who ever injected drugs and males who ever had sex with another man.

Based on previous work developing HIV risk group population estimates, we identified 3 national probability surveys providing data on lifetime (ever) sexual activity and injection drug use among persons aged 15 years and older to determine the proportion of the United States population classified as heterosexual. We then applied the proportion of heterosexual persons to census data for persons aged 13 years and older to produce population size estimates. National HIV infection rates among heterosexuals were calculated using surveillance data (cases attributable to heterosexual contact) in the numerators and the heterosexual population size estimates in the denominators.

Results: Adult and adolescent heterosexuals comprised an estimated 86.7% (95% confidence interval [CI]: 84.1%-89.3%) of the U.S. population. The estimate for males was 84.1% (CI: 81.2%-86.9%) and for females was 89.4% (CI: 86.9%-91.8%). The population proportion of heterosexuals did not differ significantly by race/ethnicity among males or females. The population proportion of heterosexuals was lowest among both males and females aged 15-24 years (70.2% [CI 65.4 – 74.9] and 72.1% [CI 68.6 – 75.4%], respectively).

The HIV diagnosis rate was 6.0 per 100,000 heterosexuals and the rate of persons living with diagnosed HIV infection was 102 per 100,000 heterosexuals. Rates of HIV infection were >20 times as high among black heterosexuals compared to white heterosexuals, indicating considerable disparity. The diagnosis rate ratios comparing blacks and Hispanics to white males are considerably higher among heterosexual men (34.8 and 6.2 per 100,000 population, respectively) than men overall (7.8 and 3.0, respectively), as rates among men overall are affected by infections attributable to male-male sexual contact (comprising 79% of diagnoses among men). Because >80% of infections among women are attributed to heterosexual contact, the rates for female heterosexuals look very similar to population-based rates for females.

Conclusions/Implications: The best available data must be used to guide decision making for HIV prevention to allocate resources according to burden of disease and address disparities. HIV rates

among heterosexuals in the U.S. are important additions to cost effectiveness and other data used to make critical decisions about resources for prevention of HIV infection.

Abstract 2254 - Examining Disparities across the HIV Care Continuum in Washington State: Foreign-Born Latinos among the Most in Need

Author(s): *Jason Carr, Lydia Guy-Ortiz, Marcos Martinez*

Background: The Washington State Department of Health (DOH) defines health disparities as differences in health or well-being which are associated with social, economic, or environmental disadvantage. HIV-related health disparities are those which are associated to the treatment or prevention of HIV, particularly outcomes along the state's HIV Care Continuum. In accordance with the National HIV/AIDS Strategy, Washington State is committed to the elimination of all HIV-related disparities.

Methods: As part of Washington State's HIV Planning System, DOH recently convened the HIV-Related Special Emphasis Workgroup (SEW). Composed of 7 subject matter experts, the SEW met three times between December 2014 and February 2015. Using a combination of HIV surveillance data and U.S. Census data, and supported by DOH surveillance and program staff, the group conducted a broad-scale epidemiologic analysis, examining potential disparities with regard to 6 key indicators: rates of new HIV diagnosis, late HIV diagnosis, linkage to care, engagement and retention in care, and viral suppression. For each indicator, populations were stratified by various demographic and risk characteristics, including sex, race/ethnicity, age, foreign-born status (combined with race/ethnicity), geography, mode of exposure, income, poverty, and educational achievement. Depending on the indicator, the SEW evaluated new HIV cases diagnosed between 2009 and 2013, or prevalent HIV cases as of year-end 2013.

Results: Some of the largest HIV-related health disparities observed by the SEW occurred among Latinos (all races) who were born outside the United States. New HIV diagnosis rates among foreign-born Latinos (20.4 per 100,000 residents) were more than 3-times higher compared to either non-Latino whites (6.0 per 100K) or U.S.-born Latinos (5.6 per 100K) during the same time frame. Foreign-born Latinos were also nearly twice as likely vs. U.S.-born Latinos (43% vs. 24%) to be a late HIV diagnosis, meaning they were diagnosed with both HIV and AIDS within a 12-month period. Although more than 90% of all Latinos were successfully linked to care within 90 days of HIV diagnosis (no disparity observed), foreign-born Latinos living with HIV in 2013 were significantly less likely to be engaged (65%) or retained in care (51%) compared to their U.S.-born counterparts (79% and 59%, respectively), and were the least likely of any racial/ethnic group to have had a test result indicating viral suppression within the past 12 months (55%).

Conclusions/Implications: The degree of disparity experienced by foreign-born Latinos surprised both HIV planners and DOH staff, and emphasized the need for timely and effective action. In March 2015, the SEW presented DOH with a detailed report describing the group's finding and recommendations on how to reduce them. These included that DOH develop ways to: 1) assure HIV medical providers in Washington are trained to deliver linguistically- and culturally-appropriate health care to foreign-born Latinos, 2) improve HIV screening and health literacy among foreign-born Latinos, 3) develop community

engagement strategies that will reduce HIV-related stigma within this population, and 4) to convene a follow-up SEW composed of members with the appropriate level of expertise to address the unique HIV prevention and care needs of foreign-born Latinos living in Washington State.

Track B

Session B13 - Barriers to Care Engagement and Viral Load Suppression, and Innovative Efforts to Overcome Them

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1276 - Factors Affecting Levels of HIV Care Engagement and Retention among U.S. MSM Living with HIV

Author(s): *Paula Frew, Alisu Schoua-Glusberg, Katherine Kenward, Diane Saint-Victor, Damian Denson, Elizabeth Gall, Nicole Pitts, Susan Berkowitz, Jay Schamel, James Carey, Deborah Gelaude*

Background: Although persons living with HIV have better individual health outcomes and are less able to transmit the virus to others if they receive treatment, many do not receive medical care. Among U.S. adults >18 years living with HIV in 2011, 38% of men who have sex with men (MSM), 40% of black/African Americans, and 40% Hispanic/Latinos were engaged in HIV medical care. This study identified factors affecting care engagement and retention among racial/ethnic minority MSM.

Methods: Purposive sampling was used to recruit Hispanic/Latino and black/African American adult MSM in various stages of their HIV care and treatment in five high-prevalence metropolitan areas (Atlanta, Baltimore, Chicago, Los Angeles, and Washington, D.C.). We conducted in-depth qualitative interviews and short socio-demographic surveys. Based on interview transcript content, we divided the sample into three groups: 1) "Care-Engaged" men reported high compliance with attendance at routine doctor visits, obtaining corresponding labs, and taking ARVs, if prescribed, according to prescription schedule; 2) "Care-Inconsistent" men did not regularly attend routine doctor visits, obtain corresponding labs reports, and took ARVs intermittently and not according to prescription schedule; and, 3) "Care-Detached" men reported general noncompliance with routine doctor visits and corresponding labs, or intentionally delayed initiation or refused ARV medications due to their own volition. Using NVivo software, we coded the qualitative data to identify common HIV care barriers and facilitators described by the men in all three groups. We present and compare illustrative quotes showing these common themes.

Results: From June to August 2014, we enrolled 84 MSM who were Hispanic/Latino (43%), black/African American/non-Hispanic (55%), and ethnicity other (2%). A majority were >36 years (71%) and had post-high school education (58%). Most used public assistance (67%) and did not possess stable housing (60%). Nearly half did not possess health insurance or experienced insurance lapses in the past 12 months (46%).

Care-Engaged MSM tended to be >36 years. Our qualitative analyses showed that older black/African Americans more often were Care-Engaged compared with Hispanic/Latinos, as were those with some college education compared with no college. Care-Engaged men frequently described strong personal

health motivation, high self-efficacy, good provider relationships, formalized care plans, medication management strategies, strong personal and community-based programmatic support, and structural support (e.g., housing, transportation). Care-Inconsistent men typically described strong health motivation, some self-efficacy, good provider relationships, and social and community-based programmatic support, and some structural support. Care-Detached tended to be young black/African Americans, and often had no college education. Care-Detached men less commonly accepted their HIV status; they also expressed lower health motivation, lower self-efficacy, and less structural support.

Conclusions/Implications: Our analysis identified self-reported qualitative factors that characterize Care-Engaged, Care-Inconsistent, and Care-Detached MSM. These include personal health motivation, HIV status acceptance, self-efficacy, strong patient-provider relationships, and personal, community or structural programmatic support. Some trends varied between age and education subgroups. Different MSM patient groups may have unique needs. Well-tailored HIV services for MSM patients may promote better individual health outcomes and improve care-continuum success, as well as potentially increasing clinic operating efficiency.

Abstract 1365 - The Patient-Centered HIV Care Model Project: a Collaboration between Community Pharmacists and HIV Clinical Providers

Author(s): *Kathy Byrd, Glen Pietrandoni, Patrick Clay, Michael Shankle, Ambrose Delpino, Kristin Darin, Kim Scarsi, Michael DeMayo, Carmelita Whitfield, Paul Weidle*

Issue: Antiretroviral therapy and monitoring of CD4 cell count, HIV viral load, adverse drug events and adherence form the backbone of medical management of HIV infection. Studies have demonstrated that pharmacist involvement with these services improves patient outcomes. Support for these services can be provided to HIV-infected patients through community pharmacist-managed HIV Medication Therapy Management (MTM) in collaboration with primary clinical providers. MTM comprises a broad range of pharmacist-delivered services intended to optimize therapeutic outcomes for individual patients. MTM can include monitoring prescription filling patterns and timing of refills, checking for medication interactions, patient education, and monitoring of patient response to drug therapy. Given the potential for such collaborative arrangements to lead to improvement in patient outcomes along the continuum of HIV care therapy, efforts to develop and evaluate such models are imperative.

Setting: The Patient-Centered HIV Care Model project is a public-private collaboration between CDC, Walgreens pharmacies and the University of North Texas Health Science Center to develop and implement a model of care that increases collaboration between community pharmacists and HIV clinical providers. The goal of the project is to increase retention in HIV care, adherence to HIV therapy and viral load suppression among minority populations. The project takes place in 10 project sites in 10 cities: Albany, GA; Chicago, IL; Ft. Lauderdale, FL; Kansas City, MO; Miami, FL; New York, NY; Palm Springs, CA; Philadelphia, PA; St. Louis, MO; Washington DC. Pharmacies are co-located in the clinic or in the community.

Project: Clinics identify eligible and willing patients taking antiretroviral therapy to participate in the program. Walgreens will provide expanded MTM services for 1000 patients for up to 24 months, which include a comprehensive medication review and quarterly visits with each patient. Partnered

pharmacies and clinics share patient information necessary for more effective MTM. Types of information shared include laboratory test results (e.g., CD4 cell count, HIV viral load, hepatitis serologies, renal function tests), immunization history, past antiretroviral therapy regimens and social history. Data will be collected throughout the project period and will be used to adjust the project model and to determine and compare program outcomes within the project cohort.

Results: We are developing a model that integrates community pharmacists with HIV clinical providers in public and private clinics. The project builds upon the established MTM model and bolsters existing and establishes new collaborative relationships between community pharmacists and HIV clinical providers. As of April 2015, of more than 324 persons referred to a project pharmacist for MTM, 144 patients have completed their first MTM session.

Lessons Learned: Pharmacists and HIV clinical providers report frequent and meaningful communication and collaboration. Early findings are that pharmacists have corrected improper medication administration by the patients, and improved patients' understanding of complex medication regimens. The project team will continue to evaluate this novel model of patient-centered HIV care.

Abstract 1692 - Drilling Down the Data: Understanding Barriers to Viral Load Suppression Among HIV Patients Retained in Care

Author(s): *Aviva Joffe, Jody Borgman, Catherine Holdsworth, Bertha Jackson*

Background: The Immunodeficiency Center (IDC) is an outpatient HIV clinic in North Philadelphia affiliated with a large hospital network. HIV/AIDS prevalence in Philadelphia is 1,282 per 100,000 through December 2013 (Philadelphia Department of Public Health). The IDC service area includes zip codes with prevalence ranging from 36 per 10,000 to 352 per 10,000 through December 2011 (Philadelphia Department of Public Health). Annually, the IDC serves 750 adults living with HIV/AIDS. The majority are African American (86%) over age 45 (65%) living below 100% of the federal poverty level (71%). Viral Load Suppression (VLS) is the clinical goal and primary indicator of high quality HIV care. An undetectable HIV viral load correlates with positive health outcomes and decreased viral transmission, and is achieved by adherence to Antiretroviral Therapy (ART) (Montaner et al., 2014). Research indicates that mental health, active substance abuse, interpersonal violence, food insecurity, and avoidance-oriented coping adversely impact adherence to ART and consequently VLS (Sullivan et al., 2015; Arnsten et al., 2002; Weaver et al., 2005; Weiser et al., 2013). Few studies, if any, look at individual barriers to VLS through a quality improvement lens, a perspective that seeks to identify areas for healthcare provider intervention. This research sought to uncover the factors that impede retained IDC patients from reaching VLS, the end of the treatment cascade, with the intention to inform quality improvement efforts.

Methods: Data analysis of all IDC patients with a medical visit in the last year was conducted using the VLS metric (Core 01) defined by the HAB/HRSA. Patients not meeting the metric were divided into 2 groups: lost-to-care (>180 days) and engaged in care (<180 days). IDC primary care providers performed a retrospective review of 42 charts of those engaged in care. A survey tool was used to gather relevant clinical indicators and barriers to VLS. Reasons for an unsuppressed viral load were collected and coded thematically.

Results: As of March 2015, 81.5% (n=613) of IDC patients met the VLS metric. Those not meeting the metric (n=139) either had a viral load >200 copies (n=112) or were missing a viral load test for the year (n=27). Of the 18.5% (n=139) who did not meet the metric, 27% (n=38) were lost-to-care and 72% (n=101) were engaged in care. The review of 42 charts of the unsuppressed and retained in care found: 21% (n=9) were new to ART or were re-starting treatment and 17% (n=7) refused ART. Only 7% (n=3) were unsuppressed due to medical failure (underlying regimen resistance). Over half (55%, n=23) faced psychosocial issues, including insurance barriers (n=3), mental health/chaotic living (n=10), and poor motivation (n=10).

Conclusions/Implications: Some patients who are engaged in medical care and prescribed ART, unfortunately, still have a detectable viral load. Psychosocial stressors, including chaotic living, mental health, and poor motivation significantly impede patients retained in care from adhering to ART and reaching VLS. Targeted, individualized, interdisciplinary interventions are being developed based on these findings to improve VLS in order to decrease viral transmission and positively impact the morbidity and mortality of HIV/AIDS.

Abstract 2419 - The Effects of Financial Incentives on Viral Load Suppression among Homeless People Living with HIV

Author(s): *Toorjo Ghose, Virginia Shubert, Vaty Poitevien, Megan Stanton, Sambuddha Chaudhuri, Charles King*

Background: This study examines the effectiveness of financial incentives in bringing about viral suppression (less than 50 copies/ml) among homeless people living with HIV/AIDS (PLWHA). The Viral Load Suppression project is an ongoing 24-month demonstration project with 700 homeless PLWHA at a large HIV-service agency in New York city . While the evidence on the association between financial incentives and viral load suppression is mixed, previous efficacy studies have not examined the effectiveness of this intervention in natural settings. We hypothesize that financial incentives are effective in establishing viral load suppression, when combined with psychosocial and primary care services in an agency providing care for PLWHA.

Methods: Using each participant as his or her own control, we assessed viral load every 3 months starting 6 months prior to VLS Project enrollment and continuing for up to 12 months after enrollment. The 6 month pre-intervention time-line establishes an extended and stable baseline, and allows us to control for the effects of engagement with the agency's services prior to enrollment in the incentive program. We utilized the proportion of time-points with undetectable viral load (a version of copy years viremia) as a measure of viral suppression.

Results: The proportion of participants who had experienced suppression at all time-points increased from 27% over the 6 month period prior to baseline, to 54% in the 6 months after enrollment ($p<.0001$). Proportion of time-points with undetectable viral loads increased from 57% to 67% from baseline to 12 months after enrollment ($p<.0005$). The costs of the incentive program were offset by the decrease in costs due to decreased transmission of the virus.

Conclusions/Implications: Financial incentives in real-world settings in agencies where they motivate clients to engage with available services may be an effective, and cost-effective intervention. Our results indicate the benefits of implementing a similar program in agencies providing services to homeless PLWHA who face multiple social and structural barriers to medication compliance.

Session B15 - Studies in HIV Testing: Routine Testing, Improving Testing in Emergency Departments, and What Works for MSM

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 1214 - Factors Associated with Routine HIV Testing Among Healthcare Providers

Author(s): *Chassidy Hanley, Anna MacMonegle, Tanesha Tutt, Jennifer Gard-Read, Kimberly Leeks, Brian Southwell, JoEllen Stryker, Nick DeLuca*

Background: The Centers for Disease Control and Prevention (CDC) estimates that more than 1.2 million people in the United States are living with HIV and 14% of these individuals are unaware of their HIV-positive status. Identifying new HIV infections is an important step to improve health outcomes of HIV-positive individuals and decrease transmission of HIV. In 2006, the CDC recommended that healthcare providers screen all patients aged 13-64 for HIV. In an effort to increase uptake of HIV screening recommendations, CDC issued a continuing medical education program (CME) emphasizing routine screening for African American/black and Hispanic/Latino patients. This study examines potential mediating factors associated with routine screening among providers 3 months after CME completion.

Methods: From November 2013 to February 2014, an online survey was administered to physicians, nurse practitioners, and registered nurses (N=298). The survey was conducted as a 3-month post-test for providers who completed a CME program. The outcome variable was routine HIV screening. Predictor variables included provider characteristics, knowledge, and beliefs. We assessed bivariate relationships between routine screening and provider characteristics and predicted routine screening as a function of knowledge and beliefs items using logistic regression, adjusting for provider characteristics.

Results: The sample consists largely of physicians and registered nurses (42.0% and 44.0%, respectively) with a smaller portion of nurse practitioners (14.1%). Physicians were significantly more likely to report routine HIV screening (45.6%) than registered nurses (29.8%). The majority of respondents were white (60.4%), followed by African American/black (11.4%), Hispanic/Latinos (8.7%), and other or multiple races (19.5%). African American/black respondents were significantly more likely to report routine screening (64.7%) than their white (32.8%) or Hispanic/Latino (34.6%) counterparts. After adjusting for provider characteristics, respondents were more likely to report routine screening if they held certain knowledge and beliefs, compared to those who did not. In particular, respondents were more likely to report routine HIV screening if they: 1) were aware of CDC's recommended screening practices (OR = 4.2, 95% CI = 2.1, 8.6, $p < 0.001$); 2) were knowledgeable about high-risk groups (OR = 2.0, 95% CI = 1.1, 3.7, $p < 0.05$); 3) believed in specific benefits to routine screening (e.g. stigma reduction) (OR = 2.4, 95% CI = 1.1, 5.2, $p < 0.05$); and 4) had higher self-efficacy to talk about screening with their patients (OR = 2.0, 95% CI = 1.1, 3.4, $p < 0.05$). Two other beliefs about the benefits of HIV screening were not significant: the belief that routine screening can help to prevent HIV transmission and belief about patient benefits of HIV testing.

Conclusions/Implications: Awareness of screening recommendations and favorable beliefs toward routine screening were demonstrated following participation in an online CME course that targeted these factors. Increasing knowledge of screening recommendations, risk groups, and beliefs regarding self efficacy and benefits of reducing stigma are likely useful approaches for CME programs that aim to promote routine screening amongst healthcare providers. It may also be beneficial for CMEs to target providers who currently do not report routinely screening for HIV (e.g. white providers).

Abstract 1353 - Time since Last HIV Test among Predominantly Black MSM Recruited Through Sociocentric Networks

Author(s): *Pamela Klein, Maria Pacella, Sergey Tarima, Chris Sanders, Michelle Broaddus, Julia Dickson-Gomez, Yuri Amirhanian, Jeffrey Kelly*

Background: The CDC recommends HIV testing every 6 months for high risk individuals, including men who have sex with men (MSM). Most studies of HIV testing among MSM have been based on convenience or venue-based sampling, and have been limited to sociodemographic predictors. To address these limitations, the current study examined diverse predictors of time since last HIV test in a sample of predominantly Black MSM recruited through sociocentric networks.

Methods: Data were collected between 2012 and 2014 as part of a baseline assessment for “Connections Creating Change (C3)”, a randomized controlled trial of a network-based HIV prevention intervention designed for Black MSM in three cities: Milwaukee, WI, Cleveland, OH, and Miami Beach, FL. Network seeds were identified at community venues known to be meeting points of Black MSM; sociocentric networks were recruited by reaching out three waves from each initial Black MSM seed. Participant interviews included measures of demographic characteristics, sexual risk practices, substance use, theory-based AIDS risk-related scales, and psychosocial contextual scales. The primary outcome was time since last HIV test, calculated as the difference between the self-reported date of last HIV test and the date of interview. Linear regression with random social network effect was used to identify predictors of log-transformed time since last HIV test. To address potential differences in HIV prevention and risk behaviors, all analyses were a priori stratified by whether or not men reported having a main male partner.

Results: This study included 323 men who reported being HIV negative or unaware of their HIV status and reported a date of their last HIV test during the baseline assessment, representing 69.6% [n=323/464] of participants recruited for the larger trial by January 2014. The majority of participants identified as African American (83.6%, n=270/323); 40.1% (n=131/323) reported having a main male partner. Overall median time since last HIV test was 6 months (interquartile range [IQR]: 3-12 months). Among men with a main male partner, the median time since last HIV test was 6 months (IQR: 3-9.5 months); a 1-point increase in the religiosity score was associated with a 5% shorter time since last HIV test time (95% confidence interval [95% CI]: 2-8%) while a 1-year increase in age was associated with a 3% longer time since last HIV test (95% CI: 0-6%). Among men without a main male partner, the median time since last HIV test was 5.5 months (IQR: 3-12 months) and a 1-point increase in the HIV-related knowledge score was associated with a 13% shorter time since last HIV test (95% CI: 5-21%).

Conclusions/Implications: Approximately half of the MSM enrolled in the study adhered to the CDC guidelines for HIV testing every 6 months. The unique predictors of time since last test for men with (i.e., religiosity and age) and without a main male partner (i.e., HIV-related knowledge) may inform the design of HIV testing and prevention interventions for each subgroup. Social network-based recruitment may expose otherwise hidden networks of Black MSM to HIV testing and prevention interventions.

Abstract 1738 - Effectiveness of HIV Testing Strategies for Men who have Sex with Men (MSM): An Overview of Systematic Reviews

Author(s): *Theresa Sipe, Emiko Kamitani, Darrel Higa, Nicole Crepaz, Julia DeLuca*

Background: It is estimated that in 2011 there were approximately 1.2 million people living with HIV in the United States. Of those, 57% are MSM; 66% of all new HIV infections occur in MSM each year. Approximately 1 in 6 people living with HIV do not know their HIV status. The purpose of this systematic review of systematic reviews is to determine effective HIV testing strategies for MSM.

Methods: We followed systematic review methods and conducted a comprehensive search for systematic reviews using electronic databases and manual searches. Since the primary study literature is large and many systematic reviews have been conducted, we decided to conduct a systematic review of systematic reviews. We included systematic reviews published between 2000 and 2013 that evaluated effectiveness of HIV testing in MSM. Two coders independently double-abstracted data.

Results: The systematic search yielded 1180 citations; we screened 687 citations at title and abstract after duplicate removal and 310 citations at full report. Nine systematic reviews representing 37 unique primary studies met inclusion criteria. Preliminary synthesis suggests that the following interventions demonstrated evidence of effectiveness: policy (e.g., policy change from opt-in to opt-out testing), media (e.g., HIV testing social marketing campaigns) and self-testing interventions. Other types demonstrated mixed results (i.e., brief interventions) or null results (i.e., peer interventions).

Conclusions/Implications: We identified several effective strategies for increasing numbers of MSM tested for HIV across the systematic reviews. Evidence from this systematic review may be used to inform recommendations on effective interventions for HIV testing among MSM

Abstract 2069 - Increasing HIV Testing Among Emergency Department Patients Aged 18-24 years, Who Initially Decline

Author(s): *Ian Aronson, Charles Cleland, David Perlman, Molly Forlines, Philip Junho Lee, Chang Yoon Moon, Wendy Sun, Theodore Bania*

Background: Although youth face disproportionate HIV risk, more than half of HIV infected young people remain unaware of their infection. Further, African American youth not only have higher HIV risk, but also as a group, are less likely to test. As a result, new interventions are needed to reduce barriers to testing for youth and HIV-related health disparities.

Emergency department (ED) testing programs are intended to reach patient populations, including youth, who may have limited or inconsistent access to healthcare. New York State law requires healthcare providers to offer HIV testing to all patients, with limited exceptions, yet far more ED patients

decline than accept, particularly patients aged 18-24. The current study hypothesized that young ED patients who declined HIV tests offered at triage would accept HIV tests after completing a brief, theory-guided, technology-based intervention targeted to youth and designed to address possibly erroneous perceptions of low HIV risk, a key factor in declining HIV testing.

Methods: During 23 days of data collection shifts in March and April 2015, research assistants (RAs) approached all eligible patients aged 18-24 years who declined tests offered by a triage nurse. Study participants (N=100) used tablet computers to enter basic demographic information, respond to pre-post-intervention knowledge test questions about HIV testing and prevention, and view a brief video (approximately 90 seconds) about the importance of HIV testing. The video, guided by the Information, Motivation, and Behavioral Skills (IMB) model, depicted a young African American physician speaking with a young African American patient, emphasizing that anyone who has sex, including young people who look and feel healthy, can potentially get HIV, and that the only way people can know their status is to test.

Results: RAs approached 206 eligible patients who had declined HIV tests at triage, 48.54% agreed to participate in the study. The sample was 66% female, and 46% self-identified as Black or African American. Participants required a mean of 8 minutes and 28 seconds to complete the intervention. Thirty percent (n=30) agreed to an HIV test offered by computer at the end of the intervention.

Conclusions/Implications: A brief, theory-guided, technology-based intervention can increase HIV test rates among young ED patients who declined tests offered at triage. Additional research is warranted to examine how brief interventions can be further refined to increase test rates among other at risk, inconsistently engaged populations in other settings, and to do so with sustainable systems that can be widely implemented.

Session B18 - PrEP Utilization and Monitoring in MSM

Room: Embassy E/F (Hyatt Regency Atlanta)

Abstract 1524 - Validation of a Truvada for PrEP algorithm through Chart Reviews from an Electronic Medical Record

Author(s): *Robertino Mera-Giler, Tara MacCannell, David Magnuson, Staci Bush, David Piontkowsky*

Background: Tenofovir/Emtricitabine (TVD) combination was approved for a Pre-exposure Prophylaxis (PrEP) indication in the US in July 2012. There are no pre-defined PrEP-specific ICD9 or procedure codes to separate PrEP TVD monotherapy from treatment of HIV+ or Chronic Hepatitis B (CHB) or Post-Exposure Prophylaxis (PEP).

Methods: A previously described algorithm of exclusion was developed in order to identify periods of exposure where TVD monotherapy was continuously used for PrEP. This study was designed to validate an algorithm through a chart review using an Electronic Medical Record. The algorithm had been previously utilized in a large claims database. Two investigators independently reviewed each chart for subjects who were prescribed TVD and assigned each exposure period as a) PrEP, b) HIV+, c) CHB, or d) PEP. A descriptive analysis and multivariate statistics were performed to characterize significant ICD9 or

procedures codes associated with PrEP". All analyses are reported at the exposure period level since a subject may have multiple diagnoses in sequence (PrEP and later HIV positive if he/she seroconverts).

Results: A total of 10,645 subjects were prescribed TVD (13,671 exposure periods) after January 1, 2012 and were considered for analysis. The algorithm identified 94.4% exposure periods as belonging to an HIV+ subject; 5.3% as PrEP exposure, and 0.21% and 0.1% as CHB and PEP, respectively. The investigators reviewed all PrEP, CHB, PEP charts/exposure periods and a randomly selected 1% of the HIV+ charts (a total of 810 subjects with 916 exposure periods). The algorithm was able to correctly classify 97.3% of all exposure periods, with a sensitivity of 75% and a specificity of 98.5%. The algorithm misclassified 4.6% of PrEP exposure periods as CHB; 8.2% as HIV+ (short periods of TVD monotherapy on an HIV+ subject). There was not enough evidence to assign a classification on 4.7% of all PrEP periods. Moreover, the investigators considered that 9.3% of mostly 1 month TVD monotherapy exposure periods among HIV- subjects corresponded to high risk sexual exposure PEP. The latter group was significantly associated with ICD9 codes such as V01.6/V01.79/V01.9. A multivariate logistic model showed that codes independently associated with PrEP were ICD9s V69.2/V15.85/V15.89/V04.89 and procedure codes 9940* and 9939*. Code V69.2 (high risk sexual behavior) was present in 23.2% of all PrEP exposure periods but only in 0.67% of HIV periods and no CHB nor PEP periods. V69.2 was 47.5 times more likely to be included in PrEP exposure periods than any other periods (95% CI 36.1 – 62.5). Procedures such as 99401/99402/99403 were present in 29.4% off all PrEP periods and were 33.2 times more likely to be present (95% CI 25.2 – 43.8) than all non-PrEP exposure eras combined.

Conclusions/Implications: An algorithm of exclusion to identify PrEP usage for administrative databases was found to be very specific and highly sensitive. The chart review concluded that most short-term periods of TVD monotherapy in HIV negative subjects were PEP for sexual exposure, and that some specific ICD9 and procedure codes are associated with PrEP TVD prescriptions.

Abstract 1769 - PrEP and PEP Awareness and Uptake, and Correlates of Use, among a Large Sample of Black Men who Have Sex with Men

Author(s): Lisa Eaton, Amy Herrick, Leigh Bukowski, Derrick Matthews, Daniel Driffin, Patrick Wilson, Ron Stall, POWER Study Team

Background: Although Pre Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP) are effective and available forms of HIV prevention, these approaches remain largely underutilized by individuals at-risk for HIV transmission. Further, there is limited empirical work that delineates what factors relate to PrEP and PEP awareness and uptake among populations in need. In this study, we sought to examine correlates of PrEP and PEP use among a large, multi-city sample HIV negative/unknown status Black men who have sex with men (BMSM).

Methods: The current paper presents data from an ongoing multi-site, community-based sample of BMSM collected in 2014 at Black Pride events in Atlanta, GA; Detroit, MI, Houston, TX, Philadelphia, PA, and Washington, DC. This study employed random time-location sampling to maximize representativeness of BMSM attending these events. Participants completed an anonymous questionnaire via an electronic tablet and were compensated \$10 for their time. BMSM reporting HIV negative/unknown HIV status were included in the current paper, N=1,281. We used bivariate and

multivariate generalized linear modeling to examine whether demographic factors (e.g. age, income, education) or sexual risk taking (frequency of condom use, receptive or insertive anal sex) factors were related to PrEP and PEP awareness and uptake. This study was approved by the University of Pittsburgh Institutional Review Board.

Results: In regards to PrEP and PEP related findings, 38% of participants had heard of PrEP, 4.6% were currently using it, 4.6% had ever used it, and 11% knew someone who had used it; 28% of participants had ever heard of PEP, 4.8% had ever taken it, and 8.9% knew someone who had taken it. Our analyses demonstrated that greater frequencies of condom use during anal sex as the receptive partner (OR=1.12, 95%CI 1.01-1.24) and as the insertive partner (OR=1.11, 95%CI 1.01-1.23) were associated with a greater likelihood of being aware of PrEP. Further, lower frequency of condom use during receptive anal sex was associated with a greater likelihood of being on PrEP (OR=1.33, 95%CI 1.10-1.64). Sexual risk taking was not associated with PEP awareness or uptake. PrEP and PEP awareness and uptake were all strongly associated with educational attainment and income.

Conclusions/Implications: Our findings offer multiple insights into the state of coverage of PrEP and PEP among a large sample of BMSM. Overall, awareness and uptake of these HIV prevention strategies continue to lag and evidence from our study suggests that PrEP may not be reaching those in greatest need of it; we found that lower frequencies of condom use were associated with less likelihood of being aware of PrEP. Importantly though, among BMSM who are using PrEP, it does appear to be reaching BMSM who could benefit most from it, i.e. men who are reporting low frequency of condom use during receptive anal sex. In order to slow the HIV epidemic among BMSM, we must place greater emphasis on engaging all BMSM to ensure we are not missing those who are in greatest need of prevention interventions.

Abstract 1829 - Low PrEP Utilization among Social Media-Using Young Adult Black, Hispanic and White MSM at Higher Risk for HIV Acquisition

Author(s): *Roland Merchant, Melissa Clark, Joshua Rosenberger, Tao Liu, Jose Bauermeister, Kenneth Mayer*

Background: The Centers for Disease Control and Prevention (CDC) recommend that healthcare providers consider prescribing HIV pre-exposure prophylaxis (PrEP) to men-who-have-sex-with-men (MSM) who are at higher risk of HIV infection acquisition, particularly MSM who do not use condoms or use them inconsistently, have a relatively high number of sexual partners, or engage in commercial sex work. The high incidence and prevalence of HIV among young adult Black, Hispanic and white MSM in the United States necessitates recognizing these young men as an important target population for HIV PrEP. Understanding current PrEP utilization in comparison to risk among these men can help shape intervention efforts. Among a national sample of young adult social media-using black, Hispanic, and white MSM, we assessed their history of using HIV PrEP in relationship to their history of condomless sex with other men, and examined factors associated with greater likelihood of their ever using PrEP.

Methods: 18-24 year-old MSM were solicited from across the United States using eight social media platforms through advertisements, email messages, and postings from August to December 2014. These MSM were study eligible if they self-identified as Black, Hispanic or white; lived in the United States;

ever had anal sex with another man; and were not known to be HIV infected. Participants completed the online study questionnaire anonymously in either English or Spanish. The survey queried participants about their demographic characteristics; sexual HIV risk behaviors with main, casual, and exchange partners; and HIV PrEP utilization. Multivariable logistic regression models were constructed to identify demographic and sexual history factors associated with greater HIV PrEP utilization. Odds ratios (ORs) with corresponding 95% confidence intervals (CIs) were estimated.

Results: Of the 2,380 participants, 19% were black, 37% were Hispanic, and 44% were white. Among all participants, 89% of Black, 85% of Hispanic, and 86% of white MSM reported a lifetime history of condomless sex with any male. Median number of lifetime condomless male sexual partners was Black (4, IQR [1-10]), Hispanic (5, IQR [2-13]) and white (5, IQR [1-12]). PrEP utilization among those reporting condomless sex with casual or exchange male sexual partners in their lifetime were: Black (2.6%), Hispanic (3.3%) and white (3.7%). In multivariable logistic regression models, greater HIV PrEP utilization was associated with having a primary healthcare provider (OR 4.73; 95% CI: 1.99-11.25) and lifetime history of condomless sex with any man (OR 2.84; 95% CI: 1.02-7.91), but was not associated with age, ethnicity/race, having healthcare insurance, years of formal education, population size of the community in which they lived, or history of HIV testing.

Conclusions/Implications: Among these social media-using young adult Black, Hispanic and white MSM, PrEP utilization was low, even though many appear to be at substantial risk of acquiring HIV from sex with other men, particularly from casual or exchange sexual partners. Interventions to increase knowledge, access, and utilization of PrEP among this higher risk population appear needed.

Abstract 2087 - Trends in Awareness and Use of Pre-Exposure Prophylaxis, New York City (NYC), 2012-14
Author(s): *Nana Mensah, Kathleen Scanlin, Zoe Edelstein, Paul Kobrak, Julie Myers*

Background: Pre-exposure prophylaxis (PrEP) is an important new HIV prevention intervention, particularly for individuals at highest risk, like men who have sex with men (MSM). The NYC Department of Health and Mental Hygiene (DOHMH) has routinely measured awareness and use of PrEP among young MSM since its FDA approval in 2012. We examined time trends and associations with PrEP awareness and use among MSM in NYC between 2012 and 2014.

Methods: Data are from 6 cycles of a semiannual online survey of NYC MSM, Spring 2012-Fall 2014. Respondents were recruited via banner ads on MSM social networking and hook-up sites/apps. Eligible respondents were NYC residents, aged 18-40, born male, who reported anal sex with a man in the past 6 months; for this analysis, MSM who reported HIV-positive status were excluded. Respondents were asked whether they were aware of PrEP and had used PrEP in the past 6 months. Time trends in awareness and use were assessed using multivariable logistic regression models with a continuous variable for survey cycle. Multivariable models were constructed to include demographic characteristics (age, race/ethnicity, highest level of education) that varied significantly across cycles or were significantly associated with the outcomes in bivariate models. Interaction terms with cycle were used to examine whether the time trend differed by characteristic; significant interaction terms were included in the final multivariable models.

Results: Among 1869 respondents over 6 cycles, 59.8% were aged 18-29 years; 22.9%, 16.1%, and 53.1% identified as black/non-Hispanic, Hispanic and white/non-Hispanic, respectively; 69.6% had greater than high school education. Awareness of PrEP increased significantly from 34.2% (n/N= 122/326) in Spring 2012 to 80.7% (n/N= 280/347) in Fall 2014. PrEP use also increased significantly from 1.6% (n/N = 5/311) in Spring 2012 to 6.6% (n/N = 23/348) in Fall 2014. Age and race/ethnicity varied significantly across cycles and were added to the multivariate models. In a multivariable model, PrEP awareness was significantly associated with more recent survey cycle (adjusted odds ratio (aOR)=1.5; 95% confidence interval (CI): 1.4-1.6), and with having greater than a high school education (aOR=2.1; 95%CI: 1.6-2.6) and older age (21-30 vs. 18-20 years-old: aOR=2.4; 95%CI: 1.5-3.9; 31-40 vs. 18-20 years-old: aOR=3.6; 95%CI: 2.2-5.9). The association between PrEP awareness and race/ethnicity differed over time, as indicated by a significant interaction term. No significant differences in awareness by race/ethnicity were found in Spring 2012. In Fall 2014, black/non-Hispanic respondents had a lower odds of reporting PrEP awareness when compared to white/non-Hispanic respondents (aOR=0.36; 95%CI: 0.19-0.71). In a multivariable model, PrEP use was significantly associated with more recent survey cycle (aOR=1.2; 95%CI: 1.1-1.5). No significant associations with PrEP use were seen with age, race/ethnicity or education.

Conclusions/Implications: Among MSM in NYC, awareness and use of PrEP have increased significantly since 2012. Increased awareness speaks to the success of PrEP education initiatives, including print and social media campaigns launched by the NYC DOHMH. While awareness is high, low levels of use have informed the development of multiple interventions to facilitate PrEP uptake among high risk MSM.

Session B19 - Seroadaptive Behaviors to Prevent HIV Transmission and Acquisition: Prevalence of Different Behaviors and Measurement

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1902 - A Single Seroadaptive Behavior Question to Examine the Prevalence and Protective Effect of Purposely Adopted Seroadaptive Behaviors among Men who Have Sex with Men

Author(s): *Christine Khosropour, Julia Dombrowski, David Katz, Lindley Barbee, Matthew Golden*

Background: Seroadaptive behaviors are common among MSM but the complexities in measuring these behaviors have typically prohibited their inclusion in short behavioral assessments employed in clinical settings.

Methods: We enrolled MSM aged >18 years attending an STD clinic in Seattle, Washington from 2013-2015 in a study of purposely adopted seroadaptive behaviors and HIV risk. Respondents completed a 10-minute, comprehensive computer-based seroadaptive behaviors questionnaire. HIV testing was performed per routine clinical care. As part of the questionnaire, we included a single summary question that asked HIV-negative MSM to indicate which of 10 seroadaptive strategies they purposely adopted in the past 12 months to reduce their risk of acquiring HIV: only insertive anal sex with all partners; used condoms with all partners; avoided sex with HIV-positive/unknown-status men; used condoms with all HIV-positive/unknown-status partners; insertive anal sex with all HIV-positive/unknown-status partners; only oral sex with HIV-positive/unknown-status partners. For behaviors captured in both the summary question and full questionnaire, we used the full questionnaire as the gold-standard to calculate the

sensitivity (number of men reporting the behavior in the summary question / number of men reporting the behavior in the full questionnaire) and specificity (number of men not reporting the behavior in the summary question / number of men not reporting the behavior in the full questionnaire) of the summary question. We compared proportions with Fisher's exact tests and used Poisson regression to calculate adjusted relative risks (aRR).

Results: We enrolled HIV-negative MSM at 3,018 (55%) of 5,535 eligible clinic visits. Compared to the full questionnaire, the sensitivity and specificity of behaviors in the summary question were: 80% and 76% for avoiding sex with HIV-positive/unknown-status partners, 76% and 80% for insertive anal sex with HIV-positive/unknown-status partners, 68% and 81% for oral sex only with HIV-positive/unknown-status partners, and 88% and 84% for condom use with all partners. From the summary question, the most commonly reported behaviors were: avoiding sex with HIV-positive (66%) or unknown-status (52%) men, and using condoms with HIV-positive (42%) or unknown-status partners (53%); 8% reported no seroadaptive behavior. Men tested newly positive for HIV at 38 (1.5%) of 2,463 visits. Using data from the summary question, men reporting no seroadaptive strategy had a significantly higher HIV test positivity (3.8%) compared to men who reported at least one strategy (1.3%; $P=0.02$). The HIV test positivity was lowest for men reporting only oral sex with HIV-positive partners (0.3%) or insertive anal sex with all partners (0.4%) and highest for men reporting avoiding sex with unknown-status partners (1.3%). Adjusting for all behaviors simultaneously, the risk of testing newly positive for HIV was significantly lower for men reporting avoiding sex with HIV-positive partners (aRR=0.4; 95% CI=0.2-0.9) and men reporting only insertive anal sex with all partners (aRR=0.2; 95% CI=0.03-1.0) than men not reporting these behaviors.

Conclusions/Implications: The single summary question performed relatively well against the full battery of questions and may be useful in clinical settings to counsel MSM on the benefits and/or risks associated with these behaviors.

Abstract 2078 - Serosorting Practices are Associated with Condom Use Among Young Black Men Having Sex Men and Residing in a Southern City with High HIV Prevalence

Author(s): *Richard Crosby, Leandro Mena, Laura Beauchamps, Angelica Geter, DeMarc Hickson, Timothy Brown, Courtney Sims*

Background: To determine whether young Black men scoring above the median on a scale of serosorting practices are less likely to use condoms for sex with males.

Methods: A convenience sample of 400 Black MSM (ages 16 through 29) completed a computer-assisted self interview in a private area of a clinic dedicated to sexual health. The questionnaire included a three-item measure assessing level of agreement/disagreement with statements suggesting that having a sex partner of the same HIV status lessens worries of HIV and the perceived need to use condoms. The scale had excellent inter-item reliability ($\alpha = .84$). Due to marked skewness, the distribution was dichotomized by a median split. Contingency table analyses and t-tests were used to determine whether those scoring above the median reported relatively less condom use.

Results: Of 387 men providing valid data, 186 (48.1%) scored above the median. These men were more likely to report: 1) having unprotected sex as a TOP in the past 90 days (37.9% vs. 21.0%; $P < .0001$), 2) having unprotected sex as a BOTTOM in the past 90 days (45.5% vs. 24.1%; $P < .0001$), 3) a greater proportion of sex as a TOP was not condom-protected ($M = 69\%$ vs. $M = 79\%$; $P = .04$), 4) a greater proportion of sex as a BOTTOM was not condom-protected ($M = 86\%$ vs. $M = 70\%$; $P < .0001$), and 5) not using condoms for sex with main partners (33.6% vs. 16.7%; $P = .003$). Frequency of unprotected oral sex was marginally greater among men scoring above the median ($M = 8.49$ times in the past 90 days vs. 5.75 times; $P = .06$). Men scoring above the median did not differ from those scoring at or below the median relative to having multiple sex partners as a TOP in the past 90 days (40.9% vs. 38.8%; $P = .68$) or having multiple partners as a BOTTOM (43.5% vs. 42.6%; $P = .87$).

Conclusions/Implications: In this clinic-based sample of young Black MSM, those indicating relatively greater agreement that having sex with same-status partners is safe were indeed more likely to report engaging in sex that was not protected by condoms. Further, this relatively greater agreement was not associated with having fewer sex partners thereby suggesting that serosorting is not a practice that limits men to having fewer male partners. Intervention strategies that promote consistent and correct condom use to MSM predisposed to serosorting may be beneficial.

Abstract 2443 - Using HIV Status and Viral Load Knowledge for Decision Making in Sexual Behavior: Outcome Analysis from Medical Monitoring Project in Texas

Author(s): *Sabeena Sears, Sylvia Odem, Jonathon Poe, Michael Wu, Osaro Mgbere, Mamta Singh, Melanie McNeese*

Background: Condom use has been the most widely recognized and promoted form of protected sexual behavior. However, research shows there are other harm reduction strategies for sexual behavior that can be effectively used by HIV-positive persons. Serosorting, selecting partners of concordant HIV serostatus, and having an undetectable viral load (VL) are two such harm reduction strategies. This analysis assessed the association of HIV status and VL knowledge with sexual behavior decision making among HIV-positive persons receiving care in Texas.

Methods: The Medical Monitoring Project (MMP) is an ongoing surveillance system that uses a three stage cluster sampling method to assess behaviors and clinical characteristics of HIV-positive persons who are receiving outpatient medical care. From the Texas and Houston MMP facilities, 450 of 800 sampled persons participated in the 2012 cycle. Data were collected using an in-person interview and a medical record abstraction. In the interview, participants were asked to rate their level of agreement to four serosorting statements and about sexual behaviors in the past 12 months. The weighted interview dataset was analyzed to assess their responses using SAS 9.3. Differences were assessed using Rao-Scott chi-square tests at significance level of $p < 0.05$.

Results: Most participants (78%) disagreed with: If my partner tells me he or she is HIV-positive, I am more likely to have unprotected sex (UPS). Among those who disagreed, and were neutral (5%), 12% and 54% had condomless sex (CLS), respectively ($p < 0.0001$). Among agreed (17%), 38% had CLS with HIV-positive partners only ($p < 0.0001$). Younger age groups were less likely to disagree with the

statement compared to the older age groups ($p < 0.05$). Most participants (84%) disagreed with: If my partner tells me he or she is HIV-positive, we don't have to worry about using condoms. Among those who disagreed, and were neutral (5%), 17% and 59% had CLS, respectively ($p < 0.0001$). Among 11% who agreed, 28% had CLS with HIV-positive partners only ($p < 0.05$). Most participants (84%) disagreed with: If I have an undetectable HIV VL, I am more likely to have UPS. Among disagreed, 15% had CLS; whereas, among agreed (13%) and neutral (3%), 43% and 60%, respectively, had CLS ($p < 0.01$). Of those who agreed and had CLS, 45% had an undetectable VL at their most recent test ($p < 0.05$). The majority of participants (89%) disagreed with: Having an undetectable VL means I can worry less about having to use condoms. Among disagreed, 18% had CLS. Among agreed (6%) and neutral (4%), 52% and 47%, respectively, had CLS ($p < 0.05$). Of those who agreed and had CLS, 47% had an undetectable VL ($p = 0.65$).

Conclusions/Implications: Texas MMP data suggest significant differences between the level of agreement with serosorting statements and condom use. As sexual harm reduction strategies are increasingly incorporated into prevention messages, a focus towards behavioral change is needed as transmission and spread of HIV depends on volitional behavior of people. It is important to use behavior change theories that consider knowledge, beliefs, and skills needed to make changes. Educating HIV-positive persons on evaluating the risks associated with each strategy is needed to make informed decisions.

Abstract 5098 - Quantifying the Harm or Benefit from Serosorting Among HIV-Negative Gay and Bisexual Men

Author(s): David Purcell, Darryl Higa, Yuko Mizuno, Cynthia Lyles

Background: As the number of biomedical and behavioral HIV prevention options has increased, up-to-date efficacy data on these various prevention strategies alone and when used in combination are needed for individual decision making around reducing HIV risk. Serosorting is a community-developed HIV prevention strategy that involves either, 1) trying to choose partners of the same HIV status, or 2) only having condomless sex with partners of the same HIV status. We conducted a systematic review and meta-analysis to quantify the prevention benefit or harm attributable to serosorting among HIV-negative men who have sex with men (MSM) when compared to either consistent condom use for anal sex / no anal sex (CCU) or having condomless discordant anal sex (CDAI).

Methods: We utilized the CDC's Prevention Research Synthesis (PRS) database, which is a cumulative, up-to-date database of HIV and STD prevention research literature, for conducting the systematic search. For this review, we searched the PRS database restricting to citations published between 1996 and 2015 and using the following key words on title or abstract: serosorting, sero-sorting, or negotiated safety. The following criteria were used to be included in this meta-analysis; 1) focus on or report on HIV-negative MSM, 2) examine serosorting, 3) included a comparison group, and 4) reported group-specific data or effect size estimate on the association between serosorting and HIV or STD infection. Two coders independently abstracted data from publications identified by the search. Effect sizes were estimated using rate ratio (RR). Standard meta-analytic methods were used to derive standardized effect size estimates and the final pooled estimate was based on a random-effects model.

Results: Of 79 citations reviewed, eight studies met our inclusion criteria and were included in the review, but two of the eight studies were excluded from our meta-analyses due to inconsistent outcomes. These 2 excluded studies, however, were consistent with our findings. Our meta-analyses indicate that serosorting, compared to CDAI, was associated with a 54% reduction in HIV risk (RR = 0.46, 95% CI: 0.33-0.65). Serosorting compared to CCU was associated with a 64% increase in HIV risk (RR = 1.64, 95% CI: 1.37-1.96).

Conclusions/Implications: Our meta-analyses shows that serosorting is protective against HIV when compared to CDAI among HIV-negative MSM, however, it is more risky than consistent condom use or no anal sex. Our results update (i.e., by increasing the number of included studies from 3 to 6) and are consistent with a previous meta-analysis that reviewed data up through April 2010 [Kennedy, 2013]. Serosorting may be an important harm-reduction strategy when other prevention strategies are not consistently being used, but should not be chosen as a strategy to replace consistent condom use, which is more protective. Modeling work is needed to better describe the benefits of serosorting when combined with other prevention strategies. In addition, accurate information about the benefits and harms of serosorting should be provided to gay and bisexual men so that they can make informed choices about how best to protect themselves from HIV.

Track C

Session C03 - Partnerships for Care (P4C): Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes

Room: A601 (Atlanta Marriott Marquis)

Abstract 1609 - Strengthening Public Health and Primary Care Partnerships: Florida's Partnerships for Care (P4C) Project

Author(s): *Mara Michniewicz, Juan Vasquez, M. Maximillion Wilson, David Andress, Marlene LaLota*

Issue: Florida is heavily impacted by HIV/AIDS, ranking second in the U.S. in new HIV infections and third in new AIDS cases. There are over 125,000 HIV-infected Floridians and almost 3,500 new infections per year. Approximately 84% (105,627) of Floridian's living with HIV infection are aware of their infection. Among those diagnosed, 81% (85,051) have been linked to care, and 63% (66,868) have been retained in care over time. Additionally, 59% (61,986) of persons diagnosed with HIV were on antiretroviral treatment, and 45% (47,171) have achieved viral suppression.

Setting: Florida's Partnerships for Care (P4C) project focuses on five counties that make up approximately 68% of Florida's HIV epidemic. Local health department staff and Disease Intervention Specialists (DIS) are working with six HRSA-funded community health centers in these heavily impacted counties: Broward Community and Family Health Centers (Broward County); Genesis Community Health (Palm Beach County); I.M. Sulzbacher Center (Duval County); Health Care Center for the Homeless (Orange County); and Community Health of South Florida and Care Resource (Miami-Dade County). These sites also represent five of Florida's six Eligible Metropolitan Areas (EMAs)- Ft. Lauderdale, Miami, West Palm Beach, Jacksonville and Orlando.

Project: To ensure a direct link between the local health departments and health centers, the Florida Department of Health (FLDOH) hired six DIS to work collaboratively with the health centers. FLDOH worked with each local health department to help define the role of the P4C DIS and provided guidance in crafting position descriptions. FLDOH also invited local health department staff to participate in programmatic readiness reviews and one-on-one calls with each health center to determine the level of technical assistance and training needed prior to full implementation. These initial calls have established open communication lines between the state health department (FLDOH), local health department staff, P4C DIS and the health centers. At the local level, health department staff, P4C DIS and health centers have worked together to develop protocols and procedures related to P4C activities, and have also collaborated to address barriers to implementation. FLDOH also initiated a P4C Data Workgroup to assist with the development of data sharing processes and address unforeseen challenges.

Results: During the development phase of the P4C project, the FLDOH has been able to demonstrate: increased health department capacity to gather, report and use surveillance data; increased health center capacity to engage newly and previously diagnosed patients in care; increased health department capacity to provide partner notification, linkage, retention and re-engagement with care for PLWH; and increased communication and data sharing between the health department and health center.

Lessons Learned: Florida's processes have provided experiential guidance on coordinating P4C activities across a culturally diverse and widespread jurisdiction. This presentation will outline best practices and challenges that have been identified thus far.

Abstract 1626 - Building Sustainable Partnerships with Health Centers to Improve HIV Prevention and Care Capacity: A New York State Quality of Care Model; Partnerships for Care Initiative

Author(s): *Rachel Hart-Malloy, Stephen Crowe, Megan Johnson, Kathleen Bogucki, Daniel Belanger, James Tesoriero*

Issue: Federally funded initiatives offer an opportunity to develop best practices and explore different approaches for implementing scalable models to support people living with HIV (PLWH) across the HIV Care Continuum. While evidence of the effectiveness of data to care interventions on improving HIV care outcomes exists, the benefits of focusing on quality of HIV care within this context is less well understood. To this end, the New York State Department of Health (NYSDOH) has implemented a multidisciplinary, team-based approach focused on improving HIV care outcomes, endorsing quality of HIV care as an imperative piece to this work.

Setting: The NYSDOH is one of four health departments funded by CDC to implement the Partnerships for Care (P4C) project, which aims to develop sustainable partnerships between health departments and health centers in an effort to improve HIV care outcomes for newly diagnosed and lost-to-care patients. In addition to data to care activities, NYSDOH includes a unique quality of care model that has a dedicated Quality Program Coordinator providing one-on-one and cross-site activities with the six HRSA-funded health centers to improve quality of care, and performance measures consistent with statewide and national standards.

Project: In an effort to foster sustainable partnerships with health centers to improve HIV prevention and care capacity, the NYSDOH funded a Quality Program Coordinator to serve as the primary contact between the NYSDOH's P4C team and its partnering health centers relative to the state's HIV Quality of Care Program. The Quality Program Coordinator is responsible for implementing and delivering all quality-related capacity building activities including: promotion and support of sustainable quality management programs; performance measurement of clinical care and services through annual quality organizational assessments; improvement coaching and consultation; exchange of improvement resources; peer learning; and collaborative participation of clinical providers and patients/consumers.

Results: Anticipated quantitative program outcomes specific to Quality Program Coordinator work include increased capacity of participating P4C health centers ability to achieve the following: (1) provide routine HIV testing and linkage to care; (2) engage newly and previously identified patients to HIV care; (3) provide prevention services to PLWH; (4) retain PLWH in health care; (5) increase patient receipt of ART; (6) improve screening and treatment for non-HIV specific clinical indicators and; (7) increase viral suppression among PLWH. These outcomes will be assessed from initial clinic-level readiness reviews, NYS evaluation databases, as well as data entered into eHIVQUAL (the electronic platform for statewide HIV quality of care measures). Initial clinic-level readiness reviews reveal that all six health centers have begun to address a spectrum of quality improvement (QI) related activities, focused on seven key domains: leadership support, staff involvement, use of performance data, consumer involvement, QI initiatives, evaluation, and addressing disparities in care. Follow-up reviews are scheduled for the fall of 2015, and preliminary findings will be presented.

Lessons Learned: With the intention of sustainable partnerships, these anticipated results suggest that a dedicated quality of care liaison might be a best practice for improving HIV outcomes beyond funded initiatives.

Abstract 1634 - Enhanced Public Health and Health Center Collaboration in Massachusetts

Author(s): *Liisa Randall, J Pernice, S Lewis, B John, D Fukuda, A Blinn, E Jackson, B Proffitt*

Issue: Addressing gaps in the HIV care continuum is a priority identified by the National HIV/AIDS Strategy. Increasing the number of individuals who know their HIV status and supporting their engagement and retention in care requires strong partnerships between public health and community health centers (CHCs). In the US, HIV services have historically been provided by infectious disease and HIV clinics, while prevention and support services have been provided by a range of clinical and community-based providers. Integrating HIV prevention, care, and treatment services into primary care and optimizing public health resources requires closer collaboration between public health and CHCs, and implementation of novel public health strategies to engage and retain individuals in the care continuum.

Setting: The Massachusetts Department of Public Health (MDPH) has historically invested in CHCs to deliver a range of HIV services. Partnerships for Care represents an opportunity to build upon existing infrastructure for service delivery, implement novel public health strategies, and leverage near-universal health insurance thereby promoting sustainability of services and optimizing public health resources.

Project: MDPH is collaborating with the Massachusetts League of Community Health Centers (the League), the state's primary care association (PCA). Collaborative activities include: assessment of CHC capacity to integrate HIV prevention and care services into primary care; develop and provide capacity building assistance to support integration; and implement novel public health strategies to support engagement and retention in primary care. Development of CHC and public health capacity to use disease surveillance and clinical data to identify out-of-care individuals and to inform public health intervention is a critical component of this partnership. A key component of the project is further development of a central data repository, maintained by the League and currently being used by CHCs for data management and reporting, which will automatically extract variables of interest from electronic health records. Data will be pushed to MDPH. This mechanism will support enhanced quality improvement and will strengthen disease surveillance, streamline disease reporting, and enable timely public health intervention. Collaboration with the League leverages their considerable experience and expertise facilitating and supporting practice transformation and spreading these new models of integrated care across the CHC network, providing capacity building support for continuous quality improvement, and promoting coordination between primary care and public health.

Results: By the end of the project participating CHCs will have implemented HIV screening pursuant to national guidelines, established interdisciplinary HIV care teams, and used clinical and surveillance data for quality improvement. MDPH will have implemented a novel public health intervention to engage out-of-care individuals in HIV care, and routinely used disease surveillance and clinical data to identify individuals who will benefit from public health intervention.

Lessons Learned: Public health - PCA collaboration is essential for making system-level changes necessary for sustainability. Development of data systems that streamline reporting and enable application of data to quality improvement are critical to enhancing the service effectiveness and monitoring continuity of care. The PCA will play a critical role in disseminating lessons learned to other CHCs.

Abstract 1658 - Maryland's Partnerships for Care (P4C) Project: Increasing Engagement in HIV Care through Health Department/Community Health Center Collaboration

Author(s): Pam Kurowski, Kelly Russo, Gwen Anderson, Hope Cassidy-Stewart, Marcia Pearl, Colin Flynn, Jeffrey Hitt

Issue: Among the approximately 30,000 diagnosed persons living with HIV (PLWH) in Maryland, only an estimated 59% are engaged in ongoing HIV medical care. These gaps in HIV care engagement are, in part, due to two critical barriers: an insufficient number of HIV care providers to meet demand in heavily impacted jurisdictions and challenges coordinating HIV linkage-to-care activities across jurisdictions, funding sources, and providers. These challenges are particularly evident in Montgomery and Prince George's counties, which border the District of Columbia and together comprise one-third of Maryland's living HIV cases.

Setting: The Maryland Department of Health and Mental Hygiene (MDHMH) is collaborating with community health centers (CHCs) and local health departments (LHDs) to support expanded HIV service

delivery in three Maryland jurisdictions highly affected by HIV (Baltimore City, Prince George’s County, and Montgomery County).

Project: Through Maryland’s Partnerships for Care (P4C) project, MDHMH, three local health departments, and four HRSA-funded CHCs are working together to expand the availability of HIV testing and care in community health settings and increase engagement in HIV care. In addition to expanding HIV testing and medical care at three CHCs in Baltimore City, the Maryland P4C project is partnering with Community Clinic Inc. (CCI) to newly integrate routine HIV testing into eight health center locations in Montgomery and Prince George’s counties, and establish an HIV primary care clinic at their new location in Prince George’s county. MDHMH is also partnering with LHDs and CHCs to ensure that PLWH are effectively linked to HIV care and partner services, and provided with re-engagement support (when needed). These activities include enhancing coordination of linkage-to-care (LTC) activities, expanding re-engagement outreach activities, and increasing the integration of LTC activities into HIV/STI field services. While LTC activities are being implemented in all three target jurisdictions, efforts to strengthen coordination of linkage-to-care services are focused in Prince George’s and Montgomery counties, which do not have the robust HIV care referral network already present in Baltimore City. Additionally, MDHMH is facilitating data sharing between CHCs, LHDs, and MDHMH to increase the utilization of HIV surveillance data to initiate and inform linkage-to-care activities and to implement ongoing case conferences to ensure client engagement, conduct quality improvement, and identify best practices.

Results: During the first year of Maryland’s P4C project, partners initiated new routine HIV testing programs in the primary care locations of four CHCs, established integrated HIV care teams at six CHC primary care clinics, increased coordination of linkage-to-care services, strengthened referral networks, and increased data sharing and utilization of surveillance data for linkage-to-care activities. These accomplishments were the result of new and enhanced partnerships between the MDHMH, LHDs, and CHCs.

Lessons Learned: Partnerships between state health departments, LHDs, and CHCs are an essential component of efforts to improve the health of PLWH and prevent new HIV infections. P4C has provided an opportunity to establish new partnerships and strengthen existing partnerships, resulting in expanded HIV service delivery, increased coordination of LTC activities, and improved engagement in HIV care in the Maryland jurisdictions most impacted by HIV.

Session C04 - Transgender Persons Served in HIV Prevention Programs at CDC-Funded Health Departments and Community-based Organizations: Characteristics, Program Outcomes, and Lessons Learned

Room: A706 (Atlanta Marriott Marquis)

Abstract 1422 - Assessment of Six Community-based Organizations’ Efforts in Preventing HIV among Young Transgender Communities of Color

Author(s): *Ekaterine Shapatava, Adanze Eke, Renata Ellington, Gary Uhl*

Issue: HIV prevention among transgender (TG) persons remains a significant challenge in the US. Studies show high HIV positivity among male-to-female TG persons, especially African American male-to-female TG persons. There are a number of behavioral, cultural and socioeconomic barriers that place TG individuals at risk for HIV infection. Among many efforts, CDC provides support and technical assistance to community-based organizations (CBOs) to implement enhanced HIV prevention programs for TG persons. The presentation describes the program achievements of six CDC-funded CBOs that provided HIV prevention services to young transgender (YTG) persons of color and their partners.

Setting: In 2011, CDC funded six CBOs through funding opportunity announcement (FOA) PS11-1113 to provide HIV prevention services to YTG persons of color and their partners for five years. The funded sites are located in NYC (2 CBOs), Washington DC, Baltimore, Detroit and Oakland.

Project: The purpose of the program is to increase the number of YTG persons of color who are aware of their HIV status and linked to HIV medical care, treatment, and prevention services. Annual FOA requirements focused on three key indicators:

- Test at least 75 to 150 YTG of color
- Reach 4% newly identified HIV positivity
- Link at least 70% of all HIV-positive individuals to HIV medical care

The Prevention Program Branch and Program Evaluation Branch routinely monitors grantee progress in achieving the FOA objectives for key indicators by using aggregate-level data from progress reports that CBOs submit to CDC semiannually.

Results: This presentation highlights overall CBO performance during the first 3 years of funding for these key indicators: number of individuals tested, percent of newly diagnosed HIV-positive individuals, and percent of newly diagnosed HIV-positive individuals linked to HIV medical care. The results showed that there were continued gains for the total number of individuals tested each year. There were modest gains in HIV positivity from year one (5.1%) to year two (7.6%) but the rate dropped to 0.9% by the third year of funding period. All CBOs were able to meet FOA goal of linking at least 70% of the HIV-positive individuals to HIV medical care for all three years. Individual CBO performance varied across the indicators. The results show that CBOs may need additional technical assistance to identify innovative strategies to conduct targeted HIV testing and find more HIV-positive TG individuals. For example, although one CBO doubled their annual target goal by conducting 375 tests per year, they did not find any HIV-positive individuals in the given year.

Lessons Learned: CBOs appear to be achieving overall FOA goals for testing YTG individuals for HIV; however, the ability to recruit YTG individuals varies across CBOs. Increased collaboration with state and/or local health department surveillance programs will assist CBOs to use data for program planning and improvement. Additionally, performance targets should be assessed relative to other key indicators and the overall goals of the program. These lessons learned will help guide future CDC program announcements to be designed for YTG of color.

Abstract 1559 - HIV Testing, Seropositivity, and Linkage to Care among Transgender Persons in CDC-Funded Testing Sites in the United States, 2012-2013

Author(s): *Mesfin Mulatu, Guoshen Wang, Hui Zhang, Wei Song, Choi Wan, John Gilford*

Background: Studies indicate high rates of HIV infection among transgender (TG) persons in the United States. Our understanding about the patterns and outcomes of HIV testing among TG persons is limited, partly because of data collection limitations on gender identity. Data collection on gender identity is often restricted in scope – relying on self-reported current gender and disregarding assigned sex at birth. This study compares the patterns of HIV testing, seropositivity, and linkage to medical care among TG persons in CDC-funded HIV testing programs nationally, using a two-step approach for determining gender identity.

Methods: We used HIV testing data reported by 61 local and state health departments in 2012 and 2013 (5.17 million test events). We combined sex at birth and current gender and identified six TG subgroups: male at birth and current gender male-to-female TG (M-MTF), female (M-F), or unspecified TG/other (M-OTH); female at birth and current gender female-to-male TG (F-FTM), male (F-M), or unspecified TG/other (F-OTH). We compared the number of test events and HIV-positives identified from TGs by using the one-step (current gender only) and two-step approaches. We examined differences in demographic (age, race/ethnicity, region) and behavioral risk characteristics (sex without condom, injection drug use) and patterns of HIV testing, seropositivity, and linkage to medical care among TG subgroups. SAS version 9.3 was used for descriptive and logistic regression analyses.

Results: Using current gender alone identified 12,485 HIV test events among TG groups; the two-step approach increased the total test events by 68.9% to 21,092. The largest numbers of test events were reported for M-MTF (48.4%), M-F (25.4%), and F-M (15.4%). Using current gender, 459 HIV-positives were identified; the two-step approach increased the count of HIV positives by 20.0% to 551. TG subgroup comparison revealed differences by age, race/ethnicity and geographic region. HIV test events among M-MTFs tend to come from younger, black or Hispanic persons, and less likely from those who live in South. F-FTMs (64.5%; $p < .001$) were less likely and F-Ms (79.5%; $p < .05$) more likely than M-MTF (76.7%) to report sex without a condom. F-M (6.1%; $p < .001$) and M-Fs (7.2%; $p < .01$) were more likely than M-MTF (8.7%) to report injection drug use. Seropositivity was 2.6% for all TG groups combined but varied by subgroups with the highest among M-MTF (4.3%), M-OTH (1.6%), and M-F (1.4%). M-MTF were significantly more likely than other TG groups to test HIV-positive ($p < .001$). Overall percentage of linkage to medical care was 70.8%; there were no statistical differences in linkage between TG subgroups.

Conclusions/Implications: The two-step approach to determining gender identity improves identification and reduces potential misclassification of TG persons who access HIV testing services. This approach also reveals differences in demographic characteristics, risk behaviors, and HIV seropositivity between TG subgroups. Further research on the underlying factors contributing to subgroup disparities will help design appropriate prevention and care programs for TG persons.

Abstract 1627 - Transgender Persons Served in Partner Services Programs Implemented by State and Local Health Departments in the United States, 2012-2013

Author(s): *Wei Song, Mesfin Mulatu, Hui Zhang, Michele Rorie, Guoshen Wang, Choi Wan, John Gilford*

Background: Studies indicate high rates of HIV infection among transgender (TG) persons in the United States. Our understanding about the patterns and outcomes of participation in HIV partner services (PS) among TG persons is limited, partly because of data collection limitations on gender identity. Data collection on gender identity is often restricted in scope – relying on self-reported current gender and disregarding assigned sex at birth. This study compares the patterns and outcomes of PS participation among TG persons in CDC-funded HIV prevention programs nationally, using a two-step approach for determining gender identity.

Methods: We used PS data reported by 55 local and state health departments for clients served in 2012-2013. Analytical sample consisted of 31,305 index patients and 14,914 partners. We combined sex at birth and current gender and identified six TG subgroups: male at birth and current gender male-to-female TG (M-MTF), female (M-F), or unspecified TG/other (M-OTH); female at birth and current gender female-to-male TG (F-FTM), male (F-M), or unspecified TG/other (F-OTH). We compared the number of TG identified by using the one-step (current gender only) and two-step approaches. We examined differences in demographic (age, race/ethnicity, region) and behavioral risk characteristics (sex without condom, injection drug use) and in PS participation (enrollment, notification of potential exposure) between TG subgroups. SAS version 9.3 was used for descriptive and logistic regression analyses.

Results: Using the two-step approach, 515 (1.1%) of the PS clients were identified as TG persons, 29.7% more than the number of TG persons identified by using current gender alone. Of these, M-MTF represented the largest subgroup (71.4%), followed by M-F (14.9%), F-M (8.0%), M-OTH (3.5%), and F-FTM (2.1%). Comparisons between M-MTF, M-F, and F-M, the three largest subgroups, revealed significant differences. M-F (33.8%) and F-M (31.7%) were more likely than M-MTF (14.7%) to be non-Hispanic white ($p < .001$). M-F (42.8%) and F-M (43.9%) were more likely than M-MTF (11.9%) to reside the South, respectively. Overall, 56.2% and 6.8% of TG persons reported sex without condom and intravenous drug use, respectively; with no significant difference between TG subgroups. Among index patients, M-F (87.8%) and F-M (80.8%) were more likely than M-MTF (61.9%) to be located by PS programs ($p < .01$). But once located, there was no significant subgroup difference in enrollment in PS programs (overall rate=86.3%). Among partners, M-F (95.6%) and F-M (90.9%) were more likely than M-MTF (48.3%) to be notifiable ($p < .01$). However, there was no significant subgroup difference in percent of partners actually notified of potential exposure (overall rate=100%).

Conclusions/Implications: The two-step approach identified about 30% more TG persons in PS programs than using current gender alone. TG subgroups in PS programs vary by race/ethnicity, region, and the level of their accessibility to services. Compared to M-F and F-M, M-MTF are less likely to be non-Hispanic white, to reside in the South and to be located for PS. These TG subgroup variations imply the need to tailor PS programs and for further studies to examine the underlying social and structural factors responsible for the disparities.

Abstract 1754 - Transgender Persons Enrolled in CDC-Funded Risk-Reduction Behavioral Intervention Implemented by State and Local Health Departments in the United States, 2012-2013

Author(s): Hui Zhang, Mesfin Mulatu, Wei Song, Goshen Wang, Choi Wan, John Gilford, Benny Ferro

Background: Studies indicate high rates of HIV infection among transgender (TG) persons in the United States. Our understanding about the patterns of participation in risk-reduction evidence-based interventions (EBIs) among TG persons is limited, partly because of data collection limitations on gender identity. Data collection on gender identity is often restricted in scope – relying on self-reported current gender and disregarding assigned sex at birth. The purpose of this study is to describe the pattern and type of HIV risk-reduction EBIs TG persons participated in at CDC-funded health departments, using a two-step approach for determining gender identity.

Methods: We used client-level data reported by 48 health departments that implemented risk-reduction EBIs in 2012-2013. For each client, data on his/her demographic characteristics, behavioral risk, self-reported HIV status, and type of intervention he/she was enrolled in were collected. Our analytical sample included 179,045 clients. We combined sex at birth and current gender, and identified six TG subgroups: male at birth and current gender male-to-female TG (M-MTF), female (M-F), or unspecified TG/other (M-OTH); female at birth and current gender female-to-male TG (F-FTM), male (F-M), or unspecified TG/other (F-OTH). We examined differences in demographic characteristics (age, race/ethnicity and region), risk behaviors (sex without condom, injection drug use) and type of risk-reduction EBI enrolled among TG subgroups. SAS version 9.3 was used for descriptive and logistic regression analyses.

Results: Using the two-step approach, 4,019 (2.2%) clients were identified as transgender. Of these, 3,291 (81.9%) were M-MTF; 169 (4.2%) were F-FTM; 297 (7.4%) were M-F; 185 (4.6%) were F-M; 65 (1.6%) were M-OTH; and 12 were F-OTH. Compared to F-FTM, M-F and F-M, M-MTF were more likely to be African American or Hispanic/Latino (79% vs 42%, 77% and 66%) respectively. Compared to F-FTM, M-F and F-M, M-MTF were more like to live in the West (46% vs 15%, 41% and 38%) respectively. Compared to F-FTM, M-MTF (OR: 3.08; 95% CI: 2.25, 4.23), M-F (OR: 3.0; 95% CI: 1.99, 4.45), and F-M (OR: 1.5; 95% CI: 1.04, 2.32) were more likely to report a history of injection drug use. The percent of self-reported HIV positivity was 40% for M-MTF; 6% for F-FTM; 33% for M-F; 32% for F-M; 23% for M-OTH and 0% for F-OTH. The top 5 risk-reduction EBIs that TG persons were enrolled in were “locally developed or homegrown intervention” (56.2%), Comprehensive Risk Counseling Services (16.3%), Popular Opinion Leader (9.3%), SISTA (6.8%), and VOICES/VOCES (3.2%). There were minimal differences in the type of EBIs enrolled by TG subgroups.

Conclusions/Implications: Using the two-step approach, we identified 16% more transgender persons than using current gender identity only. The largest proportion of TG persons was M-MTF who were more likely than other TG subgroups to report HIV positivity and injection drug use. A large proportion of TG persons are enrolled in locally developed or homegrown interventions, perhaps to meet their unique prevention needs. Efforts should be made to expand HIV prevention services for TG persons, especially for M-MTF.

Session C07 - Intersection of the HIV Continuum of Care and SAMHSA’s Trauma-Informed Approach
Room: A705 (Atlanta Marriott Marquis)

Abstract 2329 - Intersection of SAMHSA’s Targeted Capacity Expansion (TCE)-HIV Program and Trauma-Informed Approach in addressing the HIV Care Continuum

Author(s): Gerlinda Somerville, Mary Blake, Larke Huang

Issue: Substance use disorders (SUD) and co-occurring mental disorders are significant risk factors for HIV infection and impact people at all levels of the HIV Care Continuum. SUD or co-occurring mental disorders have a greater impact within racial/ethnic minority communities especially among YMSM of color, minority women and other populations at high risk for SUD and co-occurring mental disorders and who are living with or at risk for HIV/AIDS.

Setting: SAMHSA's Targeted Capacity Expansion (TCE-HIV) program is a national Minority AIDS Initiative funded program that supports the expansion of culturally appropriate SUD treatment and HIV services for high-risk racial/ethnic minority populations who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS. Populations of focus include minority young men who have sex with men (YMSM), ages 18-29 and MSM, ages 30 and over; women ages 18 and over including heterosexual, lesbian, bisexual, previously incarcerated women and their significant partners.

Project: The TCE-HIV: Minority Women program funds 40 behavioral health community-based organizations to provide behavioral health, HIV and viral hepatitis services using a family-centered, trauma-informed approach (TIA) based on SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. The document is designed to create a working model of trauma and TIA to healthcare and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups, including HIV care and treatment.

Results: Data from the first year of the TCE-HIV: Minority Women grant shows that the use of alcohol, marijuana and cocaine are the top three substances of choice among clients. During Year 1 of the program that ended August 31, 2014 nearly 3,000 clients (96.7% females, 2.7% transgender, 0.5% males) were enrolled in (SUD) treatment. The majority of clients served were Hispanic/Latino (42.1%) and African American (41.2%). Enrollment in the SUD program helped 1,601 clients to maintain their HIV negative status. Nearly 2,400 clients self-reported traumatic experiences; 66.3% of them were referred to trauma care services such as Seeking Safety. Commonly used screening tools include Post-Traumatic Stress Disorder (PTSD) Checklists and the U.S. Preventive Services Taskforce (USPSTF) recommended Slapped, Threatened, and Throw (STaT).

Lessons Learned: Exposure to traumatic events can be associated with increased risk-taking behavior, including substance use, unsafe sexual practices, and difficulty forming therapeutic relationships with medical personnel. Patients with HIV/AIDS may be affected by past trauma to the point that it manifests in problems within disease management, such as disrupted or negative interactions with medical personnel and/or medication non-adherence. Behavioral health is essential to overall health. In addition to providing HIV testing, behavioral health providers link clients to HIV care and help them adhere to both ART and SUD and mental disorder treatment. Utilizing TIA is a new way to provide HIV services and a pathway for engaging clients in ongoing behavioral health and HIV care.

Abstract 2413 - : SAMHSA's Trauma-Informed Approach – A New Pathway to HIV Services

Author(s): *Mary Blake, Gerlinda Somerville, Larke Huang*

Issue: The experiences of adversity in childhood and exposure to traumatic events have been shown through multiple studies to be associated with increased risk for HIV-AIDs. Individuals who have experienced trauma often develop coping strategies that include risk-taking behavior, including substance use, unsafe sexual practices, and difficulty forming therapeutic relationships with medical personnel. Patients with HIV/AIDS with histories of trauma manifest problems with disease management such as medication non-adherence.

Setting: SAMHSA recently released nationally Concept of Trauma and Guidance for a Trauma-Informed Approach (TIA), a document designed to create a working concept of trauma and a trauma-informed approach to healthcare and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups, including HIV care and treatment services. Through its General Adult Trauma Screening and Brief Response Initiative, SAMHSA has leveraged a public/private partnership to help primary care medical practitioners better understand their patients in the context of possible traumatic experience and engage them in health care.

Project: According to SAMHSA's Concept Paper individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients; integrate knowledge about trauma into policies, procedures, and practices; and actively resists re-traumatization.

Results: The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with behavioral health conditions. This connection offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and HIV service systems. A trauma-informed approach does not simply raise awareness of the issue of trauma, but fundamentally changes an organization or system's culture, behavior, actions, and responses. Other Federal Agencies are integrating this framework to address the impact of trauma with their constituencies and in their work.

Lessons Learned: A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing. From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed, grantees demonstrate that behavioral health and HIV treatment and services which are responsive to the traumatic experiences of patients can facilitate patient engagement in care.

Abstract 2458 - SHE PREVAILS: Empowerment Focused Prevention and Intervention for Reducing Women's Substance Use and HIV Risk

Author(s): *Lara Stepleman, K Lewis, R Floyd*

Issue: With the HIV/AIDS epidemic being largely focused in minorities and in the Southern region of the US, a multidimensional approach to HIV/AIDS prevention and care is needed with strategies that reflect the needs of the social, ethnic, and cultural diversity of the region. In the southeast, infection rates and health outcomes have been particularly deleterious for African American women, especially those with active substance use and untreated mental health concerns. Additionally, physical and sexual traumas increase the risk for substance use and HIV in women. In response, we developed an evidenced-based prevention-intervention model for substance using African American women at-risk or living with HIV.

Setting: The fifteen-county service area surrounding Georgia Regents University (GRU) is comprised of traditionally underserved and hard-to-reach populations, commonly struggling with poverty, mental illness, substance abuse, and social stigma. Further, given the many barriers women face in accessing care, it was critical that screening, prevention, and intervention services all be embedded at community sites serving high risk African American women, including shelters, housing communities, public health clinics and hospitals, pharmacies, AIDS service organizations, food pantries, and on college campuses.

Project: The SHE PREVAILS program (Supporting Health Engagement through Prevention, Recovery, and Empowerment Via Access, Intervention, and Linkage Services), utilizes a combination of complementary evidence-based approaches tailored to African American women with substance use disorder (SUD) and co-occurring trauma and mental disorders, including 1) community-embedded brief screening and referral for substance use and co-occurring mental disorders; 2) motivational interviewing; 3) treatment navigation; 4) certified peer specialists 5) trauma-informed psychotherapy and SUD treatment, and 6) community based HIV/HCV/HBV testing and risk-reduction education and empowerment programs.

Results: Since the inception of SHE PREVAILS, we have provided screening and triage services to over 1,700 individuals in the community and enrolled 172 women into the SHE PREVAILS program. Over 80% of our enrolled women are African American, with 35% reporting a history of trauma. For the many women with active trauma symptoms, we have referred 100% into trauma informed psychotherapy and SUD treatment. The risk-reduction education and empowerment prevention programs have been especially successful with increasing requests by African American community leaders to provide these services at additional sites.

Lessons Learned: In terms of prevention, we have had success in engaging SHE PREVAILS enrolled women and other women within the community into our evidenced-based prevention programs that have functioned to increase knowledge about sexual health and risk behaviors. We have noticed more difficulties engaging women in group based trauma-focused treatment for at-risk women; however, individuals have been more successfully engaged in individual treatment. We continue to examine the specific regional and cultural influences that may contribute to this particular challenge and continue to refine these services. As the program matures and undergoes comprehensive evaluation, we hope that SHE PREVAILS can serve as a unique prevention-intervention program for other communities of underserved, at-risk African American women.

Abstract 2489 - From Treatment to Healing: Towards a Model of Trauma-Informed Care for Women Living with HIV

Author(s): *Naina Khanna, Mary Blake*

Issue: Women living with HIV are disproportionately impacted by trauma due to high rates of lifetime sexual, physical and emotional abuse, interpersonal violence, and the ongoing effects of post-traumatic stress disorder (PTSD). Trauma and PTSD may impact ability to engage in care and are shown to predict poorer HIV-related health outcomes including lower quality of life, lower rates of ART adherence, lower rates of condom use, and higher mortality rates. Ending the epidemic will require national recognition of the prevalence of violence against women and girls in the US, policy changes to address it, and innovative, culturally relevant, and comprehensive approaches and interventions that effectively address the effects of violence and abuse on the lives of women living with HIV in clinical and community-based settings. Yet, the majority of care and service delivery settings for women with HIV are not currently addressing trauma, and in fact, trauma may be triggered in such settings.

Setting: Positive Women’s Network (PWN) – USA is a national membership body of women living with HIV and our allies that exists to strengthen the strategic power of all women living with HIV in the United States. PWN-San Francisco collaborated with the University of California – San Francisco (UCSF) researchers on an expressive therapy group intervention originally developed by San Francisco’s Medea Project for incarcerated women that showed highly promising effects on the health and well-being of women living with HIV.

Project: To address this issue, Positive Women’s Network – USA, a national membership body of women living with HIV, and University of California – San Francisco’s Women’s HIV Program (WHP) embarked on a partnership to develop a conceptual framework of trauma-informed primary care for women living with HIV, informed by women with HIV and clinical and community-based providers.

Results: In consultation with a number of partners, PWN-USA and WHP have developed a conceptual model of trauma-informed primary care practices, with evidence-based building blocks that comprise a menu of potential interventions that can be added by clinic and community-based organizations serving women with HIV to address this need.

Lessons Learned: Implementing trauma-informed practices in a clinic or community-based setting is possible, but requires commitment to a set of trauma-informed values, a champion, and ongoing training and education for all staff. Further, changes to the overall service delivery environment may be necessary, and there is a need to implement screening and interventions on and offsite. Given the high rates of trauma among men who have sex with men as well as transgender women, such a model likely has broad relevance for people living with HIV and should be evaluated for multiple populations at elevated risk of lifetime trauma and abuse.

Session C08 - HIV Linkage and Reengagement Training Workshop for Public Health Clinical and Community-Based Workers and Managers

Room: A707 (Atlanta Marriott Marquis)

Abstract 1439 - Missing the link: Examining Missing Data Trends and Data Quality Issues with Linkage to HIV Medical Care Data

Author(s): *NaTasha Hollis, Puja Seth, Guoshen Wang*

Issue: A goal of the White House's 2010 National HIV/AIDS Strategy (NHAS) is to increase access to care for people living with HIV (PLWH). Specifically, by 2015, 85% of newly diagnosed patients should be linked to medical care within three months of their HIV diagnosis. CDC's National HIV Prevention Program Monitoring & Evaluation (NHM&E) data are used to assess grantee progress towards meeting local, state and national HIV prevention program goals. However, it is difficult to determine if CDC-funded HIV testing programs are meeting the NHAS linkage to HIV medical care goal because of the large percentage of missing or invalid NHM&E data.

Setting: CDC funds state and local health departments to conduct HIV-testing. Health departments are required to submit their NHM&E testing data biannually (March and September). The NHM&E testing data include a set of standardized variables related to HIV testing and prevention, care, and treatment services needed to calculate key HIV prevention program indicators. Grantees have historically reported on linkage to medical care within any time frame but beginning in 2012, CDC began requiring grantees to ascertain and report whether linkage occurred within 90 days of diagnosis.

Project: NHM&E data on linkage to medical care from 2012-2013 were used to evaluate grantee progress towards reaching the NHAS goal of effectively linking 85% of newly identified HIV-positive persons to medical care within 90 days of diagnosis. We also look at trend data for 2010-2013 to also assess linkage within any time frame.

Results: To illustrate the impact of missing data, linkage to care is reported as a range of minimum (includes missing/invalid data) and maximum (excludes missing/invalid data) percentages. Among newly identified positives, 35.9-70.6%, 40.6-70.7%, 51.3%-67.1%, and 59.0%-77.5% were linked to care within any timeframe in 2010, 2011, 2012, and 2013, respectively. The percentage of missing linkage within any timeframe data by year was 49.1% in 2010, 42.5% in 2011, 23.7% in 2012, and 23.8% in 2013. Linkage to HIV medical care within 90 days was 36.0%-82.2% in 2012 and 49.1%-86.5% in 2013. The percentage missing was 56.2% and 43.2% in 2012 and 2013, respectively.

Lessons Learned: Missing/invalid data create challenges for determining true linkage to HIV medical care percentages and assessing progress toward achieving the goal of 85% linkage. The amount of missing/invalid data also varies by CDC-funded jurisdictions, creating an additional challenge to developing a streamlined approach to increase data reporting. Grantee quality assurance feedback has helped to identify common challenges with data reporting as well as positive actions taken by those grantees with more complete linkage data. These factors combined should result in continued improvements in linkage data completeness and quality.

Abstract 2290 - Effective HIV Linkage, Navigation, and Reengagement Strategies in Public Health Settings: Results from the HIV Care Collaborative

Author(s): *Julia Hidalgo, Helena Kwakwa, Marlene McNeese, Teresa Bell, Olivia Copeland, Catherine Corson*

Issue: Effective linkage services can help newly identified HIV+ individuals to engage in medical care, identify and address barriers to care, and educate clients about how to navigate the healthcare system. Community health workers (CHWs) can support clients as they engage in care and initiate antiretroviral (ARV) therapy. Public health and other data systems can be used to locate lost-to-care patients, as part of effective reengagement activities that identify and address factors contributing to previously dropping out of care. HIV prevention funders have stressed the importance of effective linkage, engagement, and reengagement services to ensure rapid clinical assessment, initiate ARVs, and reduce community viral load. Few rigorous, replicable interventions, however, have been designed and evaluated among large populations of HIV+ individuals served in public health clinic settings. Additionally, while public health and other data can play a key role in identifying and reengaging lost-to-care HIV+ individuals, evaluation results of their effectiveness are limited.

Setting: The Merck Foundation HIV Care Collaborative (HCC) for Underserved Populations funds replicable, innovative strategies in public health settings to improve outcomes and prevent further HIV infections. Local health departments in Atlanta, Houston, and Philadelphia are completing a three-year initiative to increase the rate of HIV+ adults with undetectable viral load who are linked and engaged in care.

Project: Clinic and community-based CHWs collaborate with clinicians and case managers to engage and retain newly identified HIV+ individuals and reengage HIV+ individuals that had previously dropped out of care. CHWs conduct a three-month rapid cycle intervention of intake, assessment of barriers to engagement in care, individualized service planning, referrals to address barriers, health system navigation, care coordination with the healthcare team, and transition to case managers for ongoing engagement and retention services. Clinical and surveillance databases are used to identify individuals requiring the HCC intervention.

Results: In this workshop, we present practical strategies for linkage and reengagement based on best practices and evaluation of the HCC intervention. Practical training is offered on forming multidisciplinary care teams, effective CHW roles and responsibilities, strategies for client assessment to identify and address personal and structural barriers, care planning and management techniques that promote retention and prevent loss to care, home visit safety measures, caseload management strategies, effective chart documentation, quality improvement strategies, and tools for prospectively identifying and addressing factors leading to poor engagement and loss to care. We discuss supervisors' role in supporting CHWs' services, identifying and addressing needed performance improvement, and meeting CHWs' training needs. HCC CHWs will present their unique perspective on effective strategies for supporting HIV+ individuals as they enter or are reengaged in medical care. HCC CHWs offer case studies to promote active dialogue with panel attendees and illustrate effective linkage and reengagement activities.

Lessons Learned: HIV linkage and reengagement workers in public health clinical and other settings can successfully link and engage HIV+ individuals in care. Program design, intervention methods, and staff

supervision should be carefully implemented however. Lessons learned in the HCC can be applied to avoid pitfalls resulting in loss to care, morbidity, mortality, and secondary HIV infections.

Abstract 2420 - Effective HIV Linkage and Reengagement Strategies in Public Health Settings: Lessons Learned from the Fulton County Georgia Bridging the Gap Project

Author(s): *Teresa Bell, Olivia Copeland, Daniel VanderEnde*

Issue: Effective linkage and care coordination services can help newly identified HIV+ individuals to engage in medical care, identify and address barriers to care, and educate clients about navigating the healthcare system. Community health workers (CHWs) can support clients as they engage in care and initiate antiretroviral (ARV) therapy. HIV prevention and care funders have stressed the importance of effective linkage, engagement, and reengagement services to ensure rapid clinical assessment, initiation of ARVs, and reduction of community viral load through undetectable viral load. Few rigorous, replicable interventions, however, have been designed and evaluated among large populations of HIV+ individuals served in public health clinical settings. Training of linkage workers and program managers in public health clinical and other settings is needed to promote demonstrated, effective practice models that can realistically be undertaken in resource-constrained settings.

Setting: The Merck Foundation HIV Care Collaborative (HCC) for Underserved Populations funds replicable, innovative strategies in public health settings to improve outcomes and prevent further HIV infections. The Fulton County Department of Health and Welfare (FCDHW) in Atlanta Georgia participates as one of three HCC local health department grantees. The FCDHW Bridging the Gap Project funded by the HCC is completing a three-year initiative to increase the rate of HIV+ adults linked and engaged in care.

Project: FCDHW clinic-based CHWs collaborate with clinicians and AIDAtlanta medical case managers to engage and retain newly identified HIV+ individuals in care and relink HIV+ individuals that had previously dropped out of care. HCC services are integrated into a large inner-city clinic providing HIV, STD, TB, and other communicable disease services to low income adults. HCC linkage and navigation services are part of a full continuum of public health HIV/STD counseling and testing, partner services, TB treatment, and other communicable disease surveillance and treatment services.

Results: FCDHW staff present practical strategies for linkage and retention based on best practices, lessons learned, and results of a multisite evaluation of the HCC intervention. Practical training is offered on forming care teams, effective roles and responsibilities of CHWs, strategies for client assessment, care planning and management techniques that promote retention and prevent loss to care, safety measures in conducting home visits, caseload management strategies, effective chart documentation, and tools for prospectively identifying and addressing factors that lead to loss to care. We discuss supervisors' role in supporting linkage and retention services, identifying and addressing performance improvement, and meeting the training needs of workers. FCDHW CHWs present their unique perspective on ways that clinicians can benefit further from integrating linkage and engagement workers in the healthcare team. FCDHW CHWs present case studies to demonstrate HCC intervention methods and practical strategies for assisting HCC clients to engage and be retained in care.

Lessons Learned: FCDHW staff will educate trainees about lessons learned, best practices, and practical strategies to help funders, local health department program managers, and front-line workers to adopt evidence-based techniques demonstrated in the HCC.

Abstract 2473 - Effective HIV Linkage and Reengagement Strategies in Public Health Settings: Lessons Learned From the City of Philadelphia Engaging HIV Positive Patients in Care (EHPIC) Project
Author(s): *Helena Kwakwa, Catherine Corson, Oumar Gaye, Susan Lehrman, Kathleen Brady*

Issue: Effective linkage and care coordination services can help newly identified HIV+ individuals to engage in medical care, identify and address barriers to care, and educate clients about navigating the healthcare system. Community health workers (CHWs) can support clients as they engage in care and initiate antiretroviral (ARV) therapy. HIV prevention and care funders have stressed the importance of effective linkage, engagement, and reengagement services to ensure rapid clinical assessment, initiation of ARVs, and reduction of community viral load through undetectable viral load. Few rigorous, replicable interventions, however, have been designed and evaluated among large populations of HIV+ individuals served in public health clinical settings. Training of linkage workers and program managers in public health clinical and other settings is needed to promote demonstrated, effective practice models that can realistically be undertaken in resource-constrained settings.

Setting: The Merck Foundation HIV Care Collaborative (HCC) for Underserved Populations funds replicable, innovative strategies in public health settings to improve outcomes and prevent further HIV infections. The City of Philadelphia Public Health Department Ambulatory Care Services (ACS) in Philadelphia participates as one of three HCC local health department grantees. The ACS EHPIC project funded by the HCC is completing a three-year initiative to increase the rate of HIV+ adults linked and engaged in care. EHPIC operates in eight inner-city health centers located throughout Philadelphia. The health centers provide comprehensive primary care, STD, and HIV services to low income residents. EHPIC patient navigators are employed by ACS and ActionAIDS, an HIV community-based organization (CBO) providing case management and support services.

Project: EHPIC patient navigators are integrated into health center-based multidisciplinary clinical and social work teams to engage and retain newly identified HIV+ individuals in care and relink HIV+ individuals that had previously dropped out of care. Loosely engaged HIV+ patients are also offered patient navigation services to promote medical appointment and medication adherence. EHPIC linkage, navigation and retention services are part of a full continuum of primary care services, as well as HIV and STD counseling and testing, partner services, and other communicable disease surveillance and treatment services.

Results: ACS staff present practical strategies for linkage and retention based on best practices, lessons learned, and results of a multisite evaluation of the HCC intervention. Practical training is offered on forming clinic and CBO multidisciplinary teams, effective roles and responsibilities of navigators, strategies for client assessment, care planning and management techniques that promote retention and prevent loss to care, conducting home visits, caseload management strategies, effective chart documentation, and tools for prospectively identifying and addressing factors that lead to loss to care.

Case studies are presented to demonstrate HCC intervention methods and practical strategies for assisting HCC clients to engage and be retained in care.

Lessons Learned: ACS staff will educate trainees about lessons learned, best practices, and practical strategies to help funders, local health department program managers, and front-line workers to adopt evidence-based techniques demonstrated in the HCC.

Session C24 - Clinical Practice-Based Models for HIV Testing

Room: A708 (Atlanta Marriott Marquis)

Abstract 1540 - Evaluation of an Electronic Medical Record (EMR) Intervention to Increase HIV and HCV Testing in Primary Care

Author(s): *Matthew Golden, Lisa Chew, Sara Jackson, Jane Huntington, Nancy Sugg, Johnathan Scott*

Background: Testing undertaken as part of routine primary medical care is a central component of the U.S. strategy to control HIV and HCV. Levels of testing are currently thought to be low. We evaluated an EMR-based intervention to increase HIV/HCV testing.

Methods: We used EMR data to identify patients in need of HCV or HIV testing who had medical appointments in one of three primary care clinics affiliated with Harborview Medical Center (HMC), a large public hospital in Seattle, WA. Patients age 18-64 without a documented prior HIV test were eligible for HIV testing, and patients born 1945-65 without a documented prior HCV test were eligible for HCV testing. Each day, hospital staff used EMR data collected 1997-2014 to create lists of eligible patients with upcoming scheduled appointments. Clinic medical assistants and providers used these lists to proactively identify eligible patients who needed HIV and/or HCV testing. We compared the percentage of eligible patients tested and newly diagnosed with HIV and HCV in the 18 months before and following institution of the intervention, and calculated the percent of all primary care patients seen during the study period who had ever HCV and HIV tested within the HMC system. Study staff reviewed charts for all persons identified as having new HIV diagnoses to identify and remove persons with false positive test results or known prior HIV diagnoses; this was not done for HCV. We evaluated changes in testing, test positivity and HIV/HCV case finding using generalized linear models with a binomial distribution, log link and random effects for each primary care clinic.

Results: From 1/1/12 to 12/31/14, participating clinics saw 14,004 patients age 18-64 during 114,225 visits, and 8,305 patients born 1945-65 during 65,046 visits. The proportion of visits during which eligible patients tested for HIV and for HCV both increased with institution of intervention, from 4.9% to 12.3% and from 4.3% to 12.5%, respectively (both $p < .0001$). Comparing the preintervention and intervention periods, among tested patients HIV test positivity did not significantly vary (0.71% vs. 0.52%, $p = .74$), nor did the percentage of all eligible patients diagnosed with HIV significantly change (5/2922 [0.17%] vs. 6/3530 [0.17%], $p = .80$). HCV test positivity was significantly higher in the preintervention period than in the intervention period (24.3% vs. 10.5%, $p < .0001$), and the proportion of all eligible patients who newly tested HCV positive did not change with institution of the intervention (65/1236 [5.3%] vs. 55/1522 [3.6%], $p = .26$). Comparing the final 6 month period of the preintervention

and intervention periods, the percentage of eligible patients who had ever tested for HIV and HCV both increased (HIV 53% vs. 65%, HCV 61% vs. 73%, both $p < .0001$).

Conclusions/Implications: An EMR-based intervention increased HIV/HCV testing, but did not increase HIV/HCV case-finding. Levels of testing were high, and most eligible patients had tested for HIV/HCV prior to the start of the intervention.

Abstract 1936 - Implementing and Tracking Progress toward Routine HIV Testing in a Large Hospital Outpatient Department

Author(s): Donna Futterman, Stephen Stafford, Lindsay DuBois

Background: Objective: The routine offer of HIV testing (HT) in medical settings has been recommended by the CDC since 2003 and was mandated by New York State in 2010. Like other hospitals, Montefiore Medical Center (MMC) in the Bronx, NY has improved HIV testing rates but has not yet achieved the goal of testing all eligible patients (non-pregnant and 13-64 years old). For more than a decade, MMC has worked to routinize HT in its outpatient clinics, which have a relatively stable patient population. To establish more accurate HT saturation levels, this study monitored not only annual testing rates but also percent of patients ever tested.

Methods: Methods: Since 2004, the Adolescent AIDS Program (AAP) at MMC has implemented ACTS (Advise, Consent, Test, Support) to overcome routine HT challenges in MMC's outpatient settings. Since 2011, this effort has been supplemented with support from Gilead's FOCUS program. ACTS uses existing clinical staff for testing and existing data resources, employs a streamlined HT method and follows a practice change process comprised of Buy-in, Implementation Planning, Training and Mentoring, and Monitoring and Evaluation. FOCUS added a complementary practice change framework, and technical assistance staff and materials. We report on eight years of work to "routinize" HT throughout MMC's outpatient department with analysis of annual HT among eligible patients as well as HT saturation at the sites over time.

Results: Results: By 2007 (the first year comprehensive data is available) ACTS was widely implemented in MMC's outpatient department and that year 29,706 patients were tested for HIV at its various outpatient sites. Annual testing continued to improve and with the addition of FOCUS support in 2011, the number tested rose to 50,921 and continued to increase annually with 58,288 tested in 2014. Analysis of HT saturation over time at 10 high volume outpatient sites found that at baseline (2005) 28% of clients seen that year had evidence of ever testing for HIV, a figure that more than doubled by 2014 when 57% of patients that year had evidence of HT.

Conclusions/Implications: Conclusions: Implementation of ACTS and Gilead's FOCUS program resulted in a significant increase in HT in a complex hospital outpatient department. This work revealed lessons for other outpatient departments considering or implementing routine HT, including: laws and recommendations alone do not change practice; streamlined, provider-delivered HCT is feasible; following the principles of practice change is crucial but requires perseverance; and improvements to policies and IT can enhance routine testing.

Abstract 1972 - Addressing Barriers for the Integration of Routine HIV Screening within Clinical Settings: Beliefs, Behaviors, and Cultural Change

Author(s): *Saul Zepeda, Laura Roche, Blair Harvey*

Issue: Through the implementation of CAPUS, PHIMC developed several strategies to address a number of organizational and system barriers to routine HIV testing within clinical systems including: perceived burden of time, competing priorities, lack of knowledge and training, misconception regarding consent and counseling requirements, perceived lack of patient acceptance, and most recently, inadequate reimbursement process. While working with sites, PHIMC also identified the need to address the personal feelings of health care providers which impact the delivery of health care services. To that end, PHIMC initiated the Protecting our Patients (POP) campaign, which is designed to address HIV-stigma among clinical providers in order to address HIV/AIDS in general.

Setting: The Care and Prevention in the United States (CAPUS) Demonstration Project, is focused on reducing HIV/ AIDS- related morbidity and mortality among racial and ethnic minorities in the United States. Through CAPUS, PHIMC lead an initiative to implement routine opt-out HIV testing in a variety of health care settings in Illinois. Through their participation in the project, agencies developed, expanded, or improved their capacity to: Integrate routine HIV testing into their practice. Unfortunately, stigma and discrimination towards those perceived to be at risk or living with HIV/AIDS still exists in many health care settings.

Project: Through CAPUS, PHIMC led an initiative to expand routine HIV testing in six clinical systems and four county jails. The project supported the successful achievement of the CAPUS goals, most notably by increasing the number of racial and ethnic minorities who know their HIV status, by expanding and improving the capacity of these systems to conduct HIV testing and by supporting linkage to and retention in care for those newly or previously diagnosed with HIV. POP was created to reduce barriers to routine testing by challenging individual and institutional stigma.

Results: A series of focus groups and key informational interviews were conducted to better understand the current barriers related to stigma within CAPUS sites. The results from said process showed that providers are: 1. Are receptive but apathetic to routine screening, 2. Are apathetic but open to LGBTQ-competence 2. Feel unprepared to address the concerns of this population which increased their discomfort and avoidance of the issues, 3. Has concerns for uninformed patient populations, 4. Desire testimonies, scripting, role-playing, and information tools to enhance their skills

Lessons Learned: Dissemination strategies for an effective campaign geared towards providers, must: 1. adaptable to various settings and time lengths, 2. be administered by a variety of individuals, 2. use an internal champion mobilization strategy, 3. be online in a way that optimizes the likelihood of providers findings it when searching for resources and finally, Despite attempts to integrate, routine HIV screening and GBT-competence needs to run parallel and not be integrated in logic model

Abstract 5119 - A Survey Investigation of Patients' Reasons for Opting Out of Fourth Generation HIV Testing in an Urban Emergency Department

Author(s): *Lisa Moreno-Walton, Anoop Kar, Audrey Billeaud, Cara Joyce*

Background: Understanding why patients opt out of routine HIV testing is important for reducing opt out rates, especially in high prevalence areas, and especially since most new cases are transmitted by those who are unaware that they are infected. We seek to determine why patients choose to opt out of routine fourth generation HIV testing in the Emergency Department (ED), and to qualify the demographics of those who opt out.

Methods: A cross-sectional survey study of 350 patients who opted out of routine fourth generation HIV testing in an urban ED located in a high prevalence area between November 2013 and February 2015. Patients were evenly surveyed during weeknights (125), weekends (125), and weekends (100). An anonymous 23-item survey identified patient demographics, HIV risk factors, and reasons for opting out.

Results: 52% of subjects were male. Age was evenly distributed in the range of 18 to 97 years (19% < 30; 12% > 60). 72% self-identified as Black; 12% as Latino. 67% had high school education or less. 6% identified as gay, lesbian, or bisexual. Significant percentages admitted to present or history of known risk factors: alcohol overuse (15%), drug use (14%), needle sharing (12%), sexual transmitted infection (22%), mental health problems (15%), homelessness (21%), incarceration (25%). 61% identified as being sexually active, 16% with multiple partners. 49% were unemployed, 39% have no primary care physician, 54% were uninsured. Reasons for opting out included: 42% previously tested negative, 35% recently tested, 17% believed themselves to have no risk, 16% stated they were not offered the test, 8% were too focused on their care in ED, 7% didn't want to know their status, 5% did not have time to wait for a result.

Conclusions/Implications: Patients who opt out are predominantly self-identified as heterosexual ethnic minorities. A significant percentage endorse a history of risk factors: alcohol and drug use, sexually transmitted infections, multiple partners, mental health problems, homelessness, incarceration, lack of access, and limited education. Risk factors may be underrepresented due to potential bias of a face to face survey. Though a third of patients who opt out were recently tested, many believe they have no risk and 16% stated that they were not offered the test during triage. Education interventions should be targeted towards the demographic of decliners, emphasizing that testing should not be risk based. Triage nurses need to be educated about informing all patients about the opt out policy of the ED.

Session C27 - PrEP: Clinic based Models

Room: A602 (Atlanta Marriott Marquis)

Abstract 1834 - San Francisco AIDS Foundation Launches PrEP Health Program in Community-Based Sexual Health Center

Author(s): *Steve Gibson, Robert Grant, Chris Hall, Matt Sachs, Jayne Gagliano, Kellie Freeborn, Jennifer Hecht, Pierre Crouch*

Issue: The FDA approved Pre-Exposure Prophylaxis (PrEP) in July 2012 as a safe and effective means to prevent HIV infection. As awareness of PrEP increases in San Francisco, those seeking PrEP have encountered barriers to access. Clients report being denied because their provider was unaware of the FDA approval, or the use of Truvada for prevention. Clients frequently cited denial was based on the

perception or intention to discontinue condom use. Additional barriers included complexities of health insurance, clients being under-insured or uninsured despite ACA mandates. Magnet, a sexual health center for gay men in SF, launched a PrEP health program to increase access and reduce new HIV infections.

Setting: Rates of HIV diagnoses decreased in SF from 507 in 2006 to 359 in 2014. During this same time period, data from the STOP AIDS Project indicate condom use for anal intercourse has decreased. Rates of STIs including gonorrhea, chlamydia and syphilis have increased.

Magnet staff noticed an increase in PrEP inquiries beginning in 2012 with a marked increase in 2014. Clients were surveyed in November 2014 (N=126) to better understand levels of knowledge and interest in PrEP. Results indicated 91% had heard of PrEP, 60% would be interested in accessing PrEP at Magnet, and 19% had used PrEP. Seventy-seven percent reported being insured.

Project: The PrEP health program is directed by Nurse Practitioners and leverages Registered Nurses and community HIV test counselors (HTC) to provide culturally competent care. Clients may self-refer or be referred by HTC during testing. Upon intake, NPs perform a full medical evaluation and PrEP counseling. Magnet uses point of care HIV and chemistry testing and additional lab-based tests, allowing clients to start taking Truvada the same day. Follow-up visits are conducted by RNs who provide ongoing PrEP adherence counseling. All abnormal lab results are referred to the NP for evaluation and follow-up. MDs are available for consultation as needed.

Magnet provides assistance for overcoming barriers to accessing benefits for those who are insured and new benefits for those who are under-insured. Magnet hired SF's first PrEP Benefits Navigator, who works with all medically eligible clients to access PrEP through applying for short-term, full-assistance programs; activating copay rebate cards; counseling and enrolling clients in ACA/CoveredCA plans during open enrollment; and initiating Medi-Cal applications. The Navigator interfaces with insurance companies when clients are met with prior authorization requests or other barriers.

Results: Enrollment began in November 2015. As of April 2015, 211 clients have been screened with 196 (93%) receiving Truvada. Ninety-three percent reported condom-less anal sex within the previous 12-months. Sixty-seven percent were White, 33% non-White. Mean age was 34.4. Mean number of sexual partners was 18.1. Twenty-two percent were diagnosed with an STI at enrollment. Adherence is high with 96% reporting missing 3 or fewer doses/week. Twelve percent reported an increase in condom-less anal sex, 7% reported fewer instances of condom-less sex and 32% reported no change.

Lessons Learned: Community-based sexual health centers can effectively support a sustainable and culturally competent model of offering PrEP services based on CDC recommendations.

Abstract 2293 - Scaling Up HIV PrEP: How HIV Nurses' Knowledge, Attitudes, and Behaviors Impact PrEP Implementation

Author(s): *Jeffrey Kwong, Carole Treston, Jason Farley*

Background: The Centers for Disease Control and Prevention released interim guidelines for the use of HIV pre-exposure prophylaxis (PrEP) in high-risk men who have sex with men in 2011. Evidence from several large-scale clinical trials has demonstrated the efficacy of PrEP in other high-risk populations including heterosexuals and persons who inject drugs. However, since the release of the initial guidance, uptake and use of PrEP within the general population has been low. Factors that have impacted PrEP uptake have included stigma, lack of knowledge among target populations, cost, concern about time and capacity, as well as prescribers' lack of knowledge and fears of risk compensation (i.e. increased sexual risk, including decreased condom use). Nurses play a key role in operationalizing HIV prevention interventions in clinical and community-based settings. Nurses often serve as the first-line clinician and educator, playing a pivotal role in the success of HIV prevention programs. However, there is little knowledge or data on the knowledge, attitudes, practices, and behaviors of nurses with regard to HIV PrEP. Specifically, there is little information on how nurses perceive the role of HIV PrEP as a viable HIV prevention tool, and other factors that may impede the implementation of HIV PrEP programs in real-world settings.

Methods: The Association of Nurses in AIDS Care (ANAC) PrEP Working Group developed a voluntary survey to assess the knowledge, attitudes, beliefs, and practices of nurses with regard to HIV PrEP. The working group developed an online survey that was distributed to current members of ANAC as part of an overall educational initiative on HIV PrEP. Descriptive statistics were used to analyze the results.

Results: Surveys were sent to the ANAC membership in the United States (n=1,700), which includes both front-line nurses and advanced practice clinicians. Preliminary data revealed that nurses had heard about HIV PrEP, but only a small percentage cared for patients on HIV PrEP. There was an overall favorable acceptance of PrEP as a prevention option for high-risk populations, however concern still exists regarding risk compensation and the potential for viral mutation in patients who sero-convert while using PrEP. Nurses also felt that their knowledge and ability to educate patients regarding HIV PrEP was still at a novice level. Results were used to help shape a national PrEP nursing education program coordinated by ANAC.

Conclusions/Implications: Additional education and information targeting the role of nurses in HIV PrEP education, rollout, and information regarding real-world implementation of PrEP is needed. Concerns about risk compensation remain a significant issue among HIV nurses. Additional programs to support education and skill building among nurses, especially HIV nurses, are needed to help facilitate the rollout and implementation of HIV PrEP within healthcare systems. This education will also enable nurses to play a vital role in community awareness about PrEP, as they are frequently cited as a trusted source of health information for the American public.

Abstract 2316 - Engaging Patients and Communities in PrEP Care: A PrEP Engagement Cascade

Author(s): *Helena Kwakwa, Sophia Bessias, Donielle Sturgis, Natasha Mvula, Mayla Jackson*

Issue: HIV pre-exposure prophylaxis (PrEP) was approved by the US FDA in 2012. Since then HIV prevention professionals in various settings have labored to determine the best strategies to engage individuals/communities at high risk of HIV in PrEP care. We describe an eight-month process of

engaging patients and communities, detailing successful strategies at each step of the PrEP Engagement Cascade (PEC).

Setting: The Philadelphia Department of Public Health (PDPH) operates 8 FQHC look-alike facilities in the city neighborhoods, each center housing an HIV clinic, and each providing a broad array of primary health care services including routine HIV testing. Collectively the 8 health centers provided HIV primary care to 1,044 individuals in 2014, a fraction of the 68,000 receiving non-HIV care in the health centers. In July 2014 the PDPH began offering PrEP at all 8 health centers. At one health center, the Strawberry Mansion Health Center (SMHC), a concerted campaign was launched to engage the community and patients in PrEP care. The SMHC zip code 19132 is among few Philadelphia zip codes with the highest number of People Living With HIV/AIDS (PLWHA).

Project: The goals of the project were to (1) inform the Philadelphia community, particularly those in the SMHC service area, about PrEP and its availability; and (2) engage eligible patients in PrEP care according to current CDC recommendations. We engaged community prevention providers, including the largest STD clinic in the city. We also developed and conducted training on PrEP and referrals for all clinicians, nurses and social workers at SMHC. Finally we trained HIV Rapid Testers to refer for PrEP all patients at moderate or high risk who returned a negative test and were open to PrEP in the abstract.

Results: Of 383 patients referred for PrEP, 45.7% were female and 54.3% male. The median age was 26yrs for men and 27yrs for women. More than half (54.2%) were uninsured, with men more likely to lack insurance. The vast majority of patients had not heard of PrEP prior to their referral (83% of 141 respondents). Of all referrals, 82.9% were from PDPH Rapid Testers, the remainder coming from community prevention providers, PDPH clinicians, the STD clinic, and patients receiving HIV primary care. Of all referrals, 251 were reached by PrEP staff, 172 of whom expressed maintained interest. Most of these (171) were scheduled for medical eligibility evaluation, only 87 attending scheduled evaluation visits; 34 were prescribed PrEP. Attrition rates at all steps of the PEC trended higher for women than men, the difference statistically significant only at the level of maintained interest when reached by PrEP staff.

Lessons Learned: Engaging patients and communities at high risk of HIV in PrEP care is a multi-pronged process with the potential for attrition at many steps along the engagement continuum. Prompt follow-up with referred patients and timely appointments improve retention. Full engagement of the HIV prevention infrastructure is key to identifying potential candidates, and engagement of the non-HIV general primary care infrastructure, including primary care clinicians, is critical to optimizing retention.

Abstract 2509 - PrEPare: An Organization's Journey to PrEP Implementation

Author(s): *Amy Leonard, Jason Black*

Issue: Since the 2012 FDA approval of Truvada as a drug for pre-exposure prophylaxis (PrEP), organizations dedicated to HIV prevention have strived to integrate this new biomedical prevention method into their existing programs. Despite CDC's 2014 release of comprehensive guidelines for clinical practice, PrEP awareness and access is at varying stages among the general population across the U.S.

Setting: Legacy is a Federally Qualified Health Center in Houston with roots in the GLBT community, serving the uninsured/under-insured in their pursuit of health equity. Founded in 1981 by a group of gay physicians to treat STDs in gay men, Legacy has a community-based HIV prevention program that has tested more than 130,000 people for HIV since that time.

Project: Through a collaboration of Legacy's public health, operations and clinical teams, we developed and implemented a PrEP program for communities at high risk of HIV acquisition. Key implementation steps were identified as follows: 1) establish PrEP candidate consideration; 2) create a PrEP clinical workflow; 3) establish PrEP access points; 4) identify documentation for assessment and adherence; 5) identify support for PrEP medication and labs; 6) establish process for medication patient assistance program; and 7) develop education plan for internal staff and community.

Results: Through March, 2015 over 100 individuals have been prescribed PrEP at Legacy's HIV primary care clinic. An average of 15 individuals per month is navigated through the PrEP program. All providers and support staff at Legacy's HIV primary clinic have been trained on PrEP clinical protocol. PrEP specific appointments were created in the clinic schedule. Outcome measures and tracking mechanisms were established. Potential PrEP candidates were connected with a patient navigator. Potential candidates were screened for HIV and provided comprehensive PrEP education. Patient Navigators assisted the candidates with scheduling an appointment, eligibility process and initial laboratory work. Patient Navigators assisted with follow-up appointments. The program has been marketed through street outreach, group presentations, HIV/ STD testing, and dissemination of social marketing campaigns.

Lessons Learned: A successful PrEP program is multifaceted and dependent upon collaboration among clinic and community outreach. Thorough preparation of clinical logistics is a necessity. The patient navigation component proved to be a central piece to ensuring an individual efficiently accessed PrEP services.

Track D

Session D07 - Social Marketing and HIV Prevention: From Exposure to Action

Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1399 - Reach and Perceived Effectiveness of Act Against AIDS Testing Campaigns Targeting Men Who Have Sex with Men

Author(s): *Hannah Badal, Nancy Habarta, Vanessa Boudewyns, Ameer Bhalakia, JoEllen Stryker, Nickolas DeLuca*

Background: Among gay, bisexual, and other men who have sex with men (MSM), black MSM (BMSM) and Hispanic/Latino MSM (LMSM) are disproportionately affected by HIV. To address these disparities, CDC launched two social marketing campaigns under the Act Against AIDS umbrella between 2011 and 2013, to increase HIV testing: Testing Makes Us Stronger (TMUS) for BMSM ages 18–44 and Reasons/Razones for LMSM ages 18–49. The purpose of this study is to assess reach and perceived effectiveness of TMUS and Reasons.

Methods: A web-based survey was conducted among sexually active gay and bisexually identified men from December 2014–March 2015 (N=3,104, but results reported here are from provisional dataset N=2,194). Participants were recruited from an online LGBT consumer panel. The survey oversampled younger (18–39), African American/black, and Hispanic/Latino men. Measures included channel usage and self-reported campaign exposure and ad receptivity. Descriptive statistics and logistic regression were used to assess exposure and perceived campaign effectiveness. Significant variables from the bivariate analyses were included in final multivariate models.

Results: Overall, 39% of respondents reported exposure to TMUS in the past 12 months and rated the campaign's effectiveness high (Mean=4.94 on 1 to 6 scale, SD=1.09). Being black (AOR=3.04, p<.001), multiracial (AOR=1.80, p=.01) or other race (AOR=1.69, p=.04) versus white, using public transit (AOR=1.13, p<.001), Gay Pride attendance (AOR=1.10, p<.001), reading magazines (AOR=1.08, p=.015), visiting a CDC website for HIV information (AOR=1.18, p<.001), and perception that being gay is an important part of identity (AOR=1.19, p<.001) were all significant predictors of exposure to TMUS in the multivariate model. Multivariate regression indicate that visiting a CDC website for HIV information (β =.15, p<.001), perception that being gay is an important part of identity (β =.09, p=.012), and education (β =-.12, p=.044) significantly predicted perceived effectiveness of TMUS. Among BMSM ages 18–44 (n=348), 61% reported campaign exposure and rated the campaign high (Mean=5.02, SD=1.09).

Overall, 18% of respondents reported exposure to Reasons in the past 12 months and rated the campaign highly (Mean=4.87, SD=1.17). Visiting a CDC website for HIV information (AOR=1.19, p<.001), reading newspapers (AOR=1.07, p=.039), reading magazines (AOR=1.11, p=.009), being Hispanic/Latino (AOR=1.61, p<.001) versus white, and Gay Pride attendance (AOR=1.08, p=.005) significantly predicted exposure to Reasons in the multivariate model. In the bivariate analysis, age, education, being multiracial, and using Facebook, were all significantly associated with Reasons perceived effectiveness (p<.05). While education remained significant in the multivariate model, the overall model predicting perceived effectiveness was not significant (p=.196). Among LMSM ages 18–49 (n=689), 24% were exposed to Reasons and rated the campaign high (Mean=4.99, SD=1.08).

Conclusions/Implications: CDC's testing campaigns resonated beyond the target audiences, however exposure to and perceived effectiveness of TMUS and Reasons were highest among BMSM and LMSM indicating that a targeted approach to campaign implementation is an effective way to reach these audiences with HIV testing messages. Future HIV testing campaigns for BMSM and LMSM may want to consider implementation strategies such as presence at Gay Pride events, advertising in print/online media and linking to a CDC website to increase campaign exposure.

Abstract 1496 - Testing Makes Us Stronger? Preliminary Analysis of the Effects of CDC's Testing Makes Us Stronger Campaign on HIV Testing Behavior among Black Gay and Bisexual Men

Author(s): Nancy Habarta, Vanessa Boudewyns, Hannah Badal, JoEllen Stryker, Nickolas Deluca, Jennifer Uhrig, Donata Green, Jennie Johnston, Jackie Rosenthal,

Background: Among all gay and bisexual men, black/African American gay and bisexual men (BMSM) bear a disproportionate burden of HIV. In response, CDC developed and launched Testing Makes Us Stronger (TMUS), a social marketing campaign to increase HIV testing among BMSM ages 18-44 in December 2011. CDC is triangulating data from various sources to determine campaign effectiveness. One evaluation component was a survey to assess TMUS exposure and its association with HIV testing and other behavioral factors.

Methods: A web-based survey was conducted among sexually active gay and bisexually identified men from December 2014-March 2015 (N=3,104; results reported here are from provisional dataset N=2194). Participants were recruited from an online LGBT consumer panel and oversampled younger (18-39), African American/black, and Hispanic-Latino (H-L) men. Key measures included: self-reported campaign exposure and ad receptivity; HIV testing behavior, norms, knowledge, self-efficacy, beliefs/attitudes, and intentions. Descriptive statistics, comparison of means using independent t-tests, and bivariate and multivariate regression analyses were conducted to assess characteristics associated with TMUS exposure and the key outcome of interest, HIV testing.

Results: Among BMSM ages 18-44 (n=348), 61% reported exposure to TMUS. The majority of those exposed were aged 25-34 (54%), HIV-negative (65%), had at least some college education (87%), income<30k (51%), and insured (79%). Having the belief “getting an HIV test is free, fast, and confidential” (t=-2.734 (232.348), p=.007) and the norm “most of my sexual partners get tested for HIV atleast every 6 months” (t=-2.493 (342), p=.013) were significantly associated with TMUS exposure compared to those not exposed. There was high self-efficacy for getting an HIV test among all BMSM (mean=4.82 on 1-5 scale). To assess the campaign’s association with its primary outcome, HIV testing, two binary dependent variables were created to indicate self-reported HIV testing in the past 6 and 12 months. Bivariate and multivariate analyses with age, income, education, insurance status, perceived importance of gay identity, and exposure to TMUS were conducted to assess associations of HIV testing at 6 and 12 months. In the multivariate model, exposure to TMUS (AOR=2.17, CI=1.28, 3.7) was the only significantly associated variable with HIV testing in the past 6 months. Exposure to TMUS (AOR=2.14, CI=1.11, 4.12), and having a college degree (AOR=3.30, CI=1.11, 9.81) versus high school or less, were significantly associated with HIV testing in the past 12 months in the multivariate model. In both testing outcome models, having insurance approached significant associations as well.

Conclusions/Implications: Preliminary analyses indicate that TMUS has been successful in reaching BMSM ages 18-44 effectively with high levels of exposure reported. One of TMUS’ key messages that HIV testing is free, fast, and confidential resonated with the target population and TMUS exposure was strongly associated with reported HIV testing behaviors at 6 and 12 month frequencies. National level, social media campaigns with a clear implementation strategy, focused goals and objectives, an online and event presence, such as TMUS, can have an effect on both intermediate outcomes, e.g., beliefs/norms, and also on longer term outcomes such as HIV testing behavior of specified target audience.

Abstract 1616 - Exhibitionist: A Peek into Alluring High Impact Prevention Campaigns

Author(s): *Natalie Sanchez, Ramon Garcia, Thomas Siegmeth*

Issue: Nationally, MSM account for 78% of newly infected persons a year. In Los Angeles, there are 59,500 persons living with HIV and an estimated 2500 new infections each year. 88% of new HIV infections occur among the MSM population of which Latino MSM represents 46% of these new infections. Most Latino MSM face deep-rooted issues such as HIV stigma, homophobia, acceptance, and lack of HIV information. These issues have contributed to high proportion of new HIV infections and a need for high impact prevention for Latino MSM in Southern California. In addition, there is a shortage of culturally sensitive campaigns aimed to appeal to the Latino MSM community. Many campaigns have failed to effectively engage in meaningful dialogue that results in risk reduction and prevention. This ineffectiveness can be attributed to a lack of understanding all of the components involved in a comprehensive HIV marketing campaign that goes beyond its creative design.

Setting: The High Impact Prevention Campaigns were developed to be used in Community Health Centers, Nightclub Venues, Online Platforms and Community Events.

Project: AltaMed will showcase the following campaigns from its conceptualization to production to implementation and its impact to address and reduce issues that affect the Latino MSM community. The high impact prevention campaigns that will be shared include a re-designed Top-Bottom-Vers-Pasivo-Activo bilingual mass condom distribution campaign that re-launched in early 2015. Friends with Benefits, a distinctive social networking campaign, portrayed real life scenarios through a comic strip series geared to spark HIV testing conversations. AltaMed's mass media outdoor campaigns in Southern California were strategically located and designed to increase overall awareness of primary and HIV health care. A strategic bilingual Affordable Care Act campaign focused on increasing Covered California enrollments in Southern California. The telenovela web-series, Sin Vergüenza (Without Shame), that speak on topics such as HIV stigma, homophobia, infidelity, and relationships. The Barrio Free Clinic, themed Gay & Lesbian Pride events that embrace the East LA Chicano/a history of zoot-suits and low-riders. Lastly, we will exhibit the multiple display banner campaigns that have garnered success on GRINDR.

Results: Over the course of a year, AltaMed identified over 145 positives from 2013 -2014. Through each campaign, AltaMed perfected a methodology of developing effective strategies and popular creative designs.

Lessons Learned: Mid campaign, some of the implementation tactics had to be adjusted to achieve the goals set. Some challenges encountered included overcoming red tape due to the corporation's family-oriented image and the homo-erotic imagery that's effective in MSM communities. AltaMed will share a thorough and customizable strategy guide that assist other organizations in developing their own targeted strategies and creative while overcoming red tape and building on the organization brand.

Track E

Session E01 - A CDC-supported Coalition for Applied Modeling for Prevention

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 2119 - Comparison of Interventions Across the HIV Care Continuum

Author(s): *Kathryn Risher, Maunank Shah, Gabriela Paz-Bailey, Cyprian Wejnert, R. Luke Shouse, David Dowdy, Patrick Sullivan, Eli Rosenberg, Jacek Skarbinski,*

Background: Viral suppression, the end point of the human immunodeficiency virus (HIV) care continuum, has been shown to reduce morbidity, mortality and transmission. National goals emphasize maximizing coverage along the HIV care continuum. However, the costs of such interventions are poorly understood, and the relative benefits of interventions at varying ‘steps’ of the HIV care continuum are not easily compared. Our objective was to develop a standardized reporting framework to improve comparability of costing data between interventions at different stages of the HIV care continuum with the goal to identify optimal combinations of interventions to increase the percentage of persons living with HIV who achieve viral suppression.

Methods: We conducted a literature review on interventions along the HIV care continuum including: 1) HIV testing; 2) Linkage to HIV care after HIV diagnosis; 3) Maintenance in care among persons already in care; 4) Re-engagement in care among persons who have been disengaged from care for >1 year; 5) Adherence support among those on ART. Using data from our literature review, we developed a standardized reporting framework that combines data on cost and intervention efficacy for each intervention along the HIV care continuum into a unified model that can be used to estimate the cost per virally suppressed person per year for each intervention along the HIV care continuum and thus compare the relative cost effectiveness of continuum interventions. The costing framework is submitted as part of a panel presentation on a Centers for Disease Control and Prevention (CDC)/National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention-funded modeling cooperative agreement begun in 2015.

Results: Our literature review suggests that current reporting of costs and efficacy of interventions along the HIV care continuum are inadequate to guide allocation of resources by policy makers. Substantial variability exists in literature estimates of resource input costs, targeted populations, and methods for reporting of efficacy for continuum interventions. To overcome this barrier, our framework incorporates available data on population sizes at each ‘step’ of the HIV care continuum to calculate the relative and absolute reach of proposed interventions, applies standardized efficacy measures to each care continuum intervention, and applies standard costs (e.g. standard cost per staff person) based on existing CDC and Health Resource and Services Administration budgets for programmatic activities. This framework is being developed into an open-source tool for policy makers and researchers; our tool will accept inputs on observed costs and efficacy of HIV care continuum interventions, and provide a standardized assessment of comparative (step-specific and overall) cost-effectiveness.

Conclusions/Implications: Relative incremental costs per additional virally suppressed persons per year may vary substantially across different interventions in the HIV care continuum. Future studies of continuum interventions should utilize a standardized reporting framework to allow informed comparisons that include: a) standardized ‘step’ specific measures for costs and efficacy and b) cost-effectiveness expressed as the incremental cost per virally suppressed person per year. This costing framework can be applied at the federal, state and local levels to allocate resources for maximal impact to improve outcomes along the HIV care continuum.

Abstract 2121 - Teaming Modeling with Practice: the Emory Coalition for Applied Modeling for Prevention (CAMP)

Author(s): *Jane Kelly, Eli Rosenberg, Monica Trigg, Patrick Sullivan*

Issue: Epidemic and economic models for the United States can answer complex questions in the United States' HIV epidemic. Yet if based solely on national data and perspectives, they may not serve the needs of local jurisdictions with different demographics, or where local data on some variables are missing. Engaging public health programs at the earliest stages of model design can optimize understanding of data gaps, local resource limitations, challenges in implementing recommendations, and the need for user-friendly modeling tools for local estimations.

Setting: In 2014, CDC/NCHHSTP awarded a competitive five-year cooperative agreement to design and adapt models for public health decision-making for HIV prevention and the other four Center focus areas. One of three awardees was Emory University (in partnership with Johns Hopkins University, NORC at the University of Chicago, and the University of Washington), which has become the Emory Coalition for Applied Modeling for Prevention (CAMP). In its first year of funding, Emory CAMP is developing models, manuscripts, and web tools to address 6 overarching scientific questions, 4 of which include Division of HIV/AIDS Prevention collaboration. Emory CAMP was distinct among the awardees in incorporating a Public Health Advisory (PHA) workgroup. The PHA workgroup consists of public health programs that are diverse geographically, in maturity of data systems and technical capacity, and in the population demographics served. Representatives from state and city health departments as well as non-profit organizations provide input to CAMP modeling projects via a variety of iterative means.

Project: In February 2015, the PHA workgroup met with Emory CAMP members and CDC/NCHHSTP colleagues in Atlanta to review Year 1 projects. For each of 6 proposals, researcher(s) provided a brief presentation, CDC subject matter experts described the specific national public health interest in the results, and a collective discussion regarding methods, data availability, implications of potential results and additional needs was held with PHA workgroup representatives. Ongoing discussion continues via conference calls and use of a project management website.

Results: Among the additional needs identified by the PHA workgroup were modifiable "spreadsheet" tools based on national HIV models that would allow entry of local data to generate area-specific results, and the cost estimates that include technical capacity. The PHA group emphasized jurisdiction-specific challenges that must be considered to create practical recommendations: varying availability of HIV clinical providers, assumptions that may not be appropriate locally, and the political will for HIV interventions. Other issues identified included varying data completeness, terminology consistency (e.g., the differing CDC and HRSA care continuum definitions), local laws (e.g., that may restrict Data To Care interventions), local public health analytical capacity, budgetary costs split among multiple entities, and the challenges of communicating uncertainty to decision-makers, all of which impact the translation of research into public health action.

Lessons Learned: There is immense value in including prevention programs from the beginning of question design to understand regional variations in data validity, completeness, and gaps; terminology

used by funders; political sensitivity; human and structural resources, and sensitivity analyses to account for varying local conditions.

Abstract 2134 - Estimating Populations of MSM in US States and Counties

Author(s): *Jeremy Grey, Kyle Bernstein, Patrick Sullivan, David Purcell, Harrell Chesson, Thomas Gift, Eli Rosenberg*

Background: As part of a panel presentation on a CDC/NCHHSTP-funded modeling initiative, we plan to discuss small-area estimation of MSM populations in the United States. In the US, male-to-male sexual transmission continually accounts for the greatest number of incident HIV infections and substantial numbers of annual STI infections. Since men who have sex with men (MSM) are a minority population, we can infer that prevalence and incidence rates are highest among MSM compared to other groups. However, demographic data on sexual behavior are not currently collected by the Census or American Community Surveys (ACS), and we cannot approximate rates without this denominator.

Methods: Recent estimates of the total population size of MSM in the United States were reported as part of a meta-analysis by Purcell and colleagues (2012). In addition, Lieb and colleagues (2009) developed methods for estimating populations of MSM within smaller geographic areas, including an “MSM Index” to apportion the overall percentage of MSM according to the relative representation of same-sex male households (SSMH) in a given area. The MSM Index is computed using the following formula: $MSM\ Index_i = (SSMH_i / total\ SSMH) \div (households_i / total\ households)$. Using pooled data from ACS (2009-2013), we multiplied Purcell et al.’s estimated percentage of US men who had sex with men in the past five years (3.9%) by a) the MSM Index and b) the number of men aged 18 and over, in order to estimate the number of MSM in US states and counties.

Results: We found that the number of MSM ranged from 2,851 (Wyoming) to 818,501 (California) among states. Approximately 35% (n=1,112) of US counties had no MSM, according to our method, while the top five largest populations of MSM were located in Los Angeles County, California (n=236,670); New York County, New York (n=123,023); Cook County, Illinois (n=114,036); San Francisco County, California (n=101,428); and Riverside County, California (n=81,683). Although California and Los Angeles County had the largest MSM populations of states and counties, the New York City metropolitan statistical area (MSA) had the most MSM of all MSAs (n=365,243). Finally, using these data, we were able to generate maps showing the distribution of MSM in the United States at the state and county levels.

Conclusions/Implications: Small-area estimates of MSM populations such as these provide a useful tool to local public health practitioners and policy makers for determining the burden of HIV and STIs in local contexts. The resulting incidence and prevalence rates would allow for better resource allocation, intervention development, and service delivery.

Abstract 2228 - Impact of CDC’s Pre-Exposure Prophylaxis Guidelines for Eligibility and Coverage on HIV Incidence among MSM: Results from a Stochastic Network Mathematical Model

Author(s): *Samuel Jenness, Steven Goodreau, Eli Rosenberg, Karen Hoover, Dawn Smith, Patrick Sullivan*

Background: Daily oral pre-exposure prophylaxis (PrEP) with tenofovir disoproxil fumarate and emtricitabine has proven effective to prevent HIV-1 infection among men who have sex with men (MSM) within clinical trial settings, but the population-level impact of this new technology will depend on eligibility and targeting policies, prescription coverage levels, and individual drug uptake and adherence. CDC guidance for MSM indicates PrEP for those with risk behaviors like high partnership acquisition rates. No studies have forecasted the population-level reductions in disease incidence according to these guidelines. There is a particular need to model outcomes among MSM subpopulations like young black MSM experiencing the highest disease burden.

Methods: As part of a CDC/NCHHSTP-funded modeling cooperative agreement begun in 2015 (the CAMP project), with final results for this phase completed in September 2015, this study extended stochastic models of HIV transmission dynamics in a population of young MSM in Atlanta, parameterized from prospective cohort and cross-sectional sexual-network studies in Atlanta. Our models incorporate temporally evolving sexual networks, using the statistical framework of exponential random graph models. Baseline models, calibrated to observed HIV prevalence in the target population, simulated the disease trajectories in the absence of PrEP. Counterfactual models then tested CDC indications for PrEP use, including sexual activity in the context of non-monogamous partnerships, unprotected anal sex, and serodiscordant partnerships. Relative infections averted and number needed to treat to prevent one infection were estimated for each guidance element under various levels of coverage driven by interventions that increased PrEP access and uptake.

Results: Early iterations of our models replicated the disease trajectories of HIV among young MSM in our target population. Development of PrEP modules for uptake and adherence was based on contributions from academic, CDC, and local health department partners in the CAMP project. Full results will present the epidemiological analyses on PrEP specified above to demonstrate the impact of CDC guidance and coverage interventions on reducing disease burden.

Conclusions/Implications: Estimating infections averted from adopting elements of CDC's PrEP guidelines, alone and in combination, among various MSM populations will help to optimize risk-based screening in clinical settings. Mathematical modeling is a useful approach to investigating the complex interactions between behavioral and biological elements underlying these eligibility criteria. We expect that our model will indicate demographic elements related to the sexual network structure, such as the race and age of individuals within sexual partnerships, to be candidates for incorporation within guidance. Future work will extend these models by incorporating event-based PrEP dosage and implications for STI co-infections.

Session E02 - Tackling HIV Criminalization: Public Health Advocates Working Together to Reduce Stigma and Discrimination

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1816 - Tackling Criminal Transmission of HIV: The Role of Public Health

Author(s): *Randy Mayer*

Issue: The National HIV/AIDS Strategy calls upon state legislatures to "consider reviewing HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV." Iowa was among the first states to revise its statute after release of the NHAS. Advocates worked with the state health department to modernize Iowa's statute.

Setting: The effort to modernize the statute took five years of effort within the state public health policy and legislative arenas. The Iowa Department of Public Health provided education and guidance to advocates and legislators on HIV transmission risks, research on the effects of criminal transmission statutes, and alternatives that might better promote public health goals and reduce stigma. Ultimately, a coalition formed to draft legislation that would better support the implementation of Iowa's Comprehensive State HIV Plan. The coalition included key legislators, Lambda Legal, the Iowa ACLU, and CHAIN, a statewide advocacy group that was led by people living with HIV.

Project: Iowa took a public-health approach to revise its HIV-specific disclosure statute that had been in effect since 1998. Prior to the introduction of legislation, the state department of health developed a fact sheet for legislators and advocates to help them understand the research on and implications of criminal statutes, and to suggest principles to use when modernizing Iowa's statute. Health department staff provided access to the State Attorney General's office and supported the work of the coalition as they drafted a bill to be introduced. Supportive work included providing education on HIV, the NHAS, and the state's Comprehensive HIV Plan at forums across the state, directly to legislators, and to media. In addition, the HIV Community Planning Group took a vote to more publicly support the effort.

Results: Although the original bill was altered from what the advocates worked to introduce, legislation that removed any requirement for disclosure, provided significant protections for people living with HIV, and was not specific to HIV was passed unanimously by the Iowa Senate and House, and was signed by the Governor in May 2014. From 1999 to 2011, there were 37 charges filed against 25 individuals for non-disclosure of HIV status. Fifteen of those individuals were convicted on a total of 25 counts. In the 11 months since the passage of the bill, only one person has been convicted under the new statute. That case involved exposure to a serious infectious disease in a manner intended to inflict harm.

Lessons Learned: HIV-specific criminal transmission statutes have been shown to create stigma and to impede public health programs and goals. State health departments can play critically important roles in advancing efforts to revise and modernize criminal transmission statutes in their states. Knowing how to educate about criminal transmission statutes and how to work with advocates and coalitions are keys to achieving success. At the same time, a diverse coalition, led by an articulate and dedicated advocate and advised by legal counsel knowledgeable about HIV and criminal transmission, ensured the ultimate success of the effort.

Abstract 2024 - Tackling Criminal Transmission of HIV: The Role of the Advocates

Author(s): *Tami Haught*

Issue: "HIV criminalization" is the wrongful use of HIV status in a criminal prosecution, whether it is under HIV-specific statutes that exist in 34 states and territories, or under general criminal statutes. HIV

transmission is seldom a factor in these prosecutions. HIV criminalization has led to PWHA being vilified in the media, and receiving long prison sentences and/or required sex offender registration, even when transmission was extremely unlikely or impossible.

Setting: Advocates can partner with state health department staff to change policies like criminal transmission statutes. These laws run counter to public health strategies by creating a distrust of public health and health care program programs and their staff. In some cases, laws force public health officials into the role of investigators required to report on the very people they are trying to serve. However, advocates are not likely to succeed without the support and backing of state health departments.

Project: CHAIN (Community HIV and Hepatitis Advocates in Iowa Network) consists of advocates and people living with HIV and/or hepatitis. In 2009, the group decided to change Iowa's criminal transmission law, Iowa Code 709C. It was an HIV-specific disclosure law that resulted in a class B felony (up to 25 years) and sex-offender registry for life for convictions that involve sex. For five years, CHAIN worked with legislators, lawyers, advocates, and the state health department to build support for modernizing the statute. Activities included a coordinated media plan, regular coalition meetings, and partnering with national and local agencies like the SeroProject and Lambda Legal. The group focused on the public health effects of criminal transmission statutes and ensured that the state health department was well represented in important discussions with legislators, media, and the public.

Results: Although the original bill was altered from what the advocates worked to introduce, legislation that removed any requirement for disclosure, provided significant protections for people living with HIV, and was not specific to HIV was passed unanimously by the Iowa Senate and House, and was signed by the Governor in May 2014. From 1999 to 2011, there were 37 charges filed against 25 individuals for non-disclosure of HIV status. Fifteen of those individuals were convicted on a total of 25 counts. In the 11 months since the passage of the bill, only one person has been convicted under the new statute. That case involved exposure to a serious infectious disease in a manner intended to inflict harm.

Lessons Learned: Advocates can partner with state public health officials to address state criminal transmission statutes. Each partner has an important role to play. Advocates may need to take the lead, but the support of state public health officials is imperative. Iowa has developed a model that can work in other states to modernize criminal transmission statutes. Building relationships with legislators took many years and the work of a full-time advocate working at the statehouse.

Abstract 2544 - Reducing HIV Stigma and Discrimination Through Reform of HIV Criminalization Law
Author(s): *Scott Schoettes*

Issue: With its release of the first National HIV/AIDS Strategy, the Executive Branch for the first time took a position questioning the use of HIV criminalization laws. Since that time, the Administration has taken an even stronger stand against these laws, with guidance coming from the Department of Justice as to "best practices" for states to follow in reforming their laws. This presentation will describe the landscape relating to HIV criminalization laws across the country, discuss the advances made in some jurisdictions, and examine ways in which these laws are inconsistent with current knowledge and do not support public health and human rights based approaches to preventing and treating HIV.

Setting: The United States or, to be more precise, the 38 states and U.S. territories that currently use the criminal law to punish people living with HIV for activities that would otherwise be legal or to enhance offense levels and criminal penalties based solely on a person's HIV status. More specifically, the issue plays out in the courts, legislature and executive branches of these states at the intersection of law enforcement and public health.

Project: To assess and describe the landscape of HIV criminalization laws across the country, drawing parallels and providing some basis for categorizing the ways in which different states approach this issue. In addition to assessing the landscape, Lambda Legal and others have developed and are refining arguments against use of the criminal law, except in extremely limited circumstances, to advance public health goals. Working with various state stakeholders, we are learning which of these arguments are most effective. We are also a part of research being done to test these messages in order to evaluate their effectiveness at convincing judges, prosecutors, legislators and members of the public to dismantle or reject use of the criminal laws for these purposes.

Results: The assessments of the various state laws currently in place will be presented through various maps visually depicting various aspects of the laws. The arguments against criminalization have been broken down into three broad categories: public health, legal/due process issues and human rights. These three categories each contain multiple more specific arguments against use of the criminal law in this context.

Lessons Learned: We are learning which arguments are most effective with different audiences. Lambda Legal has selectively used several of these arguments to secure the first state supreme court decision overturning an HIV criminalization conviction and refining the high court's interpretation of an existing law to make successful convictions much more limited. Furthermore, Lambda Legal worked with advocates in Iowa to use these arguments to reform the HIV-specific criminal law in that state and with stakeholders in multiple other states to turn back efforts to tighten these laws.

Special Session

Session SS13 - Unsafe Injection Practices Among People who Inject Drugs in Rural Communities: A New Phase of the HIV Epidemic?

Room: Regency V (Hyatt Regency Atlanta)

Abstract 5080 - Emergency Implementation of A Syringe Exchange Program During a Community Outbreak of HIV Infection Linked to Injection Drug Use - Indiana, 2015

Author(s): *Brittany Combs*

Issue: Syringe exchange programs (SEPs) can reduce HIV transmission among persons who inject drugs (PWID) without increasing drug use, yet access to such programs is limited in many U.S. areas. On March 26, 2015, the first-ever SEP in Indiana was authorized by emergency executive order in response to the escalating HIV outbreak among PWID in Scott County.

Setting: Scott County, located in rural southeastern Indiana, has high rates of unemployment (9%), less-than-high-school education attainment (21%), and poverty (19%). As of June 14, 2015, 170 persons were diagnosed with HIV in this outbreak. Based on the number of named contacts of cases, we estimated that about 500 PWID in Scott County were at risk for HIV infection.

Project: Nine days after its authorization, the SEP opened with the support of local government and local law enforcement. To ensure rapid distribution of sterile injection equipment and removal of contaminated equipment from the community, the SEP adopted an anonymous one-for-one exchange plus needs-based model; clients received both replacement syringes for those they returned for disposal and additional syringes based on reported need. Additional no-cost services included wound care kits, harm reduction counseling, and referral and follow-up for HIV and HCV testing, substance abuse treatment, and HIV antiretroviral therapy or pre-exposure prophylaxis. Services were provided through a fixed-site at a multi-service, community outreach center established for the outbreak response. Mobile outreach services were provided to clients unable to access the fixed site. Staff included two full-time public health nurses, two additional full-time staff, and temporary volunteer staff as needed. The SEP was funded through private grants and donations.

Results: As of June 6, 2015 (two months after opening), 184 clients had enrolled in the SEP; 142 through the fixed-site and 38 through mobile outreach. Half (53%) were male, 98% were non-Hispanic white, 93% were heterosexual, and the median age was 34 years (range: 19-67). At SEP enrollment, 82% reported injecting the opioid OPANA ER[®], and 21% reported injecting heroin. Sharing syringes to inject (29%) or to divide drugs (36%) was common as was sharing other injection equipment (e.g., cookers) (43%). Fifty-six percent of clients reported engaging in sex without a condom and 69% had received HIV testing prior to SEP enrollment. Overall, 23,163 syringes were distributed and 17,934 were returned for safe disposal. All clients (100%) were provided risk reduction counseling and offered referrals for HIV testing, HCV testing, substance abuse treatment, and hepatitis A and B vaccination. Seventy-eight percent of clients had at least one repeat visit after enrollment, with a mean of 2 visits (range: 1-6).

Lessons Learned: We report on the first emergency authorization and implementation of SEP by state and local government in response to an HIV outbreak in the US. Rapid implementation of both fixed and mobile outreach SEP was feasible in this non-urban setting. Over 180 PWID at high-risk for HIV transmission were successfully reached with key HIV prevention services within just two months.

Abstract 5042 - Emergency Deployment of HIV Clinical Care in A Rural Setting: Southeastern Indiana HIV Outbreak, 2015

Author(s): *Runa Gokhale, Erika Chapman, Janet Arno, John Brooks, Caitlin Conrad, William Cooke, Laura Cooley, Kenneth Dominguez, Joan Duwve, Shikha Garg, D Cal Ham, Daniel Hillman, Karen Hoover, Diane Janowicz, Jeanni McCarty, Jennifer Myers, Robyn Neblett-Fanfair*

Issue: On January 23, 2015, the Indiana State Department of Health (ISDH) began an outbreak investigation of HIV infections in a rural Indiana town (population, 4,200). HIV was transmitted principally through needle-sharing by persons injecting the opiate oxycodone. Identification of HIV-infected persons and initiation of effective antiretroviral therapy (ART) to reduce further HIV transmission were critical components of the outbreak response.

Setting: Before this outbreak, one family medicine practice (FMP) provided medical services to the town; the closest provider offering HIV care was over 30 miles away. HIV-infected individuals had limited access to transportation and inability to travel long distances due to severe drug addiction, both challenges to early linkage to care. Therefore, establishing local HIV care was an urgent need.

Project: The outbreak was declared a public health emergency on March 26, mobilizing local medical and community-based organizations to partner with academic institutions and local, state and federal government agencies to establish HIV care and support services. To monitor uptake of these services, data on the numbers of persons in each of the following continuum of HIV care categories were collected: diagnosed with HIV infection, engaged in care (one CD4 count or viral load [VL] reported to surveillance), enrolled in state-run care coordination services, prescribed ART, and virally suppressed (VL < 200 copies/mL).

Results: By March 31, the local FMP, with support of infectious disease specialists, had initiated HIV care in this community. In addition, a “One-Stop Shop” community center was opened that provided HIV testing, health insurance registration, care coordination, substance abuse treatment resources, vaccinations, and a locally run syringe exchange program. Care coordinators partnered with disease intervention specialists and clinic staff to locate HIV-infected individuals, facilitate their enrollment into care coordination and health insurance, make clinic appointments, and escort them to clinical services to start an integrase-based ART regimen that minimized drug/opiate interactions. As of June 26, 172 persons were diagnosed with HIV infection. Of 168 HIV-infected individuals able to be monitored (i.e., alive and in Indiana), 126 (75%) were engaged in care, 114 (67%) were enrolled in care coordination, 73 (43%) were prescribed ART, 25 (15%) were virally suppressed, and 152 (90%) were co-infected with hepatitis C virus (HCV). Of the 41 individuals with a VL after starting ART, 25 (61%) had undetectable VL, 6 (15%) had VL > 200 but < 400 copies/mL, 7 (17%) had a VL > 400 copies/mL, and 3 (7%) had VL that was higher or unchanged from baseline.

Lessons Learned: This emergency deployment of clinical care during an HIV outbreak required timely collaboration among a broad spectrum of community-based and government agencies, academic institutions, and service providers. ART scale-up, treatment adherence support, and management of co-morbid conditions such as drug addiction, mental health disorders, and HCV co-infection, are critical next steps for achieving higher rates of viral suppression and ultimately better health and reduced HIV/HCV transmission. Identifying resources to sustain clinical care and maintain HIV testing and behavioral/biomedical prevention services will be instrumental in following through on early successes.

Track A

Session A10 - HIV Incidence: From Calculation and Estimation to Implications for Health Care Policy

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1534 - Getting Close to Zero New HIV Infections: Consistency in Multiple Methods for Measuring Very Low HIV Incidence among People Who Inject Drugs in NYC, 2005-2014

Author(s): *Don Des Jarlais, Kamyar Arasteh, Courtney McKnight, Jonathan Feelemyer, Aimee Campbell, Susan Tross, Lou Smith, Hannah Cooper, Holly Hagan, David Perlman*

Background: Reliable measures of incident HIV infections are critical for evaluation of community-level combined prevention, including “treatment as prevention” (TasP), but low incidence rates are particularly difficult to measure. We compared four methods for estimating HIV incidence among persons who inject drugs (PWID) in New York City (NYC) between 2005-2014

Methods: The methods used to estimate HIV incidence were: (1) HIV seroconversions among repeat participants in a long-running research study, (2) The slope of the curve of HIV prevalence by years injecting for new injectors in the same study, (3) Incident cases of HIV among PWID in New York State (NYS) calculated using the Centers for Disease Control and Prevention (CDC) stratified extrapolation approach (SEA) divided by the estimated 103,877 PWID in NY State, and (4) using newly diagnosed cases of HIV among PWID in the HIV Surveillance program of NYC Department of Health and Mental Hygiene (DOHMH) as a surrogate for incident infections.

Results: There was great consistency among methods for estimating incidence: (1) Repeat Participants: For the 2005–2014 period, there were 2 seroconversions in 543 person-years (PY) at risk, for an HIV incidence rate of 0.37/100 PY (95% CI 0.1/100 PY to 1.3/100 PY). For the 2005-2010 period, there were 2 seroconversions in 161 PY, for an incidence rate 1.2/100 PY (95% CI 0.2/100 PY to 4.5/100 PY). For the 2011-2014 period, there were no seroconversions in 382 PY, for an incidence rate of 0/100 PY (95% CI 0.0/100 py to 0.1/100 PY). The difference between 2005-2010 and 2011-2014 approached statistical significance ($p = 0.09$)

(2) Slope of HIV prevalence by years injecting for new injectors: For the 2006-2014 period the slope was 0.58/100 PY (95% CI of 0.49/100 PY to 0.67/100 PY). There were not sufficient numbers of new injectors to estimate incidence separately for 2005-10 and 2011-14.

(3) The CDC SEA algorithm: Over the 2007 to 2012 time period, there was an average incidence of 0.32/100 PY. For 2011-2012, there was an average incidence of 0.20/100 PY. This method does not permit sampling based calculation of confidence intervals for incident cases in the population.

(4) Using newly diagnosed cases of HIV infection reported to NYC DOHMH as a surrogate for incident infections. Over the 2007 to 2012 time period, there was an average incidence of 0.130/100 PY, and for 2011 to 2012 an average incidence of 0.106/100 PY. This method also does not permit a sampling based confidence interval calculation.

Conclusions/Implications: The consistency among the estimates suggests that all are capturing the same underlying phenomenon of low/decreasing HIV transmission among PWID in NYC. Concurrent validity among the measures would greatly facilitate studying the “end of HIV epidemics.” The estimates are particularly low and consistent for the more recent time periods (2011 onwards, 0/100 PY, 0.2/100 PY and 0.1/100 PY). The HIV epidemic among PWID in NYC appears to be reaching an endemic state with close to zero new infections.

Abstract 2199 - HIV Incidence in California, 2010-2013

Author(s): *Shoshanna Nakelsky, William Wheeler, Jennie Chin, Jessica Brown, Susan Scheer*

Background: California continues to be severely impacted by HIV. In 2013, approximately 118,000 Californians were living with HIV and 4,636 newly diagnosed cases were reported representing the highest and second highest morbidity burden in the U.S. respectively. HIV incidence estimates are used to evaluate progress towards the National HIV/AIDS Strategy goal of reducing new HIV infections by 25% by 2015. The Los Angeles (LAC), San Francisco (SF), and California (CA) Departments of Public Health conduct HIV Incidence Surveillance. Previously we reported incidence estimates for each jurisdiction. We report the first collaborative HIV statewide incidence estimate for California.

Methods: We used the Local Incidence Estimation methodology developed by CDC that combines Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS) results and HIV testing and treatment history data to estimate the number of new infections among diagnosed individuals and infected people who remain undiagnosed. For this analysis, we included individuals diagnosed with HIV during 2010-2013 who were at least 13 years of age at diagnosis and were reported to a local California health jurisdiction. To calculate rates, we used population estimates from the California Department of Finance.

Results: The estimated number of new HIV infections are presented with point estimates and 95% confidence intervals in parentheses. For California overall, the estimated number of new HIV infections were 4966 (4187-5749) in 2010, 5174 (4279-6069) in 2011, 5059 (4226-5892) in 2012, and 4861 (4020-5701) in 2013. LAC had an estimated 2234 (1785-2683), 2245 (1797-2693), 2142 (1724-2560), and 1879 (1485-2273) new HIV infections during 2010-2013 respectively. SF had an estimated 451 (297-604), 566 (379-752), 581 (405-757), and 503 (345-661) new HIV infections during 2010-2013 respectively. Other California counties had an estimated 2282 (1850-2713), 2364 (1843-2884), 2336 (1872-2801), and 2479 (1968-2990) new HIV infections during 2010-2013 respectively. Each year, the estimated rate of new infection in SF (63-80/100,000) was significantly higher than in LAC (23-27/100,000) or the other California counties (7-8/100,000) ($p < 0.001$). The estimated rate of new HIV infection for men (28-30/100,000) was 7-10 times higher than for women due to the high proportion of infections in men who have sex with men (MSM; 75%-78% of cases annually). Blacks had higher estimated incidence rates than Latinos and Whites (2013: 38/100,000; 13/100,000; and 11/100,000, respectively; $p < 0.001$).

Conclusions/Implications: HIV incidence estimates remained relatively stable during 2010-2013 in California overall and in each incidence jurisdiction. However, there is evidence of significant geographic and demographic disparities. Notably, MSM and Blacks were disproportionately impacted by new HIV

infections and SF had over twice the incidence rate of other California jurisdictions. These findings highlight the continued need for HIV prevention efforts in California with resources targeted to address disparities in HIV infection rates.

Abstract 2331 - Estimating Incidence among Men Who Have Sex with Men in Texas, 2010-2012

Author(s): *Craig Boge, Jesse Campagna, Emily Rowlinson, Jonathon Poe, Miranda Fanning*

Background: As a participant in HIV Incidence Surveillance, Texas estimates counts and rates of new HIV infections for demographic groups using CDC methodology. To date, no rates have been calculated for men who have sex with men (MSM), because denominators were not available for these populations. We estimated incidence rates for MSM populations in the state and in specific metropolitan areas (MSA) using recently calculated MSM population estimates for Texas.

Methods: To allow for estimation of rates using multiple demographic factors, we estimated incidence counts for the combined years 2010-2012 among Texas MSM at least 18 years of age using the Serologic Testing Algorithm for Recent Seroconversion (STARHS). This estimation process uses results from the BED HIV-1 assay run using remnant blood specimens and testing and treatment histories collected on newly-diagnosed cases to calculate population-level incidence estimates. Missing information was imputed for cases without BED results or testing and treatment history information. Rates were calculated using estimates of the Texas MSM population.

Results: For the years 2010-2012, we estimated 10,253 (95% CI: 8847-11661) new infections among Texas MSM occurred, which corresponds to a rate of 579.4 per 100,000 person-years (95% CI: 499.9-658.9). Black MSM aged 18-24 had the highest estimated incidence rate at 4,830 per 100,000 person-years (95% CI: 3,743-5,917), a rate 4.7 times greater than Hispanic MSM peers and 8.6 times greater than White/Other MSM peers. Black MSM aged 25-34 and 35-44 and Hispanic MSM aged 18-24 also had estimated rates greater than 1,000 per 100,000 person-years. Within MSAs, Black MSM populations consistently had the highest rates and Hispanic MSMs had the second-highest. The difference in rates between the two populations varied by MSA, with Blacks having a rate 38% to 436% higher than Hispanics.

Conclusions/Implications: These findings represent the first attempts to calculate an HIV incidence rate among the MSM population in Texas as well as selected metropolitan areas. Results support national conclusions that the young MSM and black MSM populations are disproportionately affected by HIV. However, the magnitude of the disparity among racial groups varies greatly between metropolitan areas. While statewide strategies focusing on young and black populations may be most effective, metropolitan areas must be aware of trends within their own jurisdictions and target prevention efforts accordingly.

Abstract 2376 - Controlling the Massachusetts HIV/AIDS Epidemic: Implications for Health Care Policy

Author(s): *Kevin Cranston, Betsey John, H. Dawn Fukuda, Liisa Randall, Kenneth Mayer, Alfred DeMaria, Jr.*

Background: The National HIV/AIDS Strategy has set ambitious goals for reducing new HIV infections, improving health outcomes for persons living with HIV, and reducing HIV-related health disparities and inequities. To date, U.S. states and cities have shown limited progress toward these goals. As the federal Affordable Care Act has expanded treatment opportunities for persons with HIV nationwide, and as some states have expanded their Medicaid programs, improved treatment outcomes hold the promise of concurrently reducing the transmission of HIV infection. Massachusetts, as an early adopter of health care reform and Medicaid expansion, may be a test case for the impact of HIV care on new infections.

Methods: HIV infection has been reportable to the state health department since 1999, and all CD4+ lymphocyte and HIV viral load test results have been reportable since 2012. Newly reported cases of HIV infection for the period 2000-2013 were characterized by sex, age, race/ethnicity, and exposure mode using CDC criteria. Calculation of frequencies and tests of significance were performed with SAS 9.3 (SAS Institute Inc., Cary, NC). Poisson regression was employed to test the statistical significance of secular trends in diagnoses. Reported laboratory values (CD4+ and HIV viral load) for individuals reported with HIV through 2012 were characterized by the number and timing of laboratory reports received in 2013 to characterize individuals by care engagement and viral suppression.

Results: A sustained downward secular trend in reported HIV infections was observed for the period, resulting in a 41% reduction between 2000 and 2013 (1,185 to 698, $p < .0001$). Statistically significant reductions were observed across sex, race/ethnicity, and exposure mode categories ($p < .002$). Statistically significant reductions were observed for most age categories ($p < .001$), with the exception of persons age 13-24 and over 50 (NS). Reported engagement and retention in care in 2013 greatly exceeded national averages (76% and 61%, respectively) as did viral suppression (64%). Viral suppression among those retained in care was 87%.

Conclusions/Implications: The observed reductions in reported HIV infections are unprecedented for any US state and may be related to expanded health care and antiviral medication access in Massachusetts. Massachusetts added Medicaid coverage for persons with HIV (non-AIDS) earning less than 200% FPL in 2001 and further expanded health care access, particularly for low-income residents, through state health care reforms starting in 2006. Coupled with an extensive community health center and hospital system and community-based prevention, screening, and linkage to care services, this expanded health care access may have contributed to observed rates of engagement and retention in care and rates of viral suppression and, consequently, to observed reductions in reported HIV infections. These trends may have implications for health care policies under consideration in other jurisdictions.

Session A14 - Continuing the Conversation about the HIV Care Continuum

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1654 - Differences in HIV Care and Viral Suppression among Persons Aged 50 Years and Older, 18 U.S. Jurisdictions

Author(s): Laurie Linley, Sonia Singh, Tianchi Zhang, Ndidi Nwangwu-Ike, Angela Hernandez, H. Irene Hall

Background: In 2012, 40% of persons living with diagnosed HIV infection were aged 50 years and older; it is estimated that in the near future, half of all persons living with HIV will be ≥ 50 years. Given that older persons are more likely to be diagnosed late with HIV, it is particularly important to ensure that they are linked to HIV care and receive optimal treatment to improve health outcomes. We used data from the CDC National HIV Surveillance System (NHSS) to assess care and viral suppression among older persons diagnosed with HIV.

Methods: Data reported to NHSS through December 2013 from 17 states and the District of Columbia with complete CD4+ T-lymphocyte (CD4) and viral load (VL) reporting were used to determine linkage to care, retention in care, and viral suppression among persons aged ≥ 50 years newly diagnosed and living with HIV. Linkage to care was defined as ≥ 1 CD4 or VL test within 3 months after HIV diagnosis and was calculated for older persons diagnosed in 2012. Retention in care (≥ 2 CD4 or VL tests at least 3 months apart in 2011) and viral suppression (most recent VL < 200 copies/mL in 2011) were calculated for persons diagnosed by year-end 2010, who were aged ≥ 50 years at year-end 2010 and alive at year-end 2011. Data were statistically adjusted for missing HIV transmission categories.

Results: Among 3,305 persons aged ≥ 50 years diagnosed with HIV in 2012, 2,830 (85.6%) were linked to care within 3 months after diagnosis. Linkage to care was lower among blacks (81.9%) and Hispanics/Latinos (84.2%) compared with whites (90.9%). A lower percentage of black men were linked to care compared with black women (79.7% vs. 85.3%). By transmission category, linkage to care ranged from 80.1% among males with HIV infection attributed to injection drug use to 87.3% among males with infection attributed to male-to-male sexual contact. Among 158,629 persons aged ≥ 50 years living with diagnosed HIV in 2011, 53.3% were retained in care. Retention in care ranged from 39.3% among American Indians/Alaskan Natives to 70.7% among persons of multiple races, and was lower among blacks (50.9%) and whites (53.3%) compared with Hispanics/Latinos (55.3%). Compared with black and Hispanic/Latino women, lower percentages of black (48.9% vs. 55.4%) and Hispanic/Latino (53.3% vs. 62.2%) men were retained in care. Among all persons aged ≥ 50 years living with diagnosed HIV in 2011, the percentage who were virally suppressed was 50.8%; viral suppression was lower among blacks (44.7%) and Hispanics/Latinos (50.5%) compared with whites (56.5%). Among the subset of 97,689 persons who had at least 1 VL test during 2011, viral suppression was 82.6% overall, and was lower for blacks (75.7%) and Hispanics/Latinos (83.3%) compared with whites (89.1%).

Conclusions/Implications: Nearly half of all persons aged 50 and older living with HIV do not have evidence of engagement in routine care, and half have no evidence of viral suppression. The racial/ethnic disparities among older persons highlight the need for improvements in HIV care and treatment outcomes, particularly among older blacks and Hispanics/Latinos.

Abstract 1989 - Trends and Predictors of Timely Linkage to Care and Viral Suppression among Philadelphia Residents Newly Diagnosed with HIV, 2006-2013

Author(s): *Tanner Nassau, Melissa Miller, Kathleen Brady*

Background: Timely linkage to care and viral suppression within one year of HIV diagnosis are important benchmarks in the treatment of newly diagnosed HIV patients. Population trends in linkage to care and

viral suppression can provide insight into whether efforts to engage individuals in care have been successful and can help identify barriers to meeting National HIV/AIDS Strategy (NHAS) benchmarks.

Methods: Data were used from Philadelphia's electronic HIV/AIDS Reporting System to calculate timely linkage to care and viral suppression within one year of diagnosis for Philadelphia residents 18+ years of age who were newly diagnosed with HIV between 2006 and 2013 and survived past 90 days after diagnosis. Timely linkage to care was defined as a viral load and/or CD4 count within 90 days after HIV diagnosis and viral suppression within one year of diagnosis as any viral load <200 copies/mL within 365 days of diagnosis. CD4 count at diagnosis was imputed using the first CD4 after diagnosis assuming a 50-cell/year decrement. Trends in linkage to care and viral suppression were analyzed using Cochran-Armitage tests and Kaplan-Meier curves were used to calculate changes in timely linkage to care and time to viral suppression by diagnosis year. Multivariate logistic regression determined significant predictors of viral suppression adjusting for race/ethnicity, sex at birth, age and mode of HIV transmission.

Results: Cochran-Armitage test for trend showed a significant upward trend in timely linkage to care ($p < 0.0075$) and viral suppression within one year of HIV diagnosis ($p < 0.0001$) between 2006 and 2013. Kaplan-Meier results demonstrate significant association between timely linkage to care ($p < 0.0001$) and viral suppression ($p < 0.0001$) by year of diagnosis. Mean time to viral suppression decreased from 134 weeks in 2006 to 38 weeks in 2013, with 75% of those diagnosed in 2013 reaching viral suppression within 32.8 weeks (95%CI: 29.4-38.0). Adjusting for key demographics, multivariate analysis demonstrated that individuals diagnosed in 2013 were 4.65(CI: 3.68-5.88) times as likely to be virally suppressed at some point during the first year after diagnosis when compared to those diagnosed in 2006. Patients who were linked to care within 90 days were 6.65(CI: 5.51-8.02) as likely to reach viral suppression within the first year after diagnosis compared to those who linked after 90 days. Persons with CD4 levels below 200 cells at diagnosis were 2.59(CI: 2.21-3.02) times as likely to reach viral suppression within one year when compared to those diagnosed with CD4 levels greater than 500 cells. Individuals diagnosed at counseling and testing sites(AOR:0.638; CI:0.489-0.833) and correctional facilities(AOR:0.602; CI:0.475-0.763) were significantly less likely to be virally suppressed within one year of HIV diagnoses compared to those diagnosed in medical settings.

Conclusions/Implications: While significant advancements have been made over time in improving timely linkage to care and viral suppression within one year of HIV diagnosis, there is still room for improvement. Effective strategies to engage asymptomatic individuals with higher CD4 counts, persons diagnosed in non-medical settings and those not linked to care during the first three months after diagnosis are needed to meet NHAS viral suppression goals for the population.

Abstract 1999 - Quantifying the Churn Effect in the DC Metropolitan Region Using a Novel Privacy and Data Sharing Technology

Author(s): *JMF Ocampo, A. Allston, R. Bhattacharjee, J. Cadet, S. Carter, J. Collmann, C. Flynn, A. Hamp, D. Jordan, S. Kassaye, M. Kharfen, G. Lum, R. Pemmaraju, A. Rhodes, JC Smart, J. Stover, MA Young*

Background: The churn effect occurs when people receive HIV care outside of their regular care location. Details about this dynamic process and how it affects the HIV care continuum form a large

knowledge gap in HIV epidemiology. Public health departments experience the churn effect when persons diagnosed in their jurisdictions move to or access care in other jurisdictions, but maintain their original care site. Although matching mechanisms for out-of-jurisdiction cases exist, they are often labor intensive, do not report real-time numbers, and are focused on preventing case duplication instead of monitoring care. This study used a novel, automated, and real-time privacy technology to examine the churn effect affecting the HIV care continuum in the DC metropolitan region, including areas in DC, MD and VA.

Methods: This study used Ada programming language to develop a deterministic ~1,000-lines algorithm, including a person-matching system with Enhanced HIV/AIDS Reporting System (eHARS) variables: last name, first name, date of birth, sex at birth, health care identifier, race, local unique identifier, and vital status. The matching strength categories in this system were categorized into (from strongest to weakest): exact, very high, high, medium high, medium, medium low, low, and very low. Jurisdictions (DC, MD, and VA) securely transferred eHARS data records to jurisdiction-specific directories onto the privacy device configured with this algorithm. Data files were first detected and ingested. Subsequently, an in-memory representation of the data was created within the privacy device. Immediately thereafter, data were securely deleted using multiple file re-writes. The privacy device provided jurisdiction-specific output reports with matches between the host and matching jurisdictions. Reports included unique eHARS identifiers, vital status for host and matching jurisdictions, matching strength, and the variable name of the matched data field. The privacy technology was verified using conventional component testing methods, manual code inspection, and comprehensive output file examination.

Results: Of 161,343 uploaded eHARS records from DC (N=49,326), MD (N=66,200), and VA (N=45,817), a total of 21,472 persons were matched with various matching strengths. No records were matched as “medium low” or “low.” The results of person matches were bidirectional, i.e., DC-reported MD matches were equal to MD-reported DC-matches, etc. The following results are listed as exact, very high, high, medium high, medium, and very low person matches: DC-MD; 4,013; 5,907; 53; 268; 645; and 482; MD-VA: 856; 2,343; 11; 117; 377; and 865; VA-DC: 1,064; 3,340; 15; 149; 438; and 529. The total duration of the matching process was 21 minutes and 58 seconds.

Conclusions/Implications: This study quantified person matching across DC, MD and VA eHARS data and thereby illustrated the churn effect affecting the HIV care continuum in the DC metropolitan region. This novel privacy and data-sharing technology may facilitate maintaining more timely HIV surveillance data by reducing the time to complete more traditional person-matching reviews. Furthermore, this demonstrated how jurisdictions could share data safely, rapidly, and responsibly without compromising privacy to answer pre-determined questions about HIV. Future analyses will examine extensive validation methods, and generalizability of these findings to other applications.

Abstract 2439 - Interactive Online Resource to Visualize Geographic Patterns in the HIV Care Continuum in 5 Major US Cities

Author(s): *Travis Sanchez, Cory Woodyatt, Alexandra Ricca, Patrick Sullivan*

Issue: Online tools are robust for mapping illness data, and allow for insights that are not possible with aggregate or static figures. These resources can be instrumental in targeting areas that need

more/better healthcare and public health resources. Mapping HIV cases at multiple geographic levels in the US has been done for a number of years, but until now no interactive maps have ever been created for HIV care outcomes.

Setting: HIVContinuum.org was launched in February 2015 and is a free online resource for visualizing HIV care continuum outcomes in 5 US cities heavily impacted by HIV - Atlanta, Chicago, New Orleans, Philadelphia, and Washington, DC.

Project: HIVContinuum.org use disease surveillance data from public health agencies to map HIV diagnoses, late diagnoses, linkage to care, engagement in care and viral suppression. Maps are generated at the ZIP code- or neighborhood-level for each of the participating cities. The website has an intuitive user interface and allows viewing of maps by race/ethnicity, sex and age. HIVContinuum.org also has overlays of the most current information on HIV testing locations and Ryan White Care Act clinics.

Results: HIV care continua were developed for each small geographic area within the cities (ZIP code for Atlanta, Chicago, New Orleans and Philadelphia; Ward for Washington DC) for all those newly diagnosed from 2007-2011 with care outcomes through 2012. HIV care continua for demographic sub-groups were already created for each of these small areas. This process identified that even within our most heavily impacted cities there are micro-epidemics in which some areas experience higher rates of new HIV diagnoses than others, but we can now also see similar patterns in worse care continuum outcomes. For instance, in Atlanta we see that the core parts of the city have the largest 5-year risk of new HIV diagnoses, but that areas in South Atlanta and Northeast Atlanta have worse linkage to HIV care within 90 days after diagnosis.

Lessons Learned: Testing and treatment location mapping may help us understand how care outcomes may compare to the distribution of these resources in the city. HIV care providers, public health agencies and policy makers should consider how mapping of HIV care continuum outcomes could be used in our collective response to the epidemic. Further exploration of how care outcomes differ for sub-populations in different areas of these cities may help us resolve some of the pervasive disparities in care outcomes.

Session A15 - Women and HIV: Violence Against Women, Reproductive Justice and Linkage and Retention During Pregnancy

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1594 - The Intersection of HIV and Violence against Women and Girls: Collaborative Approaches

Author(s): *Linda Koenig, Dawn Fowler*

Issue: HIV infection and violence against women and girls are major and often co-occurring public health concerns. Victims of violence are at increased risk for acquiring HIV, and violence and trauma can compromise the health status of women living with HIV (WLWH). Collaborative approaches are needed to identify new ways to address the intersection of these public health problems.

Key Points: Women and adolescent girls represent about 20% of new infections and nearly one-quarter of those living with HIV in the US. Black/African American and Hispanic/Latina women continue to be disproportionately affected compared with women of other races. Intimate partner violence (IPV) affects nearly a quarter of all women in the US but about twice as many (55%) WLWH. Victims of IPV are at increased risk for acquiring HIV – often through forced sex, compromised negotiation of safer sex practices, or increased sexual risk-taking behaviors – and also for mental health problems including post-traumatic stress disorder (PTSD). PTSD can compromise health care behavior and WLWH have nearly six times the national rate of PTSD. Of women living with HIV, less than half (45%) are engaged in care, and only 32% have achieved viral suppression. WLWH who have experienced violence or trauma are less likely than those who have not to be engaged in care, adherent to antiretroviral medications and virally suppressed. Recently abused women are also more likely to engage in sex without a condom. In 2012, the White House established a "Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-related Health Disparities", with representation from numerous federal agencies. In October 2014, they released the "First Annual Update: Workgroup Report on Addressing the Intersection of HIV, Violence against Women, and Gender Disparities", documenting new activities prompted by the Working Group. In this roundtable, the facilitators will summarize current research and findings on the intersection of IPV and HIV among women and girls and describe goals and activities of the Working Group. They will discuss collaborative activities within CDC's Division of HIV/AIDS Prevention and the Division of Violence Prevention, conducted since the initiation of the Working Group, and how the work adds to the understanding and prevention of HIV and IPV in vulnerable populations.

Implications: Reducing women and girls' risk for IPV and addressing the sequelae of abuse may both reduce their risk for HIV acquisition and improve outcomes along the continuum of care for WLWH. New ideas for prevention programs are needed to address these co-occurring problems and bring together researchers, practitioners and program specialists who are often working in different areas.

Abstract 2122 - Pregnancy and Linkage to Care among Women of Childbearing Age Diagnosed with HIV Infection—61 health departments, 2013

Author(s): *Lauren FitzHarris, Natasha Hollis, Steven Nesheim, Julia Greenspan, Erica Dunbar*

Background: Pregnancy is an opportunity to engage women in care and services. This analysis identifies HIV diagnoses among women of childbearing age (CBA), pregnancy rate among all HIV-positive and newly identified positive women, receipt of prenatal care, and linkage to HIV medical care.

Methods: We analyzed HIV testing data from 2013 on women of CBA (15-44 years old) from 61 CDC-funded health departments in the United States, DC, Puerto Rico and the U.S. Virgin Islands. Associations between HIV status and pregnancy status (self-reported) and selected characteristics were tested by chi-square. Characteristics included age, race/ethnicity, testing site (healthcare vs. non-healthcare settings), referral to partner services, and linkage to HIV medical care (LTC) within 90 days of diagnosis. Engagement in prenatal care (PNC) and LTC results are reported separately as a minimum estimate (includes missing/invalid data) and maximum (missing/invalid data omitted from

denominator). PNC and LTC were analyzed among all HIV-positive women (total positives including newly diagnosed) and among newly identified HIV-positive women (new positives).

Results: Among 1,379,860 CBA women tested for HIV infection, 3,690 (0.3%) tested positive, of whom 56% (n=2,064) were newly identified positives. Of all women diagnosed with HIV infection, the racial/ethnic distribution was 67% (n=2,478) black, 15% (n=559) white, and 13% (n=463) Hispanic/Latina; the remaining 5% (n=190) were other or unknown race/ethnicity. Forty percent (n=1460) of HIV-positive women were of advanced maternal age (35-44 years). More than half (67%, n=2,467) were diagnosed in healthcare settings. A positive HIV status was associated with older age, black race, and healthcare testing site (all $p < 0.0001$) whether the analysis included all positives (total positives), or restricted to the newly positive subset.

Among total positives (n=3,690), pregnancy status was known for 54% (n=1987), of whom 7% (n=138) were pregnant at HIV diagnosis. Among pregnant women in the total positives group, 76-80% were in PNC. Pregnancy was associated with younger age ($p < 0.0001$) and healthcare testing site ($p < 0.01$). There was no association between pregnancy status and race/ethnicity and referral to partner services ($p > 0.05$).

Among new positives (n=2,064), pregnancy status was known for 61% (n=1,268), of whom 5.4% (n=69) were pregnant at diagnosis. The range for PNC was 77%-79%. Among newly identified positives, pregnancy was associated with younger age ($p < 0.01$) and healthcare testing site ($p < 0.03$), but there was no association with race/ethnicity and referral to partner services ($p > 0.05$).

Ranges for LTC were 72%-93% for pregnant women and 56%-88% for non-pregnant women among total positives; LTC was associated with pregnancy ($p < 0.01$) only by the minimum indicator. Among newly identified positives, 67%-94% of pregnant and 55%-88% of non-pregnant women were linked to care; no association was found between pregnancy and LTC.

Conclusions/Implications: Among HIV-positive women, LTC was higher for pregnant than non-pregnant women. Although this finding was only significant in the analysis with missing LTC data (which may underreport LTC), pregnancy appears to be an opportunity to engage or re-engage women into care, which could be improved further if PNC rates increased beyond the 76-80% observed in this population

Abstract 2165 - In Our Own Voice (IOOV): National Black Women's Reproductive Justice Agenda for Preventive Health

Author(s): *DD Diallo, M Howell, LD Mayes, JR Flint, LG Blount, T Middleton*

Issue: Reproductive Justice (RJ) means the human right to control our sexuality, our gender, our work, and our reproduction. That right can only be achieved when all women and girls have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives. We believe that bodily autonomy and empowerment are at the core of Black women's rights to prevention education and services to reduce their risks of STIs, including HIV, and unintended pregnancies. A Black Women's RJ Agenda is crafted to

address the key policies that either advance or hinder the ability and capacity for women to make healthy decisions and reduce the rates of STIs and unplanned pregnancies.

Setting: IOOV is a national policy initiative sponsored by Communications Consortium Media Center (CCMC), in partnership with Black Women for Wellness (Los Angeles), Black Women’s Health Imperative (Washington DC), New Voices Pittsburgh (PA), SisterLove, Inc. and SPARK Reproductive Justice Now (both in Atlanta). IOOV is designed to amplify and lift up the voices of Black women and girls at national and regional levels in our ongoing fight to secure Sexual and Reproductive Health and Justice for all women.

Project: In 2012, IOOV partnered with CCMC to commission groundbreaking public opinion research on how Black communities felt about abortion rights and other reproductive health issues. Using landline and cell phones, the firm of Belden Russonello Strategies LLC conducted a survey of 1,006 Black adults (18 and older). The findings of the survey, African American Attitudes on Abortion, Contraception and Teen Sexual Health, showed overwhelming support among Black communities for abortion rights and access, contraceptive equity and comprehensive sex education.

Results: African Americans view contraception, screenings and treatment for cervical and breast cancers, care for pregnant women, and screenings and treatment for sexually transmitted disease, including HIV as part of a woman’s basic health care. African Americans overwhelmingly support comprehensive sex education.

Over 90% believe that sex education should contain information about preventing HIV/AIDS, preventing unintended pregnancy with birth control, abstinence, and preventing domestic and sexual abuse. 73% agree that “teen sexual development is a normal part of growing up and the best approach is to ensure that young people have all the information and education about sex and contraception they need.” Services should include screenings and treatment for STIs and HIV-AIDS (91%); and contraception, such as birth control pills, diaphragms, IUDs, and Depo-Provera injections (86%).

Lessons Learned: African Americans overwhelmingly support ensuring access to affordable contraceptives, teaching comprehensive sex education and keeping abortion safe and legal. Strong majorities also believe that publicly funded contraception should be available to those who need it and that abortion should be available from health care providers in their communities. The attitudes are broadly shared across age, gender, education, income, ideology and religion.

These attitudes and opinions clearly show that we could improve all sexual and reproductive preventive healthcare services for Black women and girls with overwhelming support within our communities for greater public investment and resources.

Track B

Session B04 - To Know Us: Understanding the Unique Vulnerabilities for HIV among Young Black MSM

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1842 - Online-Mediated Anal Sex Partnerships among Young Black MSM in Los Angeles County

Author(s): *Ekow Sey, Jeffrey King, Juli Carlos-Henderson, Yingbo Ma, Jocelyn Patterson-Mosely, Damian Denson*

Background: Sex partnerships that are initiated on dating or social networking sites are posited to be characterized by higher sexual risk taking compared to those that are initiated offline. However, few investigations have focused on young black MSM or explicitly compared men's risk behavior within online-mediated anal sex (OMAS) partnerships and offline anal sex (OFAS) partnerships.

Methods: Four hundred young black MSM (ages 18- 29 years) recruited from street outreach and gay-identified public venues in Los Angeles County completed a baseline interview after enrolling in a randomized controlled trial for an HIV prevention intervention. Respondents were asked about their anal sex partnerships in the previous 3 months. Descriptive statistics, chi-square tests and logistic regression were used to compare OMAS partnerships and OFAS partnerships with respect to condomless anal sex (CAS), disclosure of HIV status and knowledge of partners' HIV status. The OMAS partnerships of HIV-positive and HIV-negative respondents were also compared.

Results: OMAS within the previous 3 months was reported by 38% of respondents. Both disclosure of the respondent's HIV status and knowledge of partner's HIV status were lower in OMAS partnerships as compared with OFAS partnerships (51% vs 61% and 22% vs 34%, $p < 0.05$). OMAS partnerships were less likely to be characterized by CAS as compared with OFAS partnerships (29% vs 71%; $p = 0.03$). After controlling for partner type (main vs non-main), there was no difference in CAS between OMAS partnerships and OFAS partnerships (AOR, 0.7; 95% CI: 0.5-1.0) however, OMAS partnerships remained characterized by less disclosure (AOR, 0.7; 95% CI: 0.5- 0.9) and less knowledge of partner's HIV status (AOR 0.6; 95% CI: 0.4-0.8). HIV-positive men were more likely to report OMAS in the previous 3 months as compared with HIV-negative men (56% vs 36%; $p = 0.002$). OMAS partnerships reported by HIV-positive and negative men were just as likely to be characterized by CAS (39% vs. 38%; $p = 0.8$). By contrast, OMAS partnerships reported by HIV-positive men were characterized by less disclosure of the respondent's HIV status (31% vs 59%; $p < 0.001$) and less knowledge of partner's HIV status (46% vs 74%; $p < 0.001$) than OMAS partnerships reported by HIV negative men. After controlling for partner type, OMAS partnerships reported by HIV-positive men remained characterized by less disclosure (AOR, 0.3; 95% CI: 0.2- 0.5) and less knowledge of partner's HIV status (AOR 0.3; 95% CI: 0.2-0.5) than OMAS partnerships reported by HIV negative men.

Conclusions/Implications: Our data suggest that OMAS is not uncommon among both HIV-negative and positive young black MSM in Los Angeles County. These data demonstrate a significant risk for the transmission of HIV in OMAS partnerships due to less frequent HIV disclosure and less knowledge of partners' HIV status and inconsistent condom use during anal sex. Additional studies are needed to increase understanding of the contextual factors associated with young black MSM's use of the internet to meet sexual partners and how best to target them with appropriate prevention efforts.

Abstract 1872 - Internalized Homophobia is not Associated with Sexual Risk Behavior Among Young Black MSM

Author(s): *Laura Beauchamps, Leandro Mena, Richard Crosby, Angelica Geter, DeMarc Hickson, Timothy Brown, Courtney Sims*

Background: There is a direct relationship between homophobia and internalized homophobia. To objective of this study is to assess internalized homophobia and the relationship of this construct to sexual risk behaviors in a clinic-based sample of young Black MSM who reside in a southern city with high HIV seroprevalence

Methods: A convenience sample of 400 Black MSM (ages 16 through 29) completed a computer-assisted self interview in a private area of a clinic dedicated to sexual health. The questionnaire included a 7-item measure of internalized homophobia that obtained an excellent inter-item reliability coefficient of .81. Scores on this measure formed a normal distribution, ranging from a low (minimal internalized homophobia) of 1.4 to a high of 7.0. A series of t-tests were used to determine whether mean values of this construct differed for a series of 14 dichotomously assessed sexual risk behaviors.

Results: The mean internalized homophobia score was 3.59 (sd = 1.37). Internalized homophobia did not vary as a function of any of the 14 assessed sexual risk behaviors. Measures were: the number of male partners men had when they were the TOP partner (P=.23) and when they were the BOTTOM partner (P=.17); having any unprotected anal sex as a TOP (P=.71) or as a BOTTOM (P=.20); using condoms with the most recent "first time" sex partner (P=.31), having sex with a partner who is HIV+ (P=.90); having sex with a stranger (P=.89); having concurrent sex partners (P=.89); having sex with casual partners (P=.39), not being tested for HIV in the past 12 months (P=.67); not being willing to take pre-exposure prophylaxis (P=.15); asking sex partners if they wanted to use a condom (P=.76); generally having older sex partners (P=.79); scoring above the median (indicating a greater tendency for serosorting) on a scale measure of serosorting attitudes (P=.19).

Conclusions/Implications: In this clinic-based sample of young Black MSM, engaging in sexual risk behaviors occurred irrespective of their scores on a measure of internalized homophobia that was normally distributed. Internalized homophobia may not be a significant factor in the prediction of elevated sexual risk behaviors among young Black MSM.

Abstract 1986 - Correlates of Engagement in the HIV Care Continuum Among Young Black HIV+ MSM

Author(s): *Judy Tan, Susan Kegeles, Lance Pollack, Greg Rebchook, John Peterson, David Huebner, Wayne Johnson, Agatha Eke*

Background: Engagement in the HIV Care Continuum (CC) may be part of the behavioral repertoire for mitigating transmission risk as well as for maintaining overall health among men who have sex with men. However, little is known about factors associated with optimal engagement in the CC among HIV+ young black men who have sex with men (YBMSM). The present study explored associations among engagement in the CC and behavioral, psychosocial, and socio-structural factors among a cohort of HIV+ YBMSM.

Methods: The present analysis was limited to self-reported HIV+ YBMSM (ages 18-29) from five annual cross-sectional samples (2009-2013) in Dallas and Houston, TX, recruited via venue-based sampling.

Participants completed the following measures: (a) CC engagement (whether or not they have a primary health care provider; any care in past six months; adherence to antiretroviral therapy [ART; any skipped doses in past 30 days]); (b) sexual behaviors (e.g., unprotected [condomless] anal intercourse, or UAI); (c) psychosocial variables (e.g., experiences with difficult sexual situations and relationships; peer social support); and (d) socio-structural variables (e.g., composite of low socioeconomic [SES] indicators). The outcome measure was derived by combining items about CC engagement into a Guttman-type index score (Saberri & Johnson, 2014) and analyzed as a continuous outcome. Bivariate relationships between potential correlates and the outcome were assessed by simple linear regression, and correlates achieving $p < 0.25$ were retained for inclusion in a multivariate model (Hosmer & Lemeshow, 1989). The final multiple linear regression model used full information maximum likelihood estimation to accommodate missing data and computed robust standard errors to guard against potential misspecification of the model.

Results: Bivariate analyses revealed that better engagement in the CC was positively associated with UAI, age, social support, but negatively associated with internalized heterosexism, frequency of experiencing difficult sexual situations and difficult sexual relationships, and number of low SES indicators. In the multivariate regression model, the most influential correlates were UAI, low SES, and frequency of experiencing difficult sexual situations and relationships ($R^2 = .083$).

Conclusions/Implications: While greater engagement in the CC was associated with UAI, less engagement was associated with lower SES and experiencing difficult sexual situations and relationships. These findings suggest that if engaging in the CC is among the behaviors by which HIV+ YBMSM mitigate transmission risks and/or maintain their health, these behaviors may be most achievable among those men who are experiencing fewer economic challenges and difficult sexual situations (Diaz et al., 2004). More conclusive evidence is needed to guide intervention development for improving engagement in the CC particularly for HIV+ YBMSM with fewer economic and social resources.

Abstract 2408 - Young Black MSM (YBMSM) with a History of Incarceration Are Especially Vulnerable to HIV and Other Societal Ills

Author(s): *Susan Kegeles, Gregory Rebchook, David Huebner, Robert Williams, Wilson Vincent, Judith Tan, Lance Pollack, Emily Arnold, John Peterson,*

Background: YBMSM are at very high risk for HIV infection. YBMSM are not a homogeneous population, and identifying subgroups that are especially vulnerable to adverse outcomes is critical in the design and implementation of HIV prevention programs. Young Black men are incarcerated at disproportionate rates, but little attention has focused on YBMSM to determine if they are also incarcerated at high rates.

Methods: As part of a multi-year evaluation of a community-level HIV prevention intervention, we collected cross-sectional data from YBMSM annually in Houston and Dallas, TX via venue-based sampling. We measured a variety of psychosocial variables and HIV risk behaviors as well as if they had ever been in juvenile detention, jail or prison. In 2013 and 2014, we surveyed 1162 YBMSM in total.

Results: Almost one-third of the sample (30.4%) has ever been incarcerated. Lifetime incarceration is significantly associated with being HIV-positive (13.5% incarcerated men vs. 8.5% of never-incarcerated men) as well as behavioral co-factors for seroconversion: unprotected anal intercourse (26.0% vs. 19.3%), STI diagnosis (23.4% vs. 9.6%), binge drinking (60.8% vs. 50.2%), and stimulant use (41.0% vs. 15.3%); all $p < .05$. Compared to never-incarcerated men, YBMSM who had been incarcerated also are more likely to have had difficult childhoods. They are significantly more likely to have lived in two or more households while growing up (55.9% vs. 42.7%), had a parent/guardian incarcerated during their childhood (43.2% vs. 22.1%), and reported coerced sexual contact under the age of 15 (16.4% vs. 5.7%); all $p < .05$. In their current lives, men with incarceration histories are less educated and more likely to have run out of money (65.2% vs. 42.1%), borrowed money (48.1% vs. 35.1%), experienced homelessness in the past year (18.9% vs. 3.7%), and to be unemployed (29.6% vs. 17.4%) and uninsured (57.2% vs. 39.9%); $p < .05$. Men who have been incarcerated have significantly more depressive symptoms, less resilience, and more frequently experience racism and homophobia (all $p < .05$). A history of incarceration is also significantly associated with psychosocial predictors of risk, including less perceived normative force for safer sex and timely HIV testing; greater internalized heterosexism and lower gay pride; lower self-efficacy to have safer sex; more negative attitudes toward condom use; and more frequent experiences of sex in difficult contexts and relationship circumstances (all $p < .05$). Yet, history of incarceration made no difference in frequency of HIV testing among HIV-negative men or level of engagement in the HIV continuum of care among HIV-positive men.

Conclusions/Implications: High rates of incarceration were found among YBMSM, as with other young Black men. YBMSM who had been incarcerated before often came from especially challenging backgrounds, with upheaval and sexual abuse. They were more likely to be economically, socially, and psychologically resource poor. Their sexual behavior made them especially vulnerable to HIV infection. Although equally likely as never-incarcerated men to have tested for HIV in the past 6 months and engaged in care if HIV+, improvement in these other demonstrated issues among YBMSM with a history of incarceration will require greater, more intense implementation of intervention resources.

Session B05 - HIV Health Disparities: Understanding the Unique Needs of Key Underserved Populations

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 1470 - Black:White Disparities in HIV Mortality in 13 Major U.S. Cities: 1990-2009

Author(s): *Kristi Allgood, Monique Glover Rucker, Bijou Hunt*

Background: Deaths due to HIV have declined substantially since the mid-1990's when effective HIV treatment became widespread, yet not all populations in the US have benefitted equally. This analysis will compare death rates for Blacks and Whites in 13 major US cities from 1990 – 2009.

Methods: Thirteen cities were selected for the analysis: the five most populous cities (New York, Los Angeles, Chicago, Philadelphia, and Houston), and eight additional cities which were among the top five metropolitan areas for HIV diagnoses in 2010 or 2011 (Washington, D.C., Memphis, Baltimore, Miami, Atlanta, New Orleans, Baton Rouge, and Jackson). Using vital records from the National Center for Health Statistics and US Census data, we calculated the race- and gender-specific HIV mortality rates and

corresponding racial rate ratios for non-Hispanic Blacks and non-Hispanic Whites in the US for four 5-year increments from 1990-2009. Rates were age-adjusted using the 2000 US standard population. Rate ratios were used to determine the level of disparity. Baton Rouge and Jackson were excluded because there were not enough deaths to reliably calculate death rates among both Blacks and Whites. We calculated excess Black deaths for 2005-2009.

Results: For the total, male, and female populations, we observed a statistically significant increase in the Black:White HIV mortality disparity between T1 (1990-1994) and T4 (2005-2009) in every city included in the analysis. The findings were consistent for both men and women. By 2005-2009 the HIV mortality disparities ranged from 3.24 (New Orleans) to 14.21 (Washington, D.C.). Among men, the disparities ranged from 3.17 (New Orleans) to 11.38 (Washington, D.C.) and among women the disparities ranged from 5.42 (Philadelphia) to 9.66 (Los Angeles). The increasing disparity was due to the fact that the decrease in mortality rates from T1 to T4 was greater among Whites than Blacks for every city included in the analysis. This disparity led to 5,603 excess Black deaths in the US at T4. In Washington, D.C., which had the largest disparity, the number was 160. New York, NY had the largest number of annual excess deaths at 516, followed by Baltimore, MD at 187.

Conclusions/Implications: Previous research suggests that as HIV becomes more treatable, racial disparities widen, as observed in this study for both men and women in every city included in the analysis. We aim to understand some of the factors that contribute to vast differences in HIV mortality disparities across major US cities such as differences in local public health response, policies affecting access to prevention and treatment, among other factors. Data such as this coupled with local surveillance reports serves to assist in thinking about how interventions such as routine screening, needle exchange programs, linkage to care initiatives, and, among others, partner service processes in cities whose disparities are improving can be applied to cities with growing disparities.

Abstract 1561 - Treatment-as-Prevention Can Reduce But Not Eliminate Racial Disparities in HIV Risk

Author(s): *Ian Spicknall, Ethan Romero-Severson*

Background: Racial difference in health service access and utilization is a cause of racial disparity in HIV prevalence: prevalence ratio (PR)=4.3 (black to white). This discrepancy arises in part from the population-level preventive effects of treatment (TasP). Recent work by Rosenberg et al. showed how ameliorating racial disparities in rates of diagnosis, care retention, and viral suppression alters racial disparity in the short-term. Building off this work, we explore the robustness of these effects to variable modeling assumptions. We attempt to answer the questions of 1) whether or not racial disparities in HIV risk can be eliminated through the TasP paradigm by addressing racial disparities in the continuum of care (CoC) and 2) for how long these disparities will persist.

Methods: We constructed a sequence of increasingly realistic and complex models to examine the robustness of racial disparities to modeling assumptions. First, we reproduced the base model used by Rosenberg et al. to confirm their original results. Second, we relaxed the assumption of incidence being independent of current prevalence to calculate transmission dynamics into the future within the same modeling framework. Next we used ordinary differential equation (ODE) based transmission models that assume either constant contagiousness or a more realistic natural history of infection with time-varying

contagiousness. The CoC parameters were implemented in the same way for each of the model forms. Models were fit to estimated HIV prevalence in black and white MSM populations by adjusting relevant parameters in each model. We then manipulated the CoC parameters to model the effects of implementing different interventions.

Results: In the simpler models without natural history of infection, intervening through CoC parameters alone is sufficient to remove racial disparity in HIV prevalence, which is the result obtained by Rosenberg et al. The effect takes roughly 50 years when black MSM have superior CoC parameters, and more than 250 years when black and white MSM have the same CoC parameters. In the ODE model where natural history of infection alters contagiousness, the prognosis is worse. In this model, even when black MSM have far superior CoC parameters, racial disparity in HIV prevalence persists in the long term (PR=3.4). In this model it is also necessary to reduce the black MSM transmission rate. When black MSM have the same transmission rate as white MSM, but their original CoC parameters, there is a greater reduction in HIV prevalence disparity (PR=1.5).

Conclusions/Implications: Regardless of model form, addressing racial disparity in HIV prevalence will take many years: decades under the most optimistic conditions, and centuries under more realistic conditions. However, in the model with a more detailed natural history of HIV infection, CoC alone does not have a very large effect. This analysis suggests that in order to remove racial disparity in HIV prevalence, it will be necessary to intervene not only in the HIV CoC parameters, but also against factors more directly related to transmission, for example by greater pre-exposure prophylaxis.

Abstract 2196 - Racism as a Determinant of Racial Disparities in HIV Infection and HIV-Related Morbidity: A Review of the Literature

Author(s): *Cynthia Prather*

Background: In the U.S., some racial/ethnic groups experience a disproportionate burden of HIV. According to the CDC, African Americans accounted for 44% of all new HIV infections and Hispanic/Latinos represented 21% of all new HIV infections though they represent 12% and 16% of the U.S. population, respectively in 2010. A large body of research suggests that racism contributes to negative experiences encountered by racial/ethnic groups and racial disparities in disease incidence, morbidity, and mortality for many health conditions. Few studies, however have investigated racism's role as a determinant of HIV-related health disparities. Moreover, studies rarely consider how a historical trajectory of racism provides context to current sexual health outcomes, including HIV. HIV prevention efforts focus on the HIV Care Continuum, including increased access to HIV testing with a focus on persons with undiagnosed infection, linkage, retention and re-engagement into medical care for newly and previously diagnosed clients, condom promotion and PreP. These efforts are critical to decreasing transmission, however an understanding of racism's impact on HIV-related disparities may encourage providers to also address some of the social barriers that affect HIV transmission. The purpose of this presentation is to present findings from my literature review that examined how racism contributes to contemporary HIV-related health outcomes.

Methods: I reviewed the literature to describe how the socio-historical context of sexual health and health care experiences of racial/ethnic groups within the United States may contribute to poor HIV

health outcomes. I searched online databases (e.g., PubMed, Sociological Abstracts, PsycINFO, and GoogleScholar) for articles published in English. Key search terms included ‘racism’, ‘historical relationship’, ‘HIV’, ‘health and health care’, and social determinants of health (i.e., poverty, unemployment). This search strategy resulted in 103 references that addressed racism, HIV, or sexual health outcomes and pertinent to the review.

Results: The literature review suggests: 1) little attention is paid to the influence of the historical context of racism on current HIV-related health outcomes, particularly for women; 2) racism-related experiences have shaped social conditions experienced by African Americans and Latinos resulting in increased levels of poverty, limited education, unemployment, and mistrust of health care professionals; and 3) experiences of racism are empirically linked with lack of access to health care, sexual risk behaviors (i.e., sex trading), cultural mistrust, lack of engagement in clinical care among racial/ethnic minorities living with HIV and likely increased viral loads.

Conclusions/Implications: Racism may contribute to the increased burden of HIV for racial ethnic minorities. Interventions that address racism and integrate intervention activities that focus on a social determinants of health approach may improve the health of African Americans and Hispanic/Latino Americans across the life course and promote health equity.

Abstract 2202 - Societal Homophobia as an Underlying Determinant of HIV Transmission among U.S. Men who Have Sex with Men

Author(s): *William Jeffries IV*

Background: Gay, bisexual, and other men who have sex with men (MSM) comprise only 2% of the U.S. adult population but accounted for most newly diagnosed and prevalent HIV infections in 2012 (67% and 51%, respectively). Individual-level (e.g., undiagnosed HIV infection) and group-level (e.g., partnership concurrency) factors promote HIV transmission among MSM. However, societal homophobia—negative attitudes toward MSM because of their sexual orientations—may underlie these factors and MSM’s high HIV burden. This review examined societal homophobia as a determinant of HIV transmission among MSM.

Methods: PubMed, Sociological Abstracts, and PsycInfo provided U.S. studies published during 2000–2015. Search terms for homophobia (e.g., “homonegativity”) and HIV (e.g., “sexual risk”) yielded 93 studies useful for understanding relationships between these factors. Social ecological theory, which emphasizes social causes of health disparities, guided the analysis.

Results: This review suggests the following: Society historically disallowed MSM’s long-term romantic partnerships, which promoted high partnership concurrency conducive to HIV transmission. Because societal homophobia encourages devaluation of MSM, it limits community-level responses to HIV. Societal homophobia contributes to interpersonal homophobia (e.g., harassment), which has predicted medical care avoidance and, for MSM living with HIV, transmissible viral load. MSM who internalize societal homophobia often exhibit increased psychological distress and substance use, which are correlates of condomless anal intercourse and HIV transmission.

Conclusions/Implications: Societal homophobia may be an underlying determinant of HIV transmission among U.S. MSM. Policy-related interventions can counteract homophobia by promoting social equality for MSM. Anti-homophobia efforts may help to curb HIV transmission and safeguard the long-term health of this population.

Session B08 - PrEP in My Clinic: Implementing PrEP in Traditional Clinical Settings

Room: Embassy E/F (Hyatt Regency Atlanta)

Abstract 1833 - Lessons Learned from Implementing Comprehensive PrEP Services in a Community Health Center Setting in NYC

Author(s): *Joey Akima, David Garcia, Jonathon Bannigan, Mihaela Mihai, Robert Murayam*

Issue: New HIV infections in NYC from 2010-2012 were primarily seen among MSM, Blacks, Hispanics, and individuals living in poverty. Despite FDA approval in July 2012, implementation of PrEP as a standard of care has been slow. Based on prior research of ART implementation for HIV-infected individuals, supportive services are needed to ensure engagement in care and medication adherence; therefore are potentially crucial for successful PrEP implementation.

Setting: Apicha Community Health Center (CHC) successfully transformed from an AIDS service organization to a Federally recognized health center providing primary care and support services to marginalized and underserved populations including those most affected by HIV. In June 2014, the Governor announced a plan to end New York States's (NYS) AIDS epidemic. Contributing to this plan is the emergence of PrEP as a highly effective biomedical approach to HIV prevention. Accordingly, CHCs play a critical role implementing biomedical prevention to reduce HIV health disparities.

Project: In 2014, because of our prior experience prescribing PrEP, Apicha CHC was invited by the NYSDOH-AIDS Institute to participate in a pilot project to become one of six health centers implementing comprehensive PrEP with supportive services. Individuals enrolled were tracked for a year with navigation services including benefit screening, assistance with insurance prior authorization, medication assistance program support, medication adherence support, risk-reduction counseling, HIV/STI screening, condom distribution, referrals and retention services for multiple medical appointments and mental health visits.

Results: From February 1, 2014 to January 31, 2015, a total of 62 patients were enrolled with 100% (62) retained in medical care with maintained HIV negative status to date. About 92% (57) identified as males and 8% (5) identified as trans-women. The majority, 51% of our patients come from communities of color with 23% (14) Hispanic, 15% (9) Asian and Pacific Islander, and 13% (8) Black. About 52% (32) had private insurance, 35% (22) Medicaid and 13% (8) uninsured. By age group, the majority, 61% (38) were young adults between ages 18-34 (13%, 18-24; 48%, 25-34). Most reported side effects included nausea and loose stools/diarrhea, but subsided dramatically after the first month of treatment. Medication adherence and less risk taking behavior were positively correlated with time. Compared to the first month on treatment, less patients reported missing 2-7 doses at 3 months and zero patients by 6 months. Condomless sex, anal sex, STIs and transactional sex risk behaviors decreased at 1 month, 3 months and 6 months on treatment compared to reported behavior 6 months prior to enrollment.

Lessons Learned: Implementing a PrEP program in CHC was not a difficult undertaking, but certain supportive services need to be in place for optimal implementation. Increased contact with health care services appeared to reduce risk-taking behaviors. Best practices for optimal implementation included culturally and linguistically appropriate: 1) education and support regarding PrEP stigma; 2) navigation support with obtaining health insurance and medication assistance benefits; 2) medication adherence support; 3) reminders for medical visits; 4) asset based risk reduction counseling; and 5) increased mental health services with motivational interviewing.

Abstract 1959 - PrEParing High-Risk Young People for Engagement in Sexual Health Services: The Pivotal Role of PrEP Retention Coordination and Patient Navigation in Clinical Research Settings

Author(s): *Kristin Kennedy, Alfonso LaCorte, Maurice Penn, Ifeoma Udoh, Michael D'Arata, Janet Myers, Mi-Suk Kang Dufour, Remi Frazier, Robert Grant, Jeffrey Burack*

Issue: Pre-exposure prophylaxis (PrEP) use has proven to be efficacious in clinical study settings for the prevention of HIV infection. While there are models of care to support HIV-positive youth, more knowledge is needed to inform best practice models for implementation of PrEP in high-risk urban populations. The complexity of young people's lives often leaves them unable to actively engage in care and adhere to daily medication regimens, particularly in a clinical research setting. The goal of Connecting Resources for Urban Sexual Health (CRUSH) is to expand services at an existing HIV care clinic, the Downtown Youth Clinic (DYC), to provide and integrate sexual health services, including PrEP, for YMSM. The CRUSH Project modeled supportive services off the successful DYC model of care, which includes case finding high-risk youth, linkage to care, retention in care, adherence support, and prevention of HIV transmission/acquisition.

Setting: The CRUSH Project is located in the East Bay AIDS Center, an outpatient HIV primary care clinic in Oakland, CA. CRUSH eligibility includes 18-29 year old MSM and individuals who identify as transgender, with a particular focus on persons of color.

Project: The CRUSH Project aims to evaluate the effectiveness of a tailored package of HIV care, treatment and prevention by integrating routine sexual health services into an existing HIV clinic. Patients can come in for scheduled or drop-in clinic visits, STI screening and treatment, PEP, PrEP, and specialized HIV testing, and receive adherence support and counseling.

Results: CRUSH has enrolled 224 high-risk YMSM since February 2014. Nearly 60% are African American or Latino, average age 25. One hundred thirty-one participants have accessed PrEP at some point throughout the study. One hundred twenty-two of the 131 PrEP users remain in care, with only 9 lost to follow-up. At the time of writing, adherence monitoring drug levels were available for 80 individuals. All tests had detectable levels of tenofovir (TFV), and 80.1% demonstrated levels consistent with at least 4 doses per week.

Lessons Learned: Peer Advocates, or Retention Coordinators play a critical role in supporting youth by engaging in conversations about sexual health, providing patient navigation throughout medical visits, calling and more often, texting reminders about upcoming appointments, and encouraging medication

adherence and retention in care. They more importantly bridge the gap between research and services to ensure that young people have a pleasant experience and feel empowered to take charge of their sexual health. Patients have expressed that they feel at ease talking to a peer about their sexual health and appreciate the support of the CRUSH Retention Coordinator investing in their health and making the process easier to navigate. As evidenced by retention and medication adherence rates, retention coordination and patient navigation are essential to integrating PrEP into clinical settings.

Abstract 2242 - Implementation of a Comprehensive PrEP Program in Routine Clinical Practice

Author(s): *Bryan Bautista-Gutierrez, Kristin Keglovitz-Baker, John Stryker, Daniel Pohl, Beau Gratzler*

Issue: CDC recommends the use of anti-retroviral pre-exposure prophylaxis (PrEP) for the prevention of HIV in populations that are at high risk of infection. Though there have been several large, multinational studies that have demonstrated high levels of uptake of PrEP as well as efficacious levels of protection, less is known about the use of PrEP in routine clinical settings in the US.

Setting: Howard Brown Health Center (HBHC) is the largest Lesbian, Gay, Bisexual and Transgender (LGBT)-focused community health center in the Midwest. HBHC implemented a PrEP Program in March 2014 to link patients and community members at high risk for HIV with access to PrEP as part of a comprehensive HIV prevention approach.

Project: The HBHC PrEP Program is intended to increase knowledge and awareness about PrEP and link patients and community members at risk for HIV infection to clinical PrEP services (counseling, laboratory, prescription and referral). Community marketing approaches included flyers and brochures available in the clinic and online, advertisements in local LGBT papers, and online/smartphone banners and advertisements catering to men seeking sex partners in virtual environments. A new PrEP Adherence Counselor position was created to serve as the point-person for PrEP related inquiries, to provide comprehensive prevention and medication adherence education to clients, and to assist clients accessing medication and copay assistance programs. HBHC medical providers also received extensive training on PrEP, and the clinic's electronic health record system was modified to collect information specifically about PrEP initiation to gauge use. This presentation will highlight the unique aspects of the program, discuss the demographics of those accessing PrEP medications, and explore the challenges/successes learned from the implementation.

Results: Between March 2014 and February 2015, a total of 303 patients were evaluated, counseled and prescribed PrEP medications. The median age of those being prescribed PrEP was 31.5 years, with a range of 18-70. Most (60.1%) were non-Hispanic White, 17.5% were Hispanic/Latino, 10.9% were Black/African-American, and 11.6% were multi-racial/other. An overwhelming majority (94.7%) identified as male; of those males, 96.5% reported that they identified as gay/bisexual/queer. Transgender females accounted for 2.6% of those prescribed medication and females accounted for 1.7%; the remainder identified as other/undisclosed. The age and gender distribution of patients prescribed PrEP medications were indistinguishable from patients diagnosed with HIV at our clinic in 2014; PrEP clients, however, were slightly less likely to be persons of color.

Lessons Learned: Several implementation challenges should be noted. We significantly underestimated the amount of time the Adherence Counselor assisted clients in processing medication and copay assistance paperwork, while overestimating the time spent providing prevention and adherence counseling. We also learned making EHRs changes take a long time to make common practice. We have struggled with data collection on the forms created due to competing primary care priorities by the medical providers in their documentation/charting. PrEP implementation leads to engaging patients in multiple primary care needs and more regular testing/preventive health.

Session B27 - Who are CDC-Funded HIV Programs Testing? CDC-Funded HIV Testing and Services Delivery by Key Populations, 2011-2014

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1435 - HIV Testing and HIV Service Delivery among Women in 61 Health Department Jurisdictions, United States, 2011-2014

Author(s): *NaTasha Hollis, Argelia Figueroa, Guoshen Wang*

Background: Approximately 1.2 million people are living with HIV (PLWH) in the United States. In 2011, women accounted for 23% of PLWH, with black/African American (referred to as African American) and Hispanic/Latino women disproportionately affected as compared to other race/ethnicities. The majority (84%) of new infections were transmitted through heterosexual contact. Of women living with HIV, approximately 88% were diagnosed, but only 45% were engaged in care, and only 32% had achieved viral suppression. HIV testing and HIV service delivery among new positives were examined to evaluate CDC-funded HIV testing programs on addressing the needs of disproportionately affected groups, i.e. women.

Methods: Data submitted through the National HIV Prevention Program Monitoring and Evaluation (NHM&E) data system were extracted and analyzed for the years 2011-2013. In 2013, 61 CDC funded jurisdictions submitted data. Standardized data elements including HIV testing, positivity, and service delivery by select client-level demographics were analyzed using SAS® version 9.3. HIV service delivery includes linkage to medical care, referral and interview for partner services, and referral to HIV prevention services. HIV service delivery data are presented as a range due to missing data, with minimum (includes missing/invalid data) and maximum (excludes missing/invalid data) values. Chi-square analysis was performed to determine if significant differences were detected in HIV testing, HIV positivity, and linkage to HIV medical care from 2011-13.

Results: In 2013, 3,343,633 CDC-funded HIV testing events were conducted in the United States and 17,426 new positives were identified. Women accounted for 50.5% (1,687,367) of all CDC-funded testing events and 18.3% (3,188) of all new positives. HIV positivity was 0.9% overall and 0.3% among women. Among newly identified persons, HIV positivity was 0.5% overall and 0.2% among women. African American women, who accounted for nearly half (47%) off all HIV tests conducted among women, had higher newly identified HIV positivity (0.3%) than other race/ethnicities. Overall, 54.6%-76.4% of newly identified HIV-positive women were linked to HIV medical care within any timeframe, 46.5%-86.5% were linked within 90 days, 66.4%-84.0% were referred to partner services, 49.0%-74.0% were interviewed for partner services, and 52.4%-77.3% were referred to HIV prevention services. There was a significant

difference in identifying positives between 2012 and 2013 ($p < .01$), but there was no significant difference between 2011 and 2012 or between 2011 and 2013. Linkage within any timeframe and linkage within 90 days significantly increased each year, $p < .0001$.

Conclusions/Implications: Women accounted for over half of all CDC-funded HIV tests conducted in 2013. African American women were disproportionately affected, accounting for 47% of all HIV tests conducted and 69% of new infections. Furthermore, only 54.4%-76.4% newly identified HIV-positive women are linked to care within any timeframe. Targeted HIV testing is just the first step to identify and improve the quality of health of vulnerable HIV-positive populations. Continued efforts to improve service delivery for sub-populations at high risk, such as African American women, are also needed to improve quality of health among positives.

Abstract 1514 - CDC-Funded HIV Testing, Linkage to HIV Medical Care, and HIV-Related Services among Men Who Have Sex With Men (MSM) in non-Healthcare Settings, 2011-2014

Author(s): *Tanja Walker, Puja Seth, Argelia Figueroa, Guoshen Wang, Lisa Belcher*

Background: In the United States, HIV infection disproportionately affects gay, bisexual, and other men who have sex with men (collectively referred to as MSM). Young black/African American (referred to as African American) MSM bear much of the burden, accounting for 55% of new infections among young MSM and 36% of all new HIV infections in 2010. A report from the 2008 National HIV Behavioral Surveillance revealed that 63% of young HIV-infected MSM were unaware that they were positive. Persons unaware of their HIV infection do not receive the timely and appropriate HIV medical care or prevention. HIV testing, HIV positivity, linkage to HIV medical care and HIV-related services were examined to evaluate CDC-funded HIV testing programs on addressing the needs of MSM.

Methods: Data were submitted by 61 health department jurisdictions in 2013. CDC-funded HIV testing, HIV positivity, linkage to HIV medical care, referral and interview for partner services, and referral to HIV prevention services were described by client characteristics. Because of missing data, a range is presented representing the minimum and maximum percent achieved for linkage and HIV service delivery. Data to identify MSM, heterosexual males, and heterosexual females are required data variables in non-healthcare settings and for HIV-positive persons only in healthcare settings. Additionally, trends on HIV testing, HIV positivity, and linkage to HIV medical care from 2011-2013 were examined. Data from 2014 will be included in the presentation.

Results: In 2013, 3,343,633 CDC-funded HIV testing events were conducted in the United States. Tests conducted in non-healthcare settings represented approximately one-third (29.2%, 977,645) of all CDC-funded HIV testing events. MSM accounted for 15.7% (153,274) of all testing events conducted in non-healthcare settings. The highest percentage of HIV tests was conducted among non-Hispanic white MSM (43.3%), MSM aged 20-29 years (44.0%), and MSM in the South (39.5%). Of all new HIV-positives identified in non-healthcare settings (7,029), 52.4% (3,681) were MSM. More than half of these new HIV-positive MSM identified were 20-29 years of age (52.1%) and in the South (52.3%); additionally, 43.8% were African American. Among new HIV-positive MSM, 62.6%-85.6% were linked to medical care within any timeframe; 57.2%-91.0% were linked to medical care within 90 days; 80.4%-85.9% were referred to HIV partner services; 56.9%-73.7% were interviewed for HIV partner services, and 63.1%-

77.9% were referred to HIV prevention services. Chi-square analyses found that there was a significant increase in the number of MSM identified as new positives between 2011 (2.6%; 3,818) and 2013 (2.7%; 4,069) ($p < .0001$) and 2012 (2.3%; 3,915) and 2013, $p = 0.0005$, but there was no significant difference between 2011 and 2012 ($p = .72$). Additionally, linkage within any timeframe significantly increased each year, $p < .0001$.

Conclusions/Implications: Although only 15.6% of testing events in non-healthcare settings were among MSM, they represented over half of all newly identified positives. White MSM were tested twice as much as African Americans; however, African American MSM accounted for 43.8% of newly infected MSM. Continued efforts to increase testing among MSM could help identify more MSM who are unaware of their HIV status.

Abstract 1535 - CDC-Funded HIV Testing, Linkage to HIV Medical Care, and HIV-Related Services among African Americans, 2011-2014

Author(s): *Puja Seth, Tanja Walker, Guoshen Wang, Argelia Figueroa, NaTasha Hollis, Lisa Belcher*

Background: More than 1.2 million people are living with HIV (PLWH) in the United States, and approximately 14.0% are not diagnosed. Some groups are disproportionately affected by HIV, such as blacks/African Americans (referred to as African Americans). While African Americans account for 12.0% of the United States' population, they accounted for 44.0% of all new HIV infections in 2010 and 41.0% of PLWH in 2011. In 2013, they comprised 46.0% of all HIV diagnoses in the United States. HIV testing, HIV positivity, linkage to HIV medical care and HIV-related services were examined to evaluate CDC-funded HIV testing programs on addressing the needs of African Americans.

Methods: Data were submitted by 61 health department jurisdictions in 2013. CDC-funded HIV testing, HIV positivity, linkage to HIV medical care, referral and interview for partner services, and referral to HIV prevention services were described by client characteristics. Because of missing data, a range is presented representing the minimum and maximum percent achieved for linkage and HIV service delivery. Data to identify gay, bisexual, and other men who have sex with men (collectively referred to as MSM), heterosexual males, and heterosexual females are required data variables in non-healthcare settings and for HIV-positive persons only in healthcare settings. Additionally, trends on HIV testing, HIV positivity, and linkage to HIV medical care from 2011-2013 were examined. Data from 2014 will be included in the presentation.

Results: In 2013, 3,343,633 CDC-funded HIV testing events were conducted in the United States, and African Americans accounted for 45.0% (1,506,016) of such events. The highest percentage of HIV tests were conducted among African Americans in the South (66.1%), females (52.7%), and African Americans aged 20-29 years (42.5%). Of all new positives in 2013 (17,426), 54.9% were African Americans. Additionally, 71.6% of new positive heterosexual males, 70.2% of new positive heterosexual females, and 45.2% of new positive MSM were African American. The highest percentage of new HIV-positive African Americans was identified among MSM (9.6%), heterosexual males (1.5%), and heterosexual females (1.1%). Among new HIV-positive African Americans, 53.5%-78.8% were linked to medical care within any timeframe; 44.5%-82.5% were linked to medical care within 90 days; 65.8%-83.7% were referred to HIV partner services; 46.4%-72.5% were interviewed for HIV partner services, and 53.6%-

79.7% were referred to HIV prevention services. Chi-square analyses found that there was a significant increase in identifying new positives between 2012 (0.6%; 9,198) and 2013 (0.6%; 9,571), $p=.03$, but there was no significant difference between 2011 and 2012 ($p=.09$) and 2011 and 2013, $p=.60$. Additionally, linkage within any timeframe and linkage within 90 days significantly increased each year, $p<.01$.

Conclusions/Implications: The current findings indicate that CDC-funded HIV testing programs are reaching African Americans, as African Americans accounted for 45.0% of HIV testing events and over half of all new positives in 2013. Continued efforts to expand routine screening as recommended by CDC and to target HIV testing services towards African American populations at high risk, such as MSM, can help identify new positives and link them into HIV medical care.

Abstract 1752 - CDC-Funded HIV Testing and HIV Service Delivery among Hispanics/Latinos in 61 Health Department Jurisdictions, United States, 2011-2014

Author(s): *Argelia Figueroa, Puja Seth*

Background: More than 1.2 million people are living with HIV (PLWH) in the United States. Some groups are disproportionately affected by HIV, such as Hispanics/Latinos, who in 2011 comprised 17% of the United States' population and accounted for 21% of new HIV infections in 2010 and 20% of PLWH in 2011. HIV testing is critical to identify those who are infected and link them to HIV medical care for their own health and to reduce transmission to partners.

Methods: National-level program data were submitted by 61 health department jurisdictions on CDC-funded HIV testing and service delivery among Hispanics/Latinos. Data to identify gay, bisexual, and other men who have sex with men (collectively referred to as MSM), heterosexual males, and heterosexual females are required data variables in non-healthcare settings and for HIV-positive persons only in healthcare settings. Persons testing HIV-positive but not reporting a previous positive test result were categorized as new positives. HIV service delivery among new positives included linkage to medical care within any time frame and within 90 days (i.e., attendance at first medical appointment), and referral for partner services and HIV prevention services.

Results: CDC funded 3,343,633 HIV testing events in 2013. Hispanics/Latinos accounted for 21% (713,058) of those testing events and 19% (3,407) of all new positives. HIV positivity among Hispanics/Latinos was 0.7% and positivity among new positives was 0.5%. Although more females (52.2%) than males (47.2%) were tested, 83.9% of HIV-positive tests and 86.4% of new positive tests were among males. While more persons aged 20-29 (36.8%) and 30-39 (26.2%) years were tested, HIV-positive tests were more common among these age groups (34.7%, 28.4%, respectively) as well as for persons aged 40-49 years (20.3%). Among HIV-positive tests among Hispanics/Latinos, 45.0% were MSM, 10.8% were heterosexual males, and 8.7% were heterosexual females. Additionally, MSM accounted for 51.5% of new positive tests among Hispanics/Latinos. The percentages of Hispanics/Latinos receiving HIV service delivery are presented as ranges due to incomplete data reporting. Overall, 59.0%-67.6% of newly identified HIV-positive Hispanics/Latinos were linked to HIV medical care within any timeframe, 49.1%-69.8% were linked within 90 days, 69.0%-74.2% were referred to partner services, and 56.4%-67.2% were referred to HIV prevention services. A significant

increase in identifying new positives was found between 2011 (0.5%; 3,473) and 2013 (0.5%; 3,407), $p=0.03$. Conversely, a significant decrease in identifying new positives was found between 2012 (0.5%; 3,520) and 2013 (0.5%; 3,407), $p=0.01$. Additionally, linkage within any timeframe and linkage within 90 days significantly increased each year, $p<.01$.

Conclusions/Implications: Implementation of routine HIV screening and targeted HIV testing among populations at high risk for infection can help identify undiagnosed HIV cases and link them into HIV medical care and prevention services. Improvements in the systematic collection and submission of service delivery data are needed to gauge whether HIV-positive persons are receiving comprehensive prevention and care services. Provision of prompt and adequate HIV services among underserved populations has important public health implications and can improve the health of HIV-positive persons and their partners.

Track C

Session C05 - Mental Health – Moving the Needle on HIV Prevention and Treatment

Room: A707 (Atlanta Marriott Marquis)

Abstract 1133 - Mental Health and Substance Abuse in HIV Prevention – Facing the Issues Head-on

Author(s): *Margaret Lampe, Gust Deborah*

Issue: Among persons infected with HIV in the United States, only 19-29% have achieved viral suppression. Research evidence indicates that HIV prevalence may be three to five times as high among persons with mental illness as among the general population, and substance abuse, which frequently occurs among those with mental health issues, is also associated with HIV risk behaviors. Findings from CDC-funded studies of enhanced-contact interventions have demonstrated their effectiveness on linkage to HIV care (Antiretroviral Treatment Access Study [ARTAS]) and retention in care (Retention in Care [RIC] Study) overall, but the findings also showed they were ineffective among HIV-infected persons with higher scores on screening tools for anxiety and/or depression indicating higher levels of anxiety or depressive symptoms. This suggests that screening persons to identify and treat mental health and substance abuse problems is essential to our efforts to both provide optimum care and treatment to those persons already HIV infected and to prevent HIV infection among those at high risk for the disease. There is also a need for effective interventions — for both HIV prevention and treatment — that specifically address the needs of persons with mental health issues, if we are to achieve further progress with the HIV Continuum of Care.

Setting: Division of HIV/AIDS Prevention (DHAP) at CDC.

Project: Recognizing the importance of a coordinated approach to the important issues of mental health, substance abuse and HIV prevention and care, a core group of scientists in CDC's Division of HIV/AIDS Prevention (DHAP) proposed a cross-branch Mental Health and HIV Prevention Working Group (MHHP). The group was officially sanctioned and has worked together since the summer of 2014. The group's mission is to facilitate increased, coordinated efforts within DHAP to achieve objectives addressing the impact of mental/behavioral health issues on key outcomes across the HIV Continuum of

Care and the impact of HIV infection and related issues on the mental health status of persons at high risk for of infected with HIV.

Results: The MHHP has developed an action plan, including a priority to work across branches of DHAP to incorporate mental health and substance abuse assessments or interventions into the funding opportunity announcements (FOAs) as appropriate and feasible. Because there is not a specific inventory of federally funded programs and the overlap of mental health and substance abuse, and there is an interest in ensuring non-duplicative FOAs, the working group has established formal collaborations with the National Institute of Mental Health, the National Institute on Drug Abuse, the Substance Abuse and Mental Health Services Administration and the HIV/AIDS Bureau at the Health Resources and Services Administration. An inventory of the agencies' work is underway and the potential benefits of co-funding future work will be considered.

Lessons Learned: Interventions to support the treatment of mental illness and substance abuse disorders are under-utilized in HIV prevention work. Developing a framework to address these overlapping, stigmatizing and challenging conditions will be needed to bring the measures of the HIV Continuum of Care in line with national goals.

Abstract 2066 - A NIDA Perspective on Substance Use and HIV Prevention Research

Author(s): *Richard Jenkins, Shoshana Kahana*

Issue: NIDA supports basic, clinical, epidemiology, prevention treatment, and services research that investigates substance use in the context of HIV/AIDS and co-occurring conditions such as Hepatitis C. NIDA has made a significant effort using the "Seek, Test, Treat, & Retain" (STTR) HIV prevention model, which integrates services for HIV prevention and treatment with substance use prevention and treatment. This approach views testing and linkage to care as most effective where high risk populations are targeted and engaged. We intend for our discussion of the STTR initiative and other NIDA-supported research to provide lessons and inform program implementation for clinicians and funding agencies who wish to address substance use and related problems in the context of HIV prevention and care.

Setting: The STTR model has been applied in two RFAs which fund 22 grants including 12 grants in criminal justice populations (including jail, prison, and community corrections settings; aggregate n = 29,868) and 10 grants in vulnerable populations, which include PWID, as well as other high risk populations where substance use is commonplace, including gay men and high risk heterosexual women (aggregate n = 40,784).

Project: These individual projects each address different pieces of the STTR spectrum, but all ultimately seek to improve testing, linkage, receipt of treatment (including opioid substitution therapies and antiretroviral treatment), retention in care, and/or referral to other needed services, including mental health services and basic needs such as housing. Engagement strategies include respondent driven sampling, partner tracing and use of phylogenetic testing. Intervention modalities include navigation, case management, mobile technologies and incentives. Clinic, as well as community outreach settings, are used in addition to the criminal justice settings and programs. These grants participate in a data

harmonization process that integrates common and unique data elements through a data center to enable analysis of aggregate data across studies and answer questions overarching questions related to improving public health for HIV+s.

Results: A striking example of the STTR model comes from NIDA-supported research in Vancouver, BC, where the number of new HIV cases among people who inject drugs (PWID) has dropped 92% since 1996 through a combination of HIV treatment at diagnosis, a range of syringe services, access to drug treatment, and centralized information systems. The decline among PWID has exceeded declines seen in other populations in Vancouver, which may speak to the importance of extensive, regularized contact with health care and public health.

Lessons Learned: This presentation will include initial findings from the STTR program, as well as details regarding other innovative elements of NIDA's HIV/AIDS research program. We also will highlight the difficulties in reaching important populations, such as young MSM, who often lack regular contact with primary care, specialty care, or outreach systems, even when these services are widely available. In addition, we will address implementation issues such as the difficulties in identifying previously undiagnosed HIV+s, following large scale testing campaigns have occurred.

Abstract 2163 - The Importance of Mental Health in HIV/AIDS Prevention and Treatment

Author(s): *Dianne Rausch*

Issue: A growing body of literature has demonstrated the importance of mental health in addressing the prevention and treatment of HIV/AIDS. Studies show that people living with HIV may be more likely than the general population to develop mental disorders such as depression or anxiety. There is an overwhelming amount of evidence demonstrating the impact of comorbid depression and post-traumatic stress disorder on non-adherence to HIV treatment. It is imperative that mental health is integrated with HIV/AIDS research, as we continue to see high transmission rates and low numbers of viral suppression in the United States.

Setting: The Division of AIDS Research at the National Institute of Mental Health (NIMH) supports research that investigates the intersection of mental health and HIV/AIDS. The NIMH research program places a high priority on the inclusion of mental health in the development of our initiatives and grant award allocation.

Project: At NIMH, we focus on both the primary and secondary consequences of co-morbid mental illness in approaches to HIV prevention and linkage to care. Our research portfolio places emphasis on the role of mental health and social well-being in the prevention of HIV transmission among at-risk individuals, including young men who have sex with men, African American women, and minority populations. Stigma and other key social-structural barriers are addressed throughout our portfolio as we search to understand the contextual factors that drive HIV transmission rates in the United States. In addition to identification of mental illness in the context of HIV/AIDS, efforts to approach effective treatment strategies are a key component in the promotion of positive health behavior. NIMH supports research to understand the underlying neurobiological mechanisms that impact mental health in people living with HIV. This includes support of studies to address the feasibility and adaptation of interventions

for mental health diagnoses in the context of co-administration of antiretroviral and psychotropic medications, and studies that investigate and address the effect of a mental health diagnosis on HIV/AIDS outcomes. Our studies focus on HIV-associated neurocognitive disorders (HAND) that have major implications for mental health among People Living with HIV/AIDS (PLWHA) due to the linkage between neurocognitive impairment and mental health disorders. From the bench to intervention evaluation, we provide a range of funding mechanisms that target specific mental illnesses/disorders, vulnerable populations, and disease-burdened areas in the context of HIV/AIDS.

Results: Our investment continues to focus on identifying and intervening on the social and structural barriers experienced by individuals with comorbid mental health issues who are at most risk for the acquisition of HIV. Our goal is to translate and operationalize these findings into novel interventions in the future.

Lessons Learned: We aim to continue our efforts in addressing mental health and HIV/AIDS research in hopes that it will become the rule and not the exception. However, engagement and collaboration with other health agencies, including those at the federal, state, and local levels, are needed to translate research findings into programs and activities in real world settings, in order to reduce the impact of HIV.

Abstract 2339 - Getting to Zero New Infections – Strengthening the Integration of HIV and Mental Health Treatment

Author(s): *Stacey Evans, Cara Alexander*

Issue: Untreated mental health disorders increase the risk of both communicable and non-communicable diseases, and may lead to unintentional and intentional injury. Conversely, many health conditions contribute to the risk of mental health disorders, and comorbidity may further complicate help-seeking, diagnosis, treatment, and influences on prognosis. Comprehensive mental health services affects progress towards the Ryan White HIV/AIDS Program Moving Forward initiative target of “zero new infections”. Individuals whose mental health and substance abuse issues go untreated are at a higher risk for having complex psychosocial issues that 1) prevent diagnosis, 2) linkage to care, and 3) continuum of care.

Setting: The Health Resources and Services Administrations (HRSA), HIV/AIDS Bureau (HAB) supports Metropolitan Areas, States, Community Health Programs, Special Populations, and provides Technical Assistance and Capacity Building for entities seeking to provide quality services to persons living with HIV (PLWH). HAB offers funding for a wide array of services, inclusive of client centered mental health and substance abuse treatment, in diverse settings with the intent of achieving the outcomes outlined in the National HIV/AIDS Strategy.

Project: HAB has and continues to explore integrated treatment interventions for dually-diagnosed PLWH. This exploration sought to identify treatment adherence models, health outcomes, and costs associated with the delivery of mental health, substance abuse disorders, and HIV/AIDS primary care services for PLWH with comorbidities. HAB has engaged in several initiatives (i.e., Integrating

Buprenorphine Therapy into HIV Primary Care Settings, Getting Started with OPTIONS, Integrating HIV Innovative Practices, etc.) that have advanced knowledge and skills in the delivery of health and supportive services to underserved populations with HIV infection.

Results: Developing and evaluating psychosocial interventions that can be integrated into the management of communicable and non-communicable diseases can strengthen healthcare systems. HRSA's Ryan White HIV/AIDS Program funding can be used to ensure that PLWH with psychosocial factors that contribute to mental health and substance abuse issues are treated holistically.

Lessons Learned: After 25 years of administering Ryan White funding HAB has discovered many lessons regarding the role that mental health and substance abuse treatment play in the treatment of PLWH. Integrating mental health and substance abuse into all aspects of health and social policy, health-system planning, and delivery of primary and secondary universal health care is essential in meeting the needs of PLWH. Addressing mental health needs of PLWH serves a dual function in that it provides intervention as well as prevention. Scientific research has provided evidence that treatment adherence can lead to viral load suppression, secondary prevention, and decreased risk taking behaviors. Using existing programs and activities, such as those which address the prevention and treatment of HIV, and psychosocial factors, can enhance the delivery of mental health care.

Session C09 - Data to Care (D2C): Building Health Department Capacity to Use Surveillance Data to Improve the HIV Care Continuum

Room: A706 (Atlanta Marriott Marquis)

Abstract 1538 - Data to Care: Essential Training for Front-Line Staff

Author(s): *Julia Dombrowski, Rebecca Hutcheson, Wendy Nakatsukasa-Ono, Mark Fleming, Angela Nunez, Cornelius Rietmeijer, David Spach, Alice Gandelman, SueAnne Payette, Matthew Golden*

Issue: Health departments are expanding HIV/STD field services to focus on improving the HIV care continuum. Modern field service activities include surveillance-guided interventions to identify persons who are out of HIV care and assist them in relinking to HIV care ["Data to Care" (DtC)]. New skills and training are often required for disease intervention specialists (DIS) to successfully conduct DtC work.

Setting: The University of Washington Public Health Capacity Building Center (UW PHCBC) works with health departments to build capacity to conduct DtC activities using a peer-to-peer learning model that emphasizes lessons learned from DtC program implementation in Seattle & King County and other state and local health departments. The UW PHCBC is a consortium of organizations with experience in public health practice and research [Public Health - Seattle & King County (PHSKC) and UW], training healthcare providers (Northwest AIDS Education and Training Center) and DIS (CA STD/HIV Prevention Training Center and NY State STD/HIV Prevention Training Center), and providing technical assistance to health departments (Cardea Services and Rietmeijer Consulting).

Project: PHSKC launched a health department DtC program in 2011, collaborated with the largest HIV clinic in WA State to implement a clinic-based DtC intervention in 2012, and worked with the WA State Department of Health to train staff to conduct DtC activities statewide beginning in 2013. Personnel

conducting DtC activities in WA State include DIS with varying levels of experience, case managers employed by a local health department or community-based organization, and staff persons hired specifically to conduct HIV care outreach. Since initiating our capacity building assistance work in 2014, the UW PHCBC has worked with health departments in 11 U.S. states and territories on issues related to DtC and has conducted visits to 9 health departments to discuss DtC and other program issues in detail.

Results: Through our experience in WA State and work with health departments in other areas, we have identified the following priority areas for training of front-line staff conducting DtC activities: 1) public health case investigation skills; 2) fundamental concepts of contemporary HIV care and antiretroviral therapy; 3) healthcare systems navigation skills; 4) familiarity with basic criteria for public healthcare and antiretroviral payment coverage and local resources that offer ancillary HIV support services; 5) expectations regarding coordination with HIV medical case managers; and 6) basic techniques of motivational interviewing. Optimal training for DtC staff likely includes a combination of didactic lessons, acquaintance with resources for future reference, planning for commonly encountered challenges, and peer mentoring.

Lessons Learned: Front-line staff members conducting DtC activities need knowledge and skills that build upon, but go beyond, traditional DIS skills. Collaboration between capacity building providers, DIS training centers, and health departments who have implemented DtC programs will increase access to training resources for health departments planning DtC activities.

Abstract 1614 - Using Routine Collected HIV Surveillance Data to Support San Francisco's HIV Linkage, Integration, Navigation and Comprehensive Services (LINCS) Program

Author(s): *Susan Scheer, Darpun Sachdev, Robert Kohn, Sharon Pipkin, Charles Fann, Erin Antunez, Viva Delgado, Ling Hsu, Stephanie Cohen,*

Issue: Improvements to the HIV continuum of care are strategic goals of the NHAS and public health agencies are exploring innovative methods to link and retain HIV-infected persons in care. As such, there is a growing interest in using HIV surveillance and other healthcare databases to monitor care indicators but also for public health practice and interventions. The Data to Care (DtoC) public health strategy uses HIV surveillance data to identify HIV-diagnosed individuals not in care and support programmatic efforts for linkage and retention in care. The San Francisco Department of Public Health (SFDPH) is a CDC funded Capacity Building Assistance (CBA) provider offering DtoC expertise and experience to other health departments.

Setting: The SFDPH's HIV Care Navigation program (LINCS) provides linkage to care, navigation for out of care patients and comprehensive HIV partner services (PS). Routine HIV case surveillance is conducted by SFDPH and cases are maintained in the Enhanced HIV/AIDS Reporting System (eHARS). HIV surveillance data is used to inform LINCS activities by identifying people needing linkage to HIV care, PS and navigation back into care.

Project: The SFDPH DtoC program has used HIV surveillance to support LINCS activities in the following ways:

- 1) Determine if patients testing HIV-positive at SFDPH funded testing sites are new or known cases to prioritize linkage and PS activities to newly diagnosed patients;
- 2) Determine if sex partners named by a newly diagnosed patient are already known to be HIV-infected to prioritize PS activities to HIV-negative partners;
- 3) Refer patients testing positive in private medical sites to LINCOS for linkage and PS;
- 4) Determine if not-in-care (NIC) clinic patients are receiving care elsewhere or have moved out of SF prior to referral of cases to LINCOS or further action by the clinic.

Results: From 2013 through 2014, HIV surveillance determined that 364 (53%) of 686 individuals who tested positive in a SFDPH-funded testing site were previously known to be HIV-positive. In addition, 15 (7%) of 203 named partners not previously known to be positive were identified as HIV-positive from surveillance. Surveillance identified 42 new positives from private testing sites that would have otherwise been unknown to LINCOS. In 2014, 19 (58%) of 33 HIV-positive clients referred to LINCOS by their primary care provider for assistance with re-linkage and engagement were identified by surveillance as having relocated or being in care elsewhere. After matching 118 loss-to-follow-up patients from a SFDPH clinic to eHARS, 73 (62%) were identified as having relocated or engaged in care elsewhere.

Lessons Learned: Substantial improvements in identifying and contacting appropriate clients for LINCOS have been realized from the collaboration with surveillance and the exchange of data. Our staff has extensive experience extracting data from eHARS to prioritize and enhance linkage and navigation programmatic activities and ensuring that surveillance data are used to support DtoC activities. We are exploring additional opportunities to use surveillance data to support LINCOS including, for example, determining if named partners known to be HIV-positive are NIC and referring these clients for navigation services.

Abstract 1812 - Use of STD Surveillance along an Expanded HIV Continuum of Care

Author(s): *Bobbi McCaffery, Peter McGrath, Raquel Ruiz, Patricia Coury-Doniger*

Issue: Traditionally, the HIV Continuum of Care begins with a positive HIV test and includes linkage to and retention in HIV medical care and the early administration of ART, with a goal of viral load suppression (VLS). Many health departments (HDs) are utilizing HIV surveillance data to increase percentages of PLWHA in each Continuum stage and to maximize the number reaching VLS, a public health strategy now referred to as Data to Care (DtoC). STD surveillance can also be used to strategically expand HIV testing and enhance linkage and re-engagement in care. Additionally, the HIV Continuum can be expanded to include high-risk negative persons who could benefit from PrEP treatment. With the FDA approval in July 2012 of HIV PrEP as an effective biomedical intervention the focus of HIV prevention has expanded to HIV negative persons, particularly high-risk MSM, IDU, and high-risk heterosexuals. By definition, these persons do not appear in HIV surveillance databases but often can be found in STD surveillance databases, and as partners of PLWHA diagnosed with STDs. Training and technical assistance services are needed to increase the capacity of HDs to use STD surveillance data along an expanded HIV Continuum of Care.

Setting: The University of Rochester's Center for Health & Behavioral Training (CHBT) is a CDC-designated Capacity Building Assistance (CBA) Program for HDs nationally. CBA services are provided in the use of evidence-based behavioral and biomedical HIV and STD prevention interventions and public health strategies including DtoC. CHBT also manages the public health STD Clinic in Rochester, New York providing integrated STD/HIV prevention services, with over 12,000 walk-in visits per year. HIV and STD surveillance data is integrated with STD Clinic EMRs and DIS records.

Project: In 2009, an analysis of clinic and surveillance data was conducted to identify risk characteristics of STD clinic patients who became HIV infected. The results were used to guide prevention programming among those at highest risk, including development of criteria which identified 95% of newly diagnosed cases of HIV.

Results: Based on direct program experience, CHBT has provided DtoC CBA services to a variety of HDs in using STD surveillance data to expand/enhance HIV Continuum services. STD data include STD Clinic EMRs, jurisdictional surveillance case reports, and DIS Interview Records. Recommendations include using these data 1) to locate PLWHA who were never linked to care or are not retained in care; 2) to increase the efficiency of HD CTR programs by selectively recalling clients for repeat HIV testing; and 3) to recruit potential PrEP candidates.

Lessons Learned: STD surveillance data can be used to expand/enhance the HIV Continuum of Care and reach persons at highest risk, but requires that HD surveillance and HIV and STD prevention divisions collaborate to: 1) allow HD programmatic access STD and HIV surveillance data; and 2) use these data to expand/enhance Continuum services. Capacity Building Assistance DtoC services can be used to address HD barriers by providing best practice examples of the utilization of both HIV and STD surveillance data for HIV prevention.

Abstract 1963 - Assessing Health Departments' Readiness to Implement Data to Care

Author(s): *Isaiah Webster III, Tiffany West*

Issue: As the HIV prevention landscape continues to change, health departments are evolving in how they utilize data to ensure that people living with HIV are linked to care. Data to Care (D2C) shifts the use of HIV surveillance data from descriptive and monitoring purposes to include using it to empower public health action. Some health departments are still implementing D2C programs, which has increased the need for capacity building and peer-to-peer technical assistance (TA) in this area.

Setting: The National Alliance of State and Territorial AIDS Directors (NASTAD) represents the nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis care, prevention, education and support programs funded by state and federal governments. NASTAD is a CDC-funded Capacity Building Assistance (CBA) provider -- with a program focused on modernizing HIV prevention systems across silos.

Project: NASTAD created a D2C Community of Practice (CoP) for health departments in April 2015. The CoP focuses on user-generated content and lessons learned, which are shared as part of NASTAD's peer-to-peer TA model. In preparation for the CoP, NASTAD commissioned an assessment to help inform the

process. The assessment focuses on health departments' readiness to implement D2C, and provides NASTAD with a general needs assessment for its broader D2C CBA efforts. In developing the survey tool, NASTAD worked with DARE Global Innovations and leaned on lessons learned from its own development of the National HIV Prevention Inventory (NHPI). Each state and territorial health department was encouraged to complete the D2C assessment, and more than 30 jurisdictions did so. The D2C CoP began with a 4-part webinar series, and will be followed-up with intensive individualized TA as part of NASTAD's distance-learning environment.

Results: More than 30 jurisdictions completed NASTAD's Data to Care assessment. The results demonstrate a broad need for technical assistance relative to surveillance, operations and integration. During this session, NASTAD will share assessment data in aggregate form, and will approach up to three jurisdictions to share specific challenges, successes and considerations.

Lessons Learned: In developing its CoP for D2C, NASTAD has gathered extensive information about how state and territorial health departments are approaching D2C. Specifically, the CoP has focused on solutions to barriers. To this end, NASTAD has worked closely with Colorado, Hawaii, South Carolina, Massachusetts and Washington State on its D2C successes. These jurisdictions have served as facilitators for the CoP, and NASTAD has been highlighting their programs as among the best in the field. This session would allow NASTAD to present data from the assessment, and share related considerations from various jurisdictions.

Session C14 - Building a Culturally Competent Workforce

Room: A602 (Atlanta Marriott Marquis)

Abstract 1493 - Deconstructing Homophobia and Transphobia: Building Institutional Change to Promote Health Equity

Author(s): *Tim Vincent, JoAnne Keatley, Deborah L Wyatt-O'Neal, Linda DeSantis*

Issue: Louisiana was one of eight states awarded a 3-year CAPUS grant to mitigate HIV-related health disparities by focusing on social determinants of health. In 2012 among new HIV diagnoses in MSM, 66% were African American. Transgender women tested for HIV in 2011 were 4 times more likely to have a positive result than males that were tested. The Louisiana STD/HIV program addressed these disparities through capacity building for their provider network. Two national capacity building assistance organizations, the California Prevention Training Center (CA PTC), and Center of Excellence for Transgender Health (COE) collaborated in Yr. 2 to develop training on homophobia and transphobia for state health department employees to 1) examine the impact of homophobia and transphobia and 2) initiate institutional changes to promote health equity among black MSM and transwomen of color.

Setting: Between June-September, 2014, 176 providers completed one of six trainings titled "Deconstructing Homophobia and Transphobia" in Baton Rouge and New Orleans. Over 75% of the participants also previously attended the workshop: "Undoing Racism" in Yr. 1.

Project: In preparation for developing training, CA PTC and COE reviewed literature concerning the impact of homophobia and transphobia on health outcomes, and consulted with the health department

to establish objectives. We reviewed content from the racism workshop to identify similarities and distinctions between heterosexism and racism. Understanding how homophobia and transphobia contribute to new infections and overall HIV-disparity was critical before considering strategies for organizational or institutional change. The two-day course included experiential learning, didactic modules, and video testimonies to engage participants and meet the objectives. The training examined sources of homophobia and transphobia, history of oppression, heterosexual privilege, layered stigma from race, sexual orientation and gender identity, and strategies to create MSM and trans-inclusive environments.

Results: Responses from 168 pre-post surveys demonstrated increased knowledge of institutional homophobia, transphobia and health disparities (+1.25 on 5 pt. Likert); and increased self-efficacy to reduce institutional homophobia (+.97) and transphobia (+1.00). An overwhelming majority (96%) reported feeling confident to transfer knowledge/skills gained back to their work environments. Additionally, 82% reported intentions to implement changes at various levels including review of policies, creation of safer environments, and examining personal bias to improve client care. Almost all (99.4%) participants recommended this training to others.

Lessons Learned: Defining homophobia, transphobia and heterosexism, and acknowledging both their differences and similarities were important. Once these terms were understood by participants, they were better able to recognize biases, discuss their impact and identify potential solutions. Addressing heterosexism in lieu of their past work on racism also provided insight into the dynamics that create disparities in their region. Understanding the interplay between these issues is complex, as they challenge deeply held beliefs and may take time for participants to fully understand. Inclusion of varied modalities and opportunities for self-reflection during the training was essential for inspiring change related to this topic, and enhanced participants awareness and intent to recognize, and respond to homophobia and transphobia.

Abstract 1586 - Addressing Institutional Racism in HIV Prevention and Services: One Health Department's Approach

Author(s): Julie Fitch, DeAnn Gruber, Samuel Burgess, Jacky Bickham, Kimberley Richards, Diana Dunn

Issue: African Americans are disproportionately affected by STDs and HIV in Louisiana. These STD and HIV-related disparities are further made clear by the fact that African Americans only account for 32% of Louisiana's population. In 2012, African Americans accounted for 86% of syphilis cases, 85% of gonorrhea cases, 77% of Chlamydia cases, 74% of new HIV diagnoses and 79% of new AIDS diagnoses. 65% of people living with HIV in Louisiana are African American, and the HIV diagnosis rate for African Americans is more than seven times higher than for Whites. Among new HIV diagnoses in women in 2012, 86% were African American, and among new HIV diagnoses in MSM, 66% were African American. Given these data, the Louisiana Office of Public Health-STD/HIV Program (SHP) formed a strategy to enable intentional conversations about racism and its effect on this disparity.

Setting: Staff from SHP and three ASOs in New Orleans and Baton Rouge participated in a series of Undoing Racism workshops and strategic planning in an effort to address HIV inequities related to race.

Project: SHP, ASO staff, and consumers participated in Undoing Racism workshops provided by the People's Institute for Survival and Beyond, which provided in-depth training and technical assistance around structural/institutional racism. Participation in the workshops was intended to:

- Develop a common definition of institutional racism among participants
- Develop a common language and analysis for examining structural racism, including a particular focus on how racism is related to HIV prevention and treatment in community based and healthcare settings;
- Understand one's own connection to institutional racism and its impact on his/her work;
- Understand why people are poor and the role of institutions in exacerbating institutional racism, particularly for people and communities of color;
- Understand the historical context for how racial and social class distinctions in the United States came to be and how they are maintained;
- Understand the role of community organizing and building effective multiracial coalitions as a means for undoing racism.

Two weeks after each workshop, participants were brought back together for a half day debrief session to further process the content and begin a dialogue about how they view their own organizations and the communities served through this new understanding of institutional racism.

Results: From June 2013-December 2013, 200 people attended six Undoing Racism workshops. Through pre and post workshop surveys, an increase was demonstrated in the following areas: knowledge of institutional racism, self-efficacy to engage in improving institutional racism, self-efficacy to explain racial privilege, and intentions to address bias related to racism.

Lessons Learned: Key staff had five meetings with trainers from the People's Institute prior to offering this workshop in Louisiana. It was crucial that workshop organizers firmly understood how an analysis of institutional racism is integral to addressing health disparities AND were able to articulate that understanding to co-workers. Taking the time to have discussions and develop a shared understanding of institutional racism has created a solid foundation upon which to build anti-racist organizations, STD/HIV programs, and community collaborations.

Abstract 1608 - Building Providers Cultural Responsiveness in Working with MSM of Color

Author(s): *Duran Rutledge, Tim Vincent, Deborah Wyatt-O'Neal, JaDawn Wright*

Issue: Florida ranked first nationally in the number of new HIV infection cases diagnosed in 2013 (N=5,377 out of 47,352 CDC 2013). Additionally, all six of Florida's large metropolitan statistical areas, reported more cases individually than many states as a whole. Black and Latino, MSM of color (MSMC) collectively account for 54% of the people in Florida living with HIV. To address these high rates, the Florida State Health Department (FSHD) offered training and technical assistance to their provider networks throughout the state to improve services and increase engagement for MSMC. The California Prevention Training Center (CA PTC) worked with FSHD to conduct provider training to increase understanding of challenges MSMC experience that impact risk behaviors and access to services. The goal of this project was to change provider knowledge and attitudes and offer strategies to mitigate these significant HIV-related disparities

Setting: From September 2013 – April 2015, 117 HIV prevention providers attended one of five trainings throughout the state of Florida in six key regions where HIV-related disparities for MSM of color are most prominent.

Project: CA PTC developed a training to address the specific and unique challenges providers faced in working with MSMC. The training was informed by input gathered from provider surveys, recent data and research about the social context unique to MSMC, and from existing CA PTC curriculum on this topic. Providers identified challenges engaging MSMC due to low health seeking behavior, lack of awareness of services, lack of education, low perceived risks and lack of culturally competent providers and services. The training sought to address those challenges by examining social determinants contributing to health disparities among MSMC, including the impact of stigma, homophobia and racism. We included a holistic health framework as a tool for providers to build their understanding and ability to intervene in a culturally relevant manner

Results: Results from 103 post training evaluations demonstrated increased efficacy in using the strategies learned to improve competency with MSMC at key levels of engagement (provider, organizational and community) (+1.08 on 5 pt. Likert). Participants indicated using strategies learned in such areas as outreach, counseling and testing, and their ability to build client rapport to engage and retain them in prevention and care services. Participants also reported increases in applying a holistic view of health to improve prevention work with MSMC (+1.39), and in understanding the social factors that influence risk behavior among MSMC (+1.02). A majority of respondents (78%) indicated specific intentions to implement knowledge and skills learned at their work place.

Lessons Learned: Working with health departments to address HIV-related disparities for MSMC at a statewide level is critical to create organizational and structural change. It is useful to provide a holistic framework for providers to reference to increase knowledge and skill in addressing some of the social and cultural barriers that impact rates of HIV for MSMC. Beyond training, there remains further need to evaluate current service delivery systems in order to improve efficacy and access.

Abstract 5129 - Social Justice Sex Ed: A Professional Development Model for Contextualizing and Understanding Adolescent Sexual Risk Behavior by Utilizing an Anti-Oppression Lens

Author(s): *Gabrielle Abouseman*

Issue: Adolescent sexual risk behavior is contextual. There are many circumstances that lead youth to engage in unhealthy sexual behavior, including experiencing poverty, racism, sexism, ageism, historical trauma, and other forms of oppression. Only when sexual health educators understand the contexts in which their students live, and use that knowledge to inform their teaching and support their students, can they work to create life-long resiliency among adolescents.

Setting: The Youth Resiliency Project (YRP) is an HIV/STI prevention education pilot program housed within the New Mexico Public Education Department that focuses on increasing the capacity of certified health educators to offer exemplary sexual health education to students by providing the necessary tools. The goal of the YRP is to develop the ability of educators to teach about sexual health in an

informed, safe, kind, and supportive way that decreases adolescent risk behavior and increases resiliency.

Project: Utilizing a social justice framework that fear and stigma are not sound pedagogical techniques, workshops were offered to staff from partner school districts and charter schools that aimed to increase health educator awareness of biases and to contextualize adolescent risk behavior. The trainings addressed oppression, privilege, racism, sexism, ageism, micro-aggressions, historical trauma, cultural humility, cultural fluency, personal values, building partnerships, and strategies for supporting all students, including those who identify as lesbian, gay, bisexual, transgender, and questioning. Participants evaluated the trainings immediately following the workshops and via an online questionnaire at a later date. The training was debriefed with all co-presenters to determine any need for changes to future trainings. This presentation will outline the theoretical basis and the initial evaluation of this pilot program.

Results: In April and May 2015, the YRP coordinator implemented a total of four different trainings for health educators. The trainings reached 42 health educators from 10 different districts and charter schools throughout New Mexico. Results from the participant evaluations showed that the content increased knowledge of various sexual health topics, for example, knowledge around contraception and sexual assault statistics. Participants also reported finding the resources provided before, during, and after the trainings useful and consistently requested more. Finally, prior to the training participants expressed concerns around sexual health education and gratitude after the training for the support offered to them as they implemented exemplary sexual health education. Results from the presenter de-briefing showed that some additional topics could be added to the presentations, such as more discussion of the school-to-prison-pipeline and its impact on sexual health. Presenters also expressed an interest in modifying adult-learning pedagogical techniques to raise teacher capacity specifically around sexual health education.

Lessons Learned: Health educators respond positively to learning about social justice in order to build their capacity to offer exemplary sexual health education. While educators have different levels of experience and willingness to engage with these topics, all workshop participants were engaged in the trainings. Teachers wanted to process the contextual issues that arise when teaching sexual health education and look forward to future trainings.

Session C16 - Developing Effective Navigation Programs

Room: A708 (Atlanta Marriott Marquis)

Abstract 1760 - Peer Educators Improve Health Outcomes for People living with HIV/AIDS

Author(s): *Sharen Duke, Ramona Cummings, Cori Madrid, Deborah Yuelles, Brenda Starks-Ross*

Issue: Numerous studies have demonstrated the efficacy of using Peer Educators in conducting HIV prevention and care with high-risk populations. Similar to clients with whom they interact, Peer Educators face challenges related to treatment and adherence, substance abuse, homelessness, and mental illness. However, there is a dearth of research examining the effect of peer interventions to improve social, behavioral and health outcomes and best practices to support and improve health and

quality of life outcomes among Peer Educators and the people they reach through peer-delivered services.

Setting: ASCNYC is one of New York City's leading AIDS Service Organizations and has been conducting Peer education and capacity skills training programs for people living with and at risk for HIV since 1992. ASCNYC has over 90 Peer Educators in paid internships at any given time, providing prevention education and access to care services through outreach, referrals, and escorts to services and medical care, and group-level educational interventions (e.g., risk reduction, and HIV treatment health education) and structured socialization.

Project: HIV-positive and at-risk men and women attend ASCNYC's 8-week "core" peer training, Peer Recovery Education Program (PREP), which provides information and skills for Peer graduates to conduct community education, outreach, enrollment, and patient navigation. PREP graduates apply for stipended Peer Internships through ASCNYC's Peer Experience Program, and receive supervision from a staff mentor, ongoing skills development, and mandatory weekly support groups. . Outcome and process evaluation was conducted from October 2013-December 2014 to assess the impact of peer-delivered services on participants reached, as well as on the Peer Educators themselves in achieving individual goals to improve health (e.g., viral suppression), prevent relapse (e.g., sustained recovery from AOD use), and increase education and skills towards self-efficacy (e.g., consistent access to medical care and support services).

Results: Of the 133 current and past peers surveyed, 91% graduated from ASC training programs; 71% responded that program participation resulted in improved health: 89.4% reported primary care provider visit within the last 3 months; 89.1% reported having a viral load completed within the last 3 months; 79% reported sustained viral suppression. 94 Peer Educator Interns conducted 703 community education presentations, served over 33,000 meals, facilitated 20 weekly support and education groups, and provided care navigation for 3,377 people undetectable.

Lessons Learned: Peer-led interventions are beneficial for Peers as well as the high-risk persons they reach. Peer Educators reflect the populations they reach in terms of culture, language, ethnicity and life experience, making Peers credible and effective messengers of health promotion messages, as well as powerful role models of recovery from substance abuse, HIV risk reduction and other health enhancing behaviors, inspiring the individuals they reach with living examples of positive change.

Abstract 2178 - The Role of Patient Navigators in Integrating HIV Health Care and Housing Support

Author(s): *Serena Rajabiun, Lisa McKeithan, Silvia Moscariello, Kate Franza*

Issue: Homeless individuals are one of the most vulnerable populations at risk for and living with HIV. Although only .4% of the general population is HIV positive, the percent climbs to 3.4% for homeless individuals. The high risk for HIV is inextricably linked to higher rates of substance use and severe mental illness. National data indicate that approximately 20-25% of the homeless population suffers from severe mental illness, and studies report a range of HIV sero-prevalence from 4-23% among people with severe mental illness. A disproportionate number of homeless persons also suffer from substance use disorders which put them at increased risk for contracting HIV. Interventions that can address the

address the multiple medical and social needs of this population are essential to ensure continuous care and viral suppression.

Setting: The Health Resources & Services Administration, HIV/AIDS Bureau through its Special Programs for National Significance (SPNS) funded a national initiative with the goal of building a medical home for HIV-positive homeless/unstably housed populations.

Project: Nine clinic and community based organizations and one multisite coordinating center are funded to implement and evaluate service delivery models aimed to achieve two main outcomes: 1) increase engagement and retention in HIV care and treatment; and 2) improve housing stability for multiply diagnosed HIV-positive homeless/unstably housed populations. One innovative service delivery is the use of patient navigators/care coordinators to engage and retain HIV homeless/unstably housed individuals in care and assist with obtaining stable housing. In this workshop, presenters will describe the role of patient navigators/care coordinators in identifying and finding persons who are in need of HIV medical and housing services and the strategies employed to engage and retain patient in HIV care and obtain stable housing. Specific strategies will be shared on training navigators, how partnerships are formed and how they work with medical, substance use, mental health and housing providers and other community partners to address individual client needs. The key role of the patient navigator will be highlighted in terms of connections to the medical home. Presenters will use case studies to illustrate their work.

Results: From September 2013 to March 2015 a total of 557 participants were enrolled in the SPNS Building a Medical Home for HIV-Positive Homeless Populations project. Enrollment is expected to close in February 2016. This is a longitudinal study with data collection at baseline and at 3, 6, 12, and 24 months follow-up points to measure primary outcomes of viral load, retention in HIV care, and housing status. Other measures include quality of life and patient experience of care.

Lessons Learned: Preliminary results of this SPNS Initiative have found that the role of patient navigators in integrating HIV primary, behavior health care and housing support for HIV-positive homeless and unstably housed populations is critical. By developing strong partnerships in the community, bridging the gap between clients and providers, and increasing access to community services and supports, the patient navigator helps clients to engage in their health care, remove barriers to care, and improve the patient experience of care.

Abstract 2246 - Health System Navigators: An Emerging Role in High Impact HIV Prevention and the HIV Care Continuum in Philadelphia

Author(s): *Helena Kwakwa, Oumar Gaye, Matthew McClain, Sue Lehrman, Tanner Nassau, Catherine Corson, Natasha Mvula, Kathleen Brady*

Issue: Controlling mature epidemics in big US cities requires aggressive coordinated pursuit of Early Identification of Individuals with HIV/AIDS, retention in care, and high impact prevention, all of which address goals of the National HIV/AIDS Strategy. Most needed are efforts to improve methods to link newly diagnosed and re-engage patients disconnected from HIV care, along with retention in care. The ultimate goal is viral suppression (VS) at the individual and community levels. Through a unique 3-year

national foundation-funded service demonstration opportunity, the Philadelphia Department of Public Health (PDPH) evaluated the use of an emerging service delivery model featuring Health System Navigators (HSN) to engage (and re-engage), link, and retain high-need patients presenting in busy safety-net primary care clinics. This presentation describes the model, results of 3 years of service delivery, lessons learned, and future directions.

Setting: HIV incidence in Philadelphia (1.3%) meets the definition of a generalized epidemic and is 3 times the national rate. HIV is associated with being of color, male, ages 24-45, and sexually active. Linkage to HIV care and VS along the Philadelphia HCC are comparable to national rates, with substantial system-wide PDPH-led efforts to improve linkage and VS. PDPH safety net clinics serve 1,000 patients with HIV/AIDS, representing about 10% of all PLWHA in the publicly funded continuum of care. An estimated 6,000 people in the Philadelphia area are unaware of their HIV infection.

Project: Beginning in 2012, PDPH implemented a demonstration project to evaluate a new role of HSN in 8 safety net health centers operated by PDPH. The 4 HSNs identify persons newly diagnosed with HIV, at risk of being lost to care, or out of care and provide intensive navigation services to link or re-link and retain these individuals in care.

Results: Demographic, utilization, and outcome data will be presented on the 77 enrollees prior to and following receipt of HSN services. Select indicators will be presented comparing HSN enrollees and non-enrolled patients seen in PDPH health centers. For example, 90.9% of newly diagnosed enrollees and 84.9% of re-engaging HSN enrollees were linked to care within 3 months. Viral suppression rates for the navigated cohort, less than the non-enrollees, increased from 33.3% 12 months pre-enrollment to 68.2% 12 months post-enrollment. Retention rates, comparable to non-enrollees, increased from 13% to 95% over the same period.

Lessons Learned: Results suggest the project targets individuals with greater care needs than in the general population. Evidence gathered to date justifies sustaining HSNs in the existing health centers and other appropriate settings such as STD clinics and FQHCs. The project was strengthened by the collaborations with PDPH medical epidemiologists for data management and analysis, community-based AIDS service organizations for personnel management and referrals, and the local AETC for training. The demonstration nature of the project also provided the opportunity to develop new protocols and procedures. Presenters will also discuss lessons learned that were unexpected.

Implications: The emerging role of HSN is worthy of replication and adaptation as a new method to better controlling generalized epidemics in big U.S. cities.

Abstract 2533 - HIV Linkage and Reengagement Services in Local Health Department Settings: Results of the HIV Care Collaborative

Author(s): *Julia Hidalgo*

Issue: HIV policymakers stress the importance of effective linkage and retention strategies to improve the HIV care continuum, ensure access to HIV care and treatment, and reduce community viral load to avoid new HIV infections. Effective linkage and engagement services are critical in ensuring that HIV+ individuals can optimally benefit from advances in HIV care and medications. Effective linkage services

can help to prevent barriers to engagement, promote treatment adherence, and avoid loss to care. Effective use of HIV surveillance databases, in conjunction with linkage services, are also imperative in locating HIV+ individuals that were previously lost to care, address factors contributing to loss, and reengage clients in care and treatment. Substantial improvement in linkage and retention in care rates are needed, however, to achieve the goals of the National HIV/AIDS Strategy.

Setting: The Merck Foundation HIV Care Collaborative (HCC) for Underserved Populations funds replicable, innovative strategies in local health departments (LHDs) to improve outcomes and prevent further HIV infections. Health departments in Fulton County, Houston, and Philadelphia are completing a three-year initiative.

Project: A three-month rapid cycle intervention is implemented by community health workers (CHWs) who assist newly identified HIV+ individuals to initiate care, relink clients that dropped out of care, help clients to navigate the healthcare system, and promote self-navigation to ensure independence. One HCC site also tested methods for locating and reengaging HIV+ individuals lost-to-care. Fulton County and Philadelphia integrated HCC services in LHD clinics, while the Houston LHD referred HCC clients to community HIV clinics. The HCC intervention were designed by the National Program Office (NPO), based on an in-depth assessment of linkage and engagement programs throughout the US. The NPO maximized routinely gathered data collected for the Ryan White Program to reduce reporting and evaluation burden. A continuous quality improvement (CQI) strategy was applied to measure and enhance CHW performance, as well as to identify best practices.

Results: We summarize the HCC intervention, including assessment, care planning, referrals to address barriers to care, and transition to the healthcare team for ongoing engagement and retention. Specific personal and structural barriers are discussed. We describe demographic, epidemiologic, and clinical characteristics of HCC clients, as well as HCC workers' demographic, educational, work experience characteristics, and turnover rates. The duration, nature, and frequency of HCC services undertaken in the intervention and client and provider factors associated with differences in those process measures are presented. The association between client and HCC worker characteristics and HCC service use on six-month retention and undetectable viral load rates is described. The relationship between HCC worker turnover and six-month retention in care and undetectable viral load rates are also examined.

Lessons Learned: LHDs can successfully adopt rigorously designed and evaluated evidence-based linkage and reengagement interventions through the deployment of trained and well supervised CHWs. CHW turnover, however, contributes to poor continuity of service and lost-to-care. CQI techniques can be used successfully to streamline the linkage and reengagement process and improve productivity and quality of services.

Session C18 - Client Engagement through Linkage-to-Care

Room: A601 (Atlanta Marriott Marquis)

Abstract 1243 - Developing Coaching and Monitoring Approaches to Support ARTAS Implementers

Author(s): *B.A. Laris*

Issue: Many HIV prevention providers are looking for effective strategies to link HIV+ clients to treatment. The public health strategy called ARTAS (Anti-Retroviral Treatment and Access to Services) is an individual-level, multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-based Case Management (SBCM) model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC). There is a two-day training for staff to be prepared to implement the strategy with clients. As with many interventions, on-going coaching and supervision to support staff and the use of monitoring and evaluation tools are critical to maintain fidelity to the intervention and realize success with clients. Capacity building assistance can provide much needed additional coaching and support to institutionalize the practices that lead to client success and staff confidence and competence.

Setting: Coaching and support for linkage coordinators implementing ARTAS can be in CBO and clinic settings in urban, rural, and suburban areas, wherever individuals newly diagnosed with HIV engage with providers. We work primarily with directly and indirectly CDC-funded community based organizations.

Project: ETR's Community Impact Solutions has developed a model to work with CBOs implementing ARTAS to monitor implementation, identify specific challenges in the field, address concerns, and provide practical strategies that can be used in real-world settings.

Results: ETR's Community Impact Solutions has worked with several different CBOs implementing ARTAS using the ARTAS coaching model. The results have highlighted key areas of need that arise as CBOs begin to implement this strategy in the community. The top 5 requested technical assistance topics are: keeping clients engaged, strategies to work with individuals with co-occurring disorders and with substance users, recruiting clients, and providing staff support with limited resources. Less than half of the programs (43%) have an agency-wide system in place to track if clients are linked to care. Staff implementing ARTAS reported feeling the least comfortable with being able to recruit clients who can successfully complete ARTAS and most able to meet the needs of ARTAS clients.

Lessons Learned: The ongoing ARTAS coaching and support provided by ETR's Community Impact Solutions has shown the critical importance of conducting local assessments of ARTAS implementation after CBO staff have been trained and have begun actual implementation in the community. This provides CBOs with practical tools and approaches to increase the confidence and comfort of staff which in turn supports the success of clients.

Abstract 1395 - The BEACON Project (Barrier Elimination and Care Navigation): A Lost to Care Program with Excellent Outcomes in Viral Load Suppression

Author(s): *Kristen Tippit*

Issue: The prevalence of PLWH/A who have been lost to care is a prevention and public health concern. In the St. Louis Ryan White Transitional Grant Area (TGA) in 2013, one-third of PLWHA had unmet need as evidenced by not having documented care. Additionally, the breakdown of those without any evidence of care was 23 % of PLWA and 42% of PLWH. Many barriers exist preventing engagement and

retention in care. By identifying and enumerating these barriers, specialized programs can work towards eliminating them and re-engaging those lost to care for positive outcomes in health and viral suppression.

Setting: The BEACON Project takes place in the St. Louis Region and is implemented by two teams, one located at the ASO and grantee, St. Louis Effort for AIDS, and the other, co-located with the Washington University Infectious Disease Clinic. The targeted program population is all PLWHA who have no evidence of HIV related medical care in over 12 months.

Project: The BEACON Project teams consist of an Engagement Coordinator, a Peer Advocate, and a Community Nurse. All team members work intensively with lost to care clients to eliminate barriers and re-engage and retain them in medical care. While in the BEACON Project, clients are followed for up to 18 months by the Engagement Coordinator who eliminates barriers through referrals to outside resources (housing, food, mental health and substance abuse treatment), provides crisis management, and facilitates the creation of stronger support systems. Clients receive support from the Peer Advocate surrounding disclosure, adherence to care and treatment, and HIV education. Clients also work closely with the Community Nurse who makes and attends appointments, and provides medical assessments and health education. Clients utilize Ryan White (RW) funding but also have access to Emergency Stabilization funds to wrap around RW services and aid in eliminating barriers like housing and transportation.

Results: For the St. Louis Ryan White TGA an overall 12% decrease in unmet need, from those PLWHA who are aware of their status but not in care, occurred from 2011 to 2013. The Project has enrolled over 300 PLWHA since its inception and has linked over 80% of those clients to care, over 50% within 30 days. Of the clients who have been enrolled for 18 months, 82% have a suppressed viral load. Looking at more long-term retention, 76% of BEACON clients are connected and retained in case management at present. As the data shows, the project has been highly successful in its goals and in targeting and lowering the lost to care population in the St. Louis Region.

Lessons Learned: Overall, this project has been highly successful and we have shown that with more intensive services, a team approach including a peer and community nurse, and additional financial resources to assist in barrier elimination, clients are more likely to remain engaged in care. Particularly of interest for treatment as prevention, this model shows stunning results for viral load suppression within the treatment cascade with over 80% of clients who are retained in care becoming virally suppressed.

Abstract 1665 - Real-time evaluation of an enhanced linkage intervention for newly HIV-infected patients: the linkage to care specialist project

Author(s): *Robert Bolan, Rhodri Dierst-Davies, Jesse Bendetson, Risa Flynn, Steven Leyva, Rivet Amico, William Cunningham, Amy Wohl*

Issue: The Health Resources and Services Administration (HRSA) defines linkage to care (LTC) among newly-infected HIV-positive individuals as having one face-to-face visit with an HIV medical provider

within 3 months after diagnosis. In the U.S., although various subsidies allow for all people living with HIV to receive medical treatment, approximately 65% link to care.

Setting: The Los Angeles LGBT Center (herein known as The Center) is one of the largest HIV testing and care facilities in the county, administering approximately 12,000 tests annually and reporting a 4% positivity rate. In response to the National HIV/AIDS Strategy LTC goals, a linkage to care specialist (LTC-S) was hired to improve linkage rates for newly-infected individuals. Following LTC-S project implementation, LTC rates at The Center increased from 70% to 90%.

Project: This demonstration project prospectively evaluates The Center's LTC strategy, in which the LTC-S meets one-on-one with each newly-diagnosed patient and offers a tailored intervention based on individual need. Activities include setting additional meetings with newly-diagnosed clients, following up through phone/email/text, and providing referrals as needed. Using the HRSA definition for LTC, this project will track which individuals have a face-to-face visit with an HIV medical provider within 3 months following diagnosis. Enrolled participants provide written informed consent and complete three assessments. The baseline assessment occurs within 2 weeks of an HIV-positive diagnosis and the follow-up survey is administered three and six months after diagnosis. Survey items explore early reactions to a new diagnosis by using existing scales that examine domains of fear, stigma, knowledge, attitudes, and support. Participants are incentivized to participate with \$40 gift cards. All evaluation activities were approved through the Los Angeles County Department of Public Health IRB.

Results: Between March 2014 and February 2015, 80 individuals were enrolled. All participants are male and self-identify as men who have sex with men (93% gay, 7% bisexual). The majority of participants are Latino (45%), White (32%), or African American (13%). Currently, 91% of participants (n=73) have linked to care within 3 months post-disclosure, with 4% (n=3) lost to care and 5% (n=4) still within the 3 month linkage window. It has taken an average of 22.5 days (SD=13.7) for these individuals to link, with an average of 2.3 hours (SD=1.1) of staff time dedicated to linkage activities. Preliminary results indicate that while most clients are knowledgeable about HIV, many report moderate levels of stigma and fear at baseline

Lessons Learned: Current HIV testing facilities and social service programs may benefit from incorporating a LTC-S into their programs to improve LTC rates in a manner that is acceptable to both patients and service providers. In addition, existing programs and services in diverse, urban communities should incorporate bilingual and bicultural LTC-S to address the needs of the surrounding community. This project demonstrates that enrolling participants in care close to diagnosis is feasible and acceptable, as long as a patient-centered approach is taken.

Abstract 2195 - No Wrong Door: Creating New Opportunities for HIV Testing and Linkage to Care (LTC)

Author(s): *Fatima Elamin, Heather Bronson*

Issue: The Virginia Department of Health, Division of Disease Prevention (DDP) is addressing a declining positivity rate by simultaneously implementing several projects aimed at increasing accessibility to HIV testing and care services. DDP's prevention projects include a partnership with Walgreens to offer free HIV testing; mapping of priority areas for new test sites by using social determinants of health;

distribution of In-Home HIV test kits; use of the Rapid-Rapid HIV testing algorithm; and system-wide changes to improve LTC outcomes.

Setting: DDP selected sites for pharmacy and community-based HIV testing under the Secretary's Minority AIDS Initiative Funding for Care and Prevention in the United States (CAPUS) using geo-mapping tools to prioritize localities with high minority and high poverty. The In-Home testing program is an online program that specifically targets men who have sex with men (MSM).

Project: DDP's "No Wrong Door" approach focuses on increasing the number of places where individuals may get tested and the number of different options available for HIV testing and LTC.

DDP used geo-mapping tools, census data, and drive-time maps to identify priority areas for community and pharmacy HIV testing sites under CAPUS. DDP selected priority areas for HIV testing based on the highest rates of minority populations and poverty.

DDP launched distribution of In-Home test kits in 2013, with community-based organizations (CBOs) giving kits to individuals at increased risk who did not want to come in for traditional testing. DDP is expanding its home testing program to specifically target MSM by placing advertisements for free home kits on web and Smartphone applications serving MSM and sending home kits through the mail to further reduce transportation barriers.

DDP's implementation of the rapid-rapid algorithm allows for same-day HIV diagnoses and quicker linkage to HIV care. To improve the coordination of referral services, DDP developed a Coordination of Care and Services Agreement (CCSA) form which allows community providers, care providers, and disease intervention specialists to communicate freely in order to facilitate seamless linkages to care.

Results: A total of 1,224 individuals have been tested through the pharmacy-based program and 11 reactive individuals were identified.

DDP distributed 810 In-Home HIV test kits, and CBOs achieved a 15% response rate to surveys collecting risk, demographic, and result information.

Rapid-Rapid testing reduced the average time from positive test to first medical appointment from 28 days in 2013 to six days in 2014. As a result of Patient Navigation services, implementation of the CCSA, and adoption of active referral protocols by disease intervention specialists, Virginia's overall LTC rate improved from 32% in 2010 to 80% in 2014.

Lessons Learned: The addition of pharmacy and community HIV testing sites in the priority areas where HIV testing services have previously been limited is helping to fill in service gaps, reducing the average drive time to a free HIV test site to 15 minutes for all Virginians. Home testing is a practical option for reducing barriers to HIV testing related to stigma and transportation. Lastly, the coordination of HIV services is essential for HIV prevention programs striving to improve LTC outcomes.

Session C22 - Effective Models of HIV Testing: Mass, Mobile, and Clinic-Based

Abstract 1956 - The Mississippi Collaborative for Inclusive Health Care: A Model to Improve Access to HIV Testing and Services for LGBT People at High Risk

Author(s): *Harvey Makadon, Leandro Mena, Mauda Monger, Janice Bacon, Robert Pugh, Nicholas Mosca, Michael Jones*

Issue: Mississippi is among the states with the highest rates of HIV diagnosis; its HIV testing rates are well below CDC's national goals. Young black men who have sex with men (MSM) and transgender women are at especially high risk for HIV infection in Mississippi, but face multiple barriers to testing and care.

Setting: In late 2014, we formed the Mississippi Collaborative for Inclusive Health Care with the goal of ensuring inclusive and affirming health care for LGBT people so that those at highest risk for HIV will come for appropriate screening and follow-up as needed. In a state without Medicaid expansion, the likeliest places to access such services are health department clinics and community health centers. The collaborative is a partnership of the Mississippi State Department of Health (MSDH), Mississippi Primary Health Care Association, University of Mississippi Medical Center (The Division of Infectious Disease, The AIDS Education and Training Center, and the Myrlie Evers-Williams Center for Elimination of Health Disparities), the National LGBT Health Education Center at The Fenway Institute, and My Brother's Keeper Inc.

Project: The Collaborative supports training for frontline and clinical staff at health centers and MSDH clinics on culturally-appropriate ways to communicate with and care for LGBT people. We also implement readiness assessments of organizational practices, attitudes, and knowledge in order to tailor our trainings.

Results: In December 2014, we conducted 2 focus groups with clinical staff, and 1 focus group with LGBT people in Jackson; we also implemented a readiness assessment with 238 clinical, registration, and managerial staff from MSDH clinics across the state. Among the findings: 71% and 58% of respondents felt very comfortable providing services to LGB people and to transgender people respectively. However, 42% were unfamiliar with the health needs of transgender people; 84% did not know of any LGBT community resources for referrals; and 16.5% had heard negative comments about LGBT people from coworkers. Focus group and assessment findings informed the development of a one-day train-the-trainer curriculum that we conducted in January 2015 for 28 selected health department staff. In a pre-post test, trainers increased their self-rated ability to train others on LGBT and HIV/STIs health from an average of 3.4 to an average of 4.5 (on a scale of 1-5). Qualitative comments were extremely positive. A District-wide training of frontline staff is planned for May 2015.

The Collaborative has also begun technical assistance with 2 health centers in Mississippi – one in Jackson, and one in Hattiesburg. A readiness assessment and training has been completed for one health center, and more are scheduled for 2015.

Lessons Learned: There is a strong need for education and training on providing LGBT-affirming health care in Mississippi. A strong collaboration with key stakeholders demonstrates vital state-wide support for this initiative. Initial outreach efforts by the Collaborative have been welcomed by the MSDH and health centers. A train-the-trainer workshop, which showed positive increases in knowledge and capacity to train others, has laid a foundation for educating health care staff at safety net clinics throughout the state.

Abstract 2085 - Diving Into the Fight to End AIDS: HIV Testing During the Houston Splash Gay Pride Event
Author(s): *Dwayne Morrow*

Issue: HIV/AIDS has been an epidemic in the United States for the last 30 years. Gay, bisexual, and non gay identified men have been the most affected group. These populations are collectively referred to as men who have sex with men (MSM). While HIV mostly affected Caucasian MSM in the early years of the disease, MSM of color have seen rising rates of infection over the last 15 years. According to the CDC, among all MSM, black/African American MSM accounted for 36% of the new HIV infections in 2010 and Hispanic MSM accounted for 22%. The largest number of new infections among black/African American MSM (45%) occurred in those aged 13 to 24. The largest number of new infections among Hispanic MSM (39%) occurred in those aged 25-34. The high rate of HIV infection needs to be addressed through targeted strategies designed specifically for these populations.

Setting: Across the United States, gay pride events are held in cities to express solidarity and provide positive support to members of the GLBT community. Often times, community based organizations (CBOs) and health departments will have a presence at these events to provide testing, education, & safer sex kits. Some of these gay pride events cater to specific ethnic demographics. In Houston each spring, there is a gay pride event aimed at black/African American MSM called "Houston Splash". Each year, this event is attended by thousands of MSM not only from Texas, but from all over the United States. It provides an opportunity to engage a large concentration of the MSM of color community in order to provide them with HIV testing.

Project: Since 2010, AIDS Foundation Houston has partnered with Loud, Inc (the company that organizes Houston Splash) & provided HIV testing to participants attending Houston Splash. We begin our advertised testing approximately one month before the event and offer the incentive of a VIP pass to the Houston Splash events when a person gets tested for HIV & Syphilis. Clients who self identified as HIV positive were allowed to only be tested for syphilis. During the 4 days of Houston Splash, AFH provides testing at the venues hosting the Splash events such as the host hotel, clubs, and Galveston Beach.

Results: AFH has tested 408 participants attending Houston Splash for HIV. Of those 408 people tested 26 new HIV positive individuals were identified for a positivity rate of 6.4%. Additionally, we have an RPR reactive rate of 9.6%. We were also able to provide linkage to care services to individuals who were previously diagnosed back into to care.

Lessons Learned: Providing testing at gay pride events allows us the chance to reach a large number of previously undiagnosed individuals. Providing HIV testing in nontraditional, nonclinical settings also

allows us to test those people who would not normally come to our CBO or go to the doctor's office for a test. Using these events as a strategy for HIV prevention allows us to increase the number of people aware of their HIV infection and link them into HIV care.

Abstract 2160 - Enlaces Por La Salud: Development and Evaluation of a Transnational Intervention for Mexican MSM and Transgender Women

Author(s): *Joaquín Carcaño, Clare Barrington, Lynne Sampson, Amy Heine, Heidi Swygard, Lisa Hightow-Weidman*

Issue: HIV in North Carolina (NC) disproportionately affects Latino men who have sex with men (MSM) and transgender women (TW). In 2013, the rate of new HIV diagnoses for adult/adolescent Hispanic/Latino males was 2.7 times that for White males and statewide 80.2% of all male cases are among MSM. Latinos also made up the largest proportion (35.7%) of "late testers" in 2013, defined as receiving an AIDS diagnosis within 6 months of testing positive. Latino MSM/TW's access to and engagement in HIV care is shaped by the interplay between structural and social factors including immigration and labor policies, overlapping forms of stigma and discrimination, social isolation, gender norms, and limited access to culturally competent health services.

Setting: Enlaces por la Salud is one of ten Health Resources and Services Administration (HRSA), Special Projects of National Significance (SPNS) demonstration projects. From 2002 to 2012, the estimated Latino population in North Carolina (NC) increased by 88.6%; the majority of Latinos in NC are from Mexico. The goal of Enlaces is to facilitate access and retention in HIV care for newly diagnosed or out of care Mexican men/TW. The intervention reflects a collaborative effort between the University of North Carolina, two community based organizations and five HIV clinical facilities.

Project: Enlaces is a six session face-to-face intervention delivered by two bilingual personal health navigators (PHN) to address both the psychosocial and structural barriers to care. The concept of transnationalism is the core foundation of Enlaces, which is reflected in session content that is anchored in the individual's migration story, and addresses cultural views on health care, stigma, language, and social networks in NC and Mexico. The approach also takes into account the intersections of sexual orientation, gender identity, country of origin, and ethnic minority and immigration status. Enlaces was adapted from the Anti-Retroviral Treatment and Access to Services (ARTAS) strengths-based case management model. Major revisions to the model were made to integrate concepts of culture and country of origin in order to facilitate engagement of both foreign and US-born Latinos in HIV care. Intervention development was informed through retrospective reviews of NC state surveillance records, examination of established evidence-based interventions and formative research with key informants and HIV-positive Latino MSM or TW engaged in HIV care.

Results: Enrollment began in October 2014. Twelve participants (11 men and 1 TW) of our planned 100-person sample have been enrolled. Baseline, 6 and 12-month surveys administered via ACASI as well as clinical data (e.g. CD4 counts, viral load, appointment adherence) are being collected. Qualitative process evaluation with study participants, providers and stakeholders will be conducted.

Lessons Learned: Given that Southeastern US continues to see the concurrent increase in the Latino population and HIV rates, interventions to facilitate diagnosis, entry and retention in care are urgently needed. Enlaces, our tailored, transnational intervention addresses key structural and individual-level factors identified during formative work. Intervention adaptation was critical given the lack of evidence-based strategies for reaching and engaging this marginalized and underserved and growing community.

Abstract 5125 - HIV and HCV: Tandem Testing of Substance Users in Metro Atlanta: The Imagine Hope Project

Author(s): *Marie Sutton, Winona Holloway*

Issue: The recent outbreak of HIV infection linked to injection drug use in Indiana demonstrates the importance of timely HIV and Hepatitis C surveillance and rapid response to interrupt disease transmission. An estimated 2.7 – 3.9 million Americans have chronic HCV infection. Of those, 50 – 70% are unaware of their infection. Three out of every 4 Americans with HCV were born from 1945 – 1965. People who inject drugs account for more than half of new HCV cases. Within 5 years of beginning injection drug use, 50 – 80% of injection drug users (IDUs) become infected with HCV. Studies indicate that 12 – 80% of homeless people may be infected with HCV. Since 2007, HCV-related deaths have surpassed HIV-related deaths. CDC reported 19,368 death certificates listing HCV as a cause of death in 2013, adding that this figure represents a fraction of deaths attributable to HCV.

Setting: The project is based in metropolitan Atlanta, Georgia, at 5 agencies serving substance using populations including 2 abstinence-based substance abuse treatment centers, an outreach organization, a methadone clinic, and a drop in center serving individuals in recovery from substance use.

Project: Imagine Hope, supported by Gilead Sciences, initiated HCV rapid testing in April 2015. The project offers free, routine HCV testing and linkage to care by nurses and counselors who already conduct rapid HIV testing. The goal is to provide HCV antibody testing to 2050 individuals from April 2015 to February 2016. Additionally, HCV RNA tests will be provided to 200 Ab+ clients at the methadone clinic.

Results: Over 3 months, 279 consumers received HCV antibody testing. Of those, 67 (24%) were HCV antibody positive (Ab+). Of 67 HCV Ab+ clients, 46% (31) were born between 1966-1985, 30% (20) between 1945-1965, and 23% (16) in 1986 or later. To date we have identified no HIV/HCV co-infections. Among those who tested HCV Ab+, 21 were first time testers (31%), 23 either had unknown status or previously tested negative, and 23 reported being HCV Ab+ but had no RNA confirmation. By June 30, 2015, our navigator was working with 32 HCV Ab+ clients to link them to RNA testing and 34 had received RNA screening at the methadone clinic. Of those receiving the RNA test, 23 (67%) were confirmed positive and all were IDUs; 11 were negative. To date, 21 clients have kept their first medical appointment, including 12 who were confirmed RNA positive at the methadone clinic.

Lessons Learned: HCV testing in tandem with HIV testing in Substance Abuse facilities is feasible. Among substance users, HCV prevalence is high and awareness of infection is low. Linkage to care is enhanced by the use of a navigator. RNA screening prior to the 1st medical appointment expedites

linkage to care; RNA positive clients are more motivated to keep appointments and RNA negative clients do not clog an already burdened system of care for the uninsured.

Track D

Session D12 - PrEP & TASP

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1419 - Accelerating the Implementation of Antiretroviral Medications to Prevent HIV Infection in New York City (NYC)

Author(s): *Demetre Daskalakis, Zoe Edelstein, Patti Abshier, Adriana Andaluz, Christine Borges, Sarit Golub, Paul Kobrak, Nana Mesah, Ben Tsoi, Julie Myers*

Issue: Mounting data and guidelines support the need for scaling up the use of antiretroviral medications for the prevention of HIV (ARV-P). Despite scientific advances in this area, implementation of ARV-P interventions requires addressing knowledge gaps and stigma among potential users and providers as well as barriers in the health delivery systems.

Setting: NYC is a large urban area with a mature HIV epidemic, and a tradition of early adoption of HIV-related technologies and interventions. The speed of innovation in the realm of ARV-P, specifically pre- and post-exposure prophylaxis (PrEP and PEP), required the NYC Health Department to rapidly develop a multi-domain, collaborative ARV-P program portfolio to greatly expand awareness and uptake of these interventions. In order to maximize impact, the portfolio integrates community needs with City and State initiatives.

Project: The NYC Health Department has launched programs in several domains to accelerate ARV-P implementation in NYC. The domains addressed include: awareness among potential ARV-P users, education and implementation support for potential prescribers of ARV-P, development of an ARV-P referral network, direct delivery of PEP, advocacy for state-level PrEP assistance programs, and redefining HIV testing as a gateway to ARV-P related care for those testing negative.

- Social marketing and new media have been utilized to promote ARV-P to high priority populations through the development of a campaign designed to increase awareness of PrEP and PEP.
- Training in basic concepts of ARV-P has been provided to staff who educate and refer potential ARV-P users from a range of organizations.
- Implementation assistance has been provided to potential ARV-P prescribing sites through:
 - o A public health detailing campaign using HIV surveillance data to target providers in various practice settings;
 - o Creation of materials to facilitate program implementation;
 - o Implementation workshops that engages both medical and administrative directors of potential sites.
- Development of a well-vetted, publicized list of providers willing and able to provide ARV-P has been facilitated through a readiness checklist.

- Free PEP delivery has been implemented at DOHMH sexually transmitted disease clinics and at several external sites funded by DOHMH to offer comprehensive sexual health services to populations at risk who are uninsured/underinsured.
- DOHMH staff have participated on the New York State End of Epidemic Taskforce and advocated for the development of a care assistance program for uninsured ARV-P users.
- PrEP was added as a pillar of the newly launched New York Knows jurisdictional testing campaign.
- Evaluation of the uptake of PrEP and PEP in NYC has begun by leveraging existing data sources.

Results: Given the urgent need for biomedical HIV prevention scale-up, NYC has developed a well-rounded ARV-P portfolio. The Department's PrEP/ PEP-related programs target both providers and individuals who can most benefit from these interventions. Materials and programs are already being adapted by other municipalities; they are likely scalable to others.

Lessons Learned: Early implementation of new technologies to prevent HIV infection requires contextualized and multi-domain strategies to accelerate uptake beyond the realm of early adopters. Effective scale-up requires close collaboration with other government agencies and community stakeholders.

Abstract 1430 - Getting the Word Out About PrEP: Assessing Current Awareness and Understanding to Develop Targeted Messaging for Gay and Bisexual Men

Author(s): *Tina Hoff, Caroline Jackson, Sarah Levine*

Background: Recent research shows that antiretrovirals (ARVs), which already have helped to dramatically increase the quality and length of life for people with HIV, also play a powerful role in prevention. Pre-exposure prophylaxis (PrEP) is a daily pill shown to be highly effective in reducing the risk of getting HIV. Additionally, with ongoing ARV treatment people with HIV can reduce the risk of passing the virus to others by as much as 96 percent (treatment as prevention or TasP).

Higher risk populations, including gay and bisexual men, have much to gain from these advances. Yet, a recent survey from the Kaiser Family Foundation reveals few are aware of these options and few are they having conversations about HIV with their loved ones and healthcare providers that have the potential to have an impact on PrEP use.

Methods: To understand what gay and bisexual men know and think about HIV, and the obstacles to this population taking greater advantage of PrEP and TasP, Kaiser conducted a survey of gay and bisexual men in the U.S. focusing on attitudes, knowledge, and experiences with HIV/AIDS and new HIV therapies. The survey was conducted July 17-August 3, 2014 with a sample of 431 men who self-identified as either gay or bisexual using a nationally representative, probability-based Internet panel. Few representative surveys have been done with this population, none recently have focused specifically on HIV/AIDS.

Greater Than AIDS, a public information response managed by Kaiser is utilizing the findings from the survey to inform targeted messaging for gay and bisexual men about PrEP and TasP.

Results: The survey found that most gay and bisexual men are not aware of current treatment recommendations for those who are HIV positive, or of the latest developments in reducing new infections. Only about a quarter know about PrEP (26%) or TasP (25%).

Contributing to this low awareness is that few gay and bisexual men report talking much about HIV today, not even with those closest to them or their healthcare providers. Large majorities say that HIV “rarely” or “never” comes up in conversations with their friends (68%), family members (84%), or intimate partners (60%). Six in ten (61%) say that HIV doesn’t come up very often when they visit the doctor.

Based on these learnings, Greater Than AIDS has created new messages around PrEP and TasP, as well as complementary HIV information aimed at gay and bisexual men. During the presentation, Greater Than AIDS will discuss how PrEP and TasP messages have been integrated in to campaign approaches, including using digital and social media to reach gay and bisexual men.

Conclusions/Implications: To help stem the spread of HIV in the U.S., there is a need for improved education for gay and bisexual men around new HIV treatment and prevention technologies, especially PrEP and TasP. The presentation will highlight opportunities for outreach efforts to engage and educate gay and bisexual men, as well as encourage gay and bisexual men and their loved ones and healthcare providers to have conversations around HIV.

Abstract 1888 - The Essential Role of Community Activism in Scaling up PrEP and PEP Access in New York State

Author(s): *Jeremiah Johnson*

Issue: Community activism has long been a key driver of HIV research, prevention, treatment, and care advancement in the United States. As a new renaissance of HIV prevention unfolds with the advent of PrEP and TasP, community activism continues to play a vital role in the implementation of expanded prevention options throughout the country. This has been especially apparent in New York, where grassroots activism and community coalition building have greatly contributed to recent PrEP and PEP efforts throughout the state.

Setting: Treatment Action Group (TAG) is a New York-based independent AIDS research and policy think tank fighting for better treatment, a vaccine, and a cure for AIDS. TAG’s HIV Prevention program, founded in September 2013, is dedicated to advocacy that improves access to comprehensive prevention options for all priority populations in the U.S.

Project: Since 2013, TAG has been involved in several collaborative projects that have significantly impacted efforts to improve community access to PrEP and PEP. TAG has been a leading organization in community coalition efforts to advocate for a plan to end AIDS as an epidemic in New York. Throughout 2013 and 2014, TAG, in close partnership with ACT UP’s Prevention of HIV/AIDS Action Group (PHAG), engaged in local, state, and national activism to raise awareness for PrEP and PEP and a modernized approach to providing HIV prevention services. TAG has also worked extensively with New York activists,

the Foundation for AIDS Research (amfAR), and other key community, academic, service provider, and government partners to develop a national HIV prevention research and implementation action plan. Increased communication with New York City and State public health officials has also led to several productive meetings and collaborative projects.

Results: Renewed partnership between community leaders and public health officials has been especially productive in scaling up PrEP and PEP implementation throughout New York. Most notably, in June 2014 Governor Andrew Cuomo announced a plan to end HIV/AIDS as an epidemic in New York State, with PrEP featured as one of the 3 key pillars. TAG and other coalition members played a major role in the task force appointed by the Governor to design a blueprint to end the AIDS epidemic, directly engaged with pharmaceutical companies to secure necessary ARV supplemental rebates for the state Medicaid, and educated state legislative leaders on the evidence-base behind PrEP, PEP, and TasP as key tools to help end the epidemic. In 2014, discussions between the New York State Department of Health (NYS DOH), TAG, and PHAG regarding PrEP and PEP implementation ultimately led to the development and release of a groundbreaking report: *Toward Effective Pre-Exposure Prophylaxis, Post-Exposure Prophylaxis, and Comprehensive HIV Prevention Messaging in New York State*.

Lessons Learned: Thanks to community-led efforts and significant collaboration between community and city and state public health officials, New York State is poised to ensure that all New Yorkers who are vulnerable to HIV infection have access to PrEP and PEP. Further cooperative efforts will be vital to the success of prevention efforts and the Governor's plan to end the epidemic.

Abstract 2022 - Leveraging Healthcare Through Community Engagement to Reach End AIDS Washington Campaign Goals

Author(s): *Justin Hahn, David Kern*

Issue: Preventing HIV exposure and infection are key conditions to achieve HIV case reduction goals outlined in the End AIDS Washington Campaign (EAW). PrEP, nPEP, condoms, and clean needles / syringes among men who have sex with men (MSM) and people who inject drugs (PWID) in cities have been identified by the state HIV planning group as priority prevention outcomes to achieve EAW prevention goals. HIV prevention provider community engagement activities encourage, motivate and mobilize high risk populations in cities to access and utilize healthcare on a scale unachievable by existing state and federal HIV resources.

Setting: HIV prevention community engagement activities take place in Washington State cities that contribute to over 79% of new and 83% of prevalent HIV cases. HIV prevention community engagement activities focus on MSM and PWID. The purpose of HIV prevention community engagement activities is to leverage healthcare to reach the EAW goal of reducing the rate of new HIV infections in Washington State by 50% by 2020.

Project: Healthcare access and utilization among high risk urban populations are essential components to scaling up utilization of EAW disciplined HIV prevention interventions. Washington State HIV prevention partners use different mechanisms to promote, mobilize and pay for prioritized prevention services including: 1) An Affordable Care Act (ACA) promotion and enrollment campaign via a sustained

health and wellness media brand for MSM in the central Puget Sound; 2) Community mobilization via a coalition of HIV prevention providers in cities that promotes the message, “Get Healthcare. Get Tested. Get PrEP. Get Treatment” to MSM; and 3) A statewide PrEP Drug Assistance Program (PrEP DAP) that pays for medication and health insurance expenses for qualifying HIV negative clients. This presentation will highlight the implementation and initial process evaluation results of these activities.

Results: The ACA promotion and enrollment campaign started on November 15, 2014 and ended April 17, 2015. Initial process evaluation shows over 39 million impressions and almost 108,000 click throughs via applications such as Grindr, Gay Ad Network, Google Ad Network and You Tube. Other initial measures include website traffic, distribution of promotional materials and the number of verified in-person health insurance sign-ups. Community mobilization is in the second year of a two-year process. Process evaluation include the creation and promotion of the myHIVmoment.org website, hiring and using in-person health insurance assisters, gay-friendly business outreach, ACA enrollment at HIV testing events and LGBTQ focused health fairs. PrEP DAP has enrolled 273 high risk HIV negative persons of which 85% are insured and need co-payment assistance and 15% are uninsured and need full PrEP drug assistance. 97% of clients are male and 80% identify as MSM. PrEP DAP currently pays health insurance premiums for 18 clients.

Lessons Learned: Establishing the EAW first was essential to identifying HIV prevention, care and treatment priorities. Implementing community engagement activities that promote healthcare access and utilization have been critical to support EAW goals. Leveraging the potential of the ACA for high risk HIV negative populations is a best practice approach to achieving high impact HIV prevention results.

Track E

Session E04 - Cost of HIV Prevention Making Good Decisions

Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1412 - Allocation of HIV Prevention Funds in Local US Health Departments: Scenario Analysis Based on HIV Prevalence and Prevention Budgets

Author(s): *Emine Yaylali, Paul Farnham, Stephanie Sansom*

Background: US health departments receive public funds to implement high-impact and comprehensive HIV prevention programs to achieve maximum impact on reducing new HIV infections. Health departments need to allocate these funds among effective interventions and risk populations to prevent the most new infections. We developed a resource allocation model and applied the model to 5 representative health departments to demonstrate the optimal allocation of funds to maximize the number of new HIV infections prevented.

Methods: We categorized health departments into 5 groups based on their average HIV prevalence from 2008-2010 using CDC surveillance data for 50 states, District of Columbia and Puerto Rico. (Median HIV prevalence: low = 516, low-to-moderate = 2,314, moderate = 7,956, moderate-to-high = 14,449, and high = 32,799). For each of those groups, we estimated the median CDC 2012 allocation for HIV prevention and testing. The budgets ranged from \$1.1M to \$13M. Interventions in the model included

testing in clinical and non-clinical settings, partner services, continuum-of-care-related interventions designed to improve linkage to care, retention in care, and adherence to antiretroviral therapy (ART), and behavioral interventions for HIV-negative and HIV-positive persons. Some of these interventions were targeted to a particular risk population (MSM, IDU and heterosexuals) resulting in 16 combinations of interventions and populations. Our resource allocation model first estimated the annual risk of HIV transmission with and without the interventions. Then, we determined the cost per case of HIV prevented for each intervention. Finally, the model optimized the allocation of a fixed budget among interventions and risk populations and estimated the number of infections prevented annually.

Results: We estimated the average annual allocated funding per case prevented for five scenarios (low = \$471,863, low-to-moderate = \$209,097, moderate = \$166,247, moderate-to-high = \$175,798, and high = \$173,071). Cost-effectiveness rankings of interventions were the same across all scenarios, with testing in non-clinical settings and partner services for MSM being the most cost-effective and behavioral interventions for HIV-negative heterosexuals and IDUs being the least cost-effective. Recommended funding for the most cost-effective interventions increased proportionate to the total budget. The average number of new infections prevented in each jurisdiction under the optimal allocation was proportional to the HIV prevalence (low = 3, low-to-moderate = 7, moderate = 18, moderate-to-high = 35, and high = 76). Under the optimal allocation, 4-9% of new infections were prevented compared to the median number of new HIV diagnoses that would have otherwise occurred.

Conclusions/Implications: Our model presents the optimal allocation of HIV prevention funds for health departments with varying budgets and HIV prevalence. Testing, interventions targeting MSM, and interventions improving the continuum of care received funding under the optimal allocation. Health departments can assess their budgets and HIV prevalence to determine their appropriate scenario category. The optimal allocation for their category could then be used as a starting point to guide their resource allocation decisions.

Abstract 1994 - Funding Allocation Methods for High Impact Prevention and Linkage to Care in Louisiana
Author(s): *DeAnn Gruber, Samuel Burgess*

Issue: The Division of HIV/AIDS Prevention's funding opportunity announcements (FOAs) emphasize delivering the most effective interventions to populations at highest risk for HIV. State health department HIV prevention programs must develop methods to appropriately allocate cooperative agreement and demonstration project funds to have the maximum impact on the HIV epidemic in their jurisdiction as well as to meet grant reporting requirements.

Setting: The Louisiana Department of Health and Hospitals Office of Public Health STD/HIV Program (SHP) receives CDC cooperative agreement funds (PS12-1201) and Care and Prevention in the United States (CAPUS, PS12-1210) demonstration project funds to conduct high impact HIV prevention, including HIV testing and linkage, reengagement and retention to care activities in the jurisdiction; both funding streams require appropriate funding allocation to achieve maximum impact.

Project: SHP developed funding allocation methods based on local HIV surveillance data for both PS12-1201 and PS12-1210 in addition to utilizing the CDC-developed FOA-specific allocation data collection templates for required data reporting.

Results: During the first three years of PS12-1201 (January 2012- December 2014) and the first two years of PS12-1210 (October 2012 – September 2014), SHP strategically allocated funds to the areas of the state with the greatest HIV burden using various metrics based on surveillance data such as the prevalence of people living with HIV (PLWH), the proportion of PLWH out of care and/or PLWH in care, but who were exhibiting treatment failure (those who had not achieved viral suppression after multiple care visits). Linking funding allocations to surveillance data ensured that demographic and risk groups most impacted by HIV in the jurisdiction were the primary recipients of the prevention and linkage/navigation services provided and enables SHP to meet federal funding allocation reporting requirements.

Lessons Learned: Although FOA specific funding allocation reporting is clearly a logical and needed requirement for the sake of accounting for federal grant funds, it is not very useful for planning or implementing HIV prevention or linkage/navigation services at a jurisdiction level. Locally developed allocation methods based on jurisdiction wide HIV surveillance data will serve that purpose, and improved coordination and guidance at the federal level are needed to ensure jurisdictions are allocating funds to address areas and populations that have the highest need.

Abstract 2059 - Implementing a Pay-for-Performance Model for Los Angeles County HIV Testing Programs: Successes and Lessons Learned

Author(s): *Constance Chavers, Mike Janson, Rangell Oruga, Jeremiah Garza, Domingo Moronta*

Issue: Well-accepted strategies have focused on increasing the percentage of people living with HIV who know their serostatus, yet 15% percent of individuals remain unaware of their status, precluding timely access to effective treatment and resulting in poor health outcomes. Pay for performance strategies aligned with increasing testing among high-risk populations and identifying new positives may yield significant results.

Setting: Los Angeles County Department of Public Health, Division of HIV and STD Programs (LACPH's DHSP) implemented the New Directions in HIV Testing (NDHT) Model to improve the infrastructure of contracted HIV Testing programs and incentivize improvement in the targeting and identification of high risk individuals in Los Angeles County. Two goals of NDHT were to increase testing volume and increase the proportion of at-risk individuals who know their serostatus.

Project: In July/August 2011 LACPH's DHSP replaced a fee-for-service model with a cost reimbursement pay structure with pay-for-performance incentives for contracted HIV Testing programs conducting targeted testing. A pretest-posttest non-equivalent comparison group evaluation was conducted to assess changes in testing volume and the proportion of HIV positive individuals identified 12 months before and 12 months after implementation of NDHT. The NDHT new payment structure (treatment) was implemented in twenty-six community-based HIV programs. The counterfactual or comparison

group consisted of seven CDC directly-funded targeted programs, equivalent to the treatment in all but the pay structure change.

Results: Both NDHT and comparison programs reported an increase in testing volume (62.41% and 132.74%, respectively) during the observation period. The proportion of self-reported new positives increased 0.21%, $t = -3.78$, $p = .0002$ at NDHT sites. This result was consistent with the observed increase in the proportion of new positives at NDHT sites as documented by surveillance data (0.52% to 0.69%, $t = -4.80$, $p < .0001$). The comparison sites exhibited a decrease in the proportion of new positives (whether self-reported or surveillance indicated). While the decrease among self-reported new positives was not significant, that reported by surveillance, -0.75%, $t = 2.31$, $p = .0221$ was significant in the comparison sites. Overall, compared with what the proportion of positives would have been (the comparison), the NDHT change in pay structure increased the percent of new positives (as reported by surveillance) by 0.92%.

Lessons Learned: The change in pay structure observed among NDHT HIV prevention programs in part may contribute to an increase in testing volume and in the identification of a greater number of new positives. While the comparison group also increased tests, they experienced a decrease in the identification of positives. As an additional strategy, local jurisdictions might consider aligning payment structure and incentives to increase the number of targeted testing in order to help high-risk individuals become aware of their HIV status.

MONDAY, DECEMBER 7 | ROUNDTABLE SESSIONS | 5:15 PM – 6:00 PM

Track B

Session BR03 - Prime the PrEP: Deconstructing the Role and Meaning of PrEP Research & Implementation for Women

Room: Baker (Hyatt Regency Atlanta)

Abstract 2528 - Prime the PrEP: Deconstructing the Role and Meaning of PrEP Research & Implementation for Women

Author(s): *DD Diallo, AS Forbes, M Chatani-Gada, D Grant*

Issue: Multiple studies of Pre-Exposure Prophylaxis (PrEP) have shown tremendous efficacy in the daily use of oral anti-retrovirals to prevent acquisition of HIV in non-reactive MSMs. Vastly different results have indicated that PrEP for women is less effective because of a significant lack of adherence to the regimen. Despite the most prominent studies which have demonstrated that for women who were adherent to the daily ingestion of the drug, the drug is as effective as it has proved in men. Many prevention advocates and researchers continue to invest their expectations in finding the best delivery mechanisms, messages and venues that will be more favorable to women's uptake of PrEP, and future biomedical prevention strategies that show efficacy in the future. Secondary to the concern of future biomedical prevention strategies, the role of long-acting reversible contraceptives in increased risk of HIV transmission in women, is of interest to this conversation.

Key Points: The US Women & PrEP Working Group was organized to respond to the approval of the use of Truvada for prevention of HIV among adult men and women in the US. Over the past three years, we have engaged with women's health community advocates, women living with HIV, prevention researchers and clinicians, industry representatives, federal government partners and funders to advance the effort to ensure women's inclusion in PrEP implementation strategies in the US. Since the approval of PrEP, there has been a lag in the implementation of PrEP for women, especially in clinics and health care services where they are more likely to access HIV testing and prevention services with their reproductive health care, such as family planning clinics. Women at greatest risk for HIV need more education, more access to providers of PrEP, and ability to navigate pay for PrEP prescriptions. In addition, women deserve the right to know the risks and interactions of long-acting reversible contraceptives and HIV prevention medicines.

Implications: The US National HIV AIDS Strategy has achievable aims that would be greatly advanced with the strategic implementation of PrEP in local, state and federal strategies to reduce HIV infections. Without a national plan for implementation and dissemination, the time lapse to ensure equitable delivery of PrEP education and service to women will grow, and many women at risk will be left behind. Understanding how, why and in what best circumstances are women going to be able to access, utilize and benefit from PrEP is crucial in accelerating the reduction in the rate of new HIV infections in women.

In clinical trial, PrEP has demonstrated efficacy for women in partnerships where they know their partners' status. We need more information and data that explains why and for whom a PrEP implementation strategy would be successful in US women. Further studies must also include protocol that examines women who are using long-acting reversible contraceptives and biomedical interventions such as PrEP and newer products.

Session BR04 - Utilizing Geosocial Networking Applications to Reach MSM Populations for Prevention and Care of HIV/AIDS

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1142 - Utilizing Geosocial Networking Applications to Reach MSM Populations for Prevention and Care of HIV/AIDS

Author(s): *Diane Dye Hansen, Lyell Collins*

Issue: Geosocial networking applications (GSN apps) used for meeting sexual partners have become increasingly popular with men who have sex with men (MSM) since 2009. These applications are a viable option for use in sampling and delivering interventions to young MSM who are often missed through other methods. MSM 18-34 are increasingly relying upon the Internet, social media, and mobile applications as their source of information. This presents both a challenge and an opportunity for health communicators.

Key Points: A 2014 study of 379 MSM in the District of Columbia (Use of Geosocial Networking (GSN) mobile phone application to find men for sex by men who have sex with men (MSM) in Washington DC. AIDS and Behavior. 2014 September 18) found that 63.6% of those surveyed reported using GSN applications to find men in the past year. Nearly one-quarter of the population surveyed had sex with a man met using a GSN application in the prior year. These men were more likely to be under 35 years old and have had sex with a man met on the Internet. Additionally, an independent study of MSM persons living with HIV/AIDS in Nevada, (currently living at 400% Federal Poverty Level (FPL) or less), showed that in the 18-34 age group 68.6% access the Internet at least once a day, with 50% of those using a cell phone to access the Internet. 87.5% access Facebook, 71.8% watch videos on YouTube, 68.7% search actively for new apps to download, and 56.3% report visiting health provider web sites on their mobile device.

Implications: Public health communicators cannot afford to avoid the impact of mobile applications on high risk behavior. Our target populations are open to utilizing their mobile device for health education and care compliance. The same independent study of MSM persons living with HIV/AIDS in Nevada showed that 60.6% would be likely to use the Internet and mobile applications for HIV/AIDS support. Utilizing the Internet, social media, and mobile applications can help prevent infections, strengthen care, and reduce disparities. As evidence continues to mount regarding the benefits of supplementing outreach and care efforts with mobile tools, health communicators, educators, and case managers must integrate them into their strategies, or risk falling behind. This round table will discuss how to update existing tools and processes as well as create new tools to meet this need.

Track C

Session CR01 - Are Mobile Units HIP? Assessing the Pros and Cons of Mobile Unit Testing in the Era of High Impact Prevention

Room: Greenbriar (Hyatt Regency Atlanta)

Abstract 2433 - Are Mobile Units HIP? Assessing the Pros and Cons of Mobile Unit Testing in the Era of High Impact Prevention

Author(s): *Jamila Shipp, Robin Pearce*

Issue: After CDC's 2011 High Impact Prevention announcement, community based organizations reassessed their testing strategies and changed the way they deliver services. Recruitment through location-based social networking applications, faster rapid HIV tests, and social networking testing are all innovations that have improved HIV testing services.

Despite these changes, much of service delivery looks the same now as it did twenty years ago: community outreach and testing in non-clinical settings. In hopes of bringing the two strategies together, many organizations often consider using a mobile unit to deliver services to their communities. Mobile units have many benefits as well as costs, both obvious and hidden. This interactive session will present case studies from community based organizations using mobile testing units and a cost-benefit assessment of their usefulness. This session is ideal for HIV testing managers who are contemplating mobile unit testing and managers who want to align their mobile units with CDC's High Impact Prevention strategy.

Key Points: In its long history of delivering capacity building services to community based organizations in the area of recruitment and retention, Capacity for Health has helped organizations develop new delivery and recruitment strategies. When considering new strategies, many organizations suggest mobile unit testing as a way to eliminate the barriers of transportation and awareness for hard to reach communities.

What is needed, is an assessment of the pros and cons that HIV programs must address before moving forward with a mobile testing service delivery plan. This workshop will use case studies from two community based organizations, CrescentCare Health in New Orleans, Louisiana and the California Prostitutes Education Project (CAL PEP) in Oakland, California to illustrate the way mobile HIV testing services can be used to reach highly targeted groups and the role of mobile testing in community awareness raising events. Mobile testing is a complicated service delivery method that might not be appropriate for every community or every organization, so both case studies will speak to the challenges of acquiring, maintaining, and sustaining a mobile testing unit. This discussion will help organizations using, or contemplating the use of, mobile testing units to assess the effectiveness of their own programs and share promising practices with one another.

Implications: The roundtable discussion will pull from over 20 years of Capacity for Health, program of Asian and Pacific Islander American Health Forum providing HIV testing recruitment and retention capacity building, training, and individual technical assistance. The presenters will use case studies from

Gloria Lockett at California Prostitutes Education Project (CAL PEP) in Oakland, California and Joseph Olsen at CrescentCare Health in New Orleans, Louisiana to share their success and challenges when using mobile testing units for targeted HIV testing initiatives as well as awareness raising non-targeted events in their community. The presenters will also provide a readiness assessment to help participants discover whether or not their staff has the right skills and support to bring testing into their community. This interactive discussion will include opportunities for relationship building, hands-on learning, self-assessment, and sharing of promising practices.

Session CR05 - Addressing Challenges in Implementing Strengths-Based Case Management (SBCM) Approach in Anti-Retroviral Treatment and Access to Services (ARTAS)

Room: Techwood (Hyatt Regency Atlanta)

Abstract 1709 - Addressing Challenges in Implementing Strengths-Based Case Management (SBCM) Approach in Anti-Retroviral Treatment and Access to Services (ARTAS)

Author(s): *Jordan Blaza, Miguel Bujanda*

Issue: The new funding announcements for HIV programs (such as PS11-1113 and PS15-1502) require the provision of comprehensive HIV prevention with HIV-positive persons to promote early linkage to medical care and navigation services to remain in care. Strengths-Based Case Management (SBCM), as the foundation of ARTAS, is proven to be effective in linking newly diagnosed HIV-positive clients to care and is delivered by linkage to care providers. Through trainings and technical assistance, AIDS Project Los Angeles (APLA) has identified challenges to implementing the SBCM approach in linkage to care programs: remaining client-driven, the perception of SBCM as a lengthy process affecting contract deliverables and defining when the linkage provider role begins and ends within their spectrum of services.

Key Points: Widely used in social work, the SBCM approach is client-driven and focuses on outcomes, emphasizing the identification and usage of clients' strengths. It is rooted in social cognitive theory, (especially the concept of self-efficacy) and humanistic psychology (in particular, the belief that clients are capable of handling their personal challenges). By building a client's self-efficacy in linkage to care, SBCM promotes clients' ownership of their individual care plan. Enhancing and supporting the implementation of SBCM would increase the success of linkage to care and navigation services. APLA will facilitate a discussion on linkage to care programs' experiences and provide examples of how challenges can be overcome using SBCM.

Implications: The session will increase participants' knowledge and skills to implement the SBCM approach effectively in their linkage to care work. Participants will learn how SBCM supports the National HIV/AIDS Strategy by increasing access to care and improving health outcomes of people living with HIV. They will also identify how SBCM addresses the key components of CDC's High-Impact HIV Prevention, especially by combining appropriate interventions for targeted populations. The session will show how empowering newly diagnosed HIV-positive clients in identifying and using their strengths can help them overcome their barriers in linking to medical care.

Session CR07 - Monitoring “Newly identified” HIV Positives: Examining Measurement Issues with Self-Reported Prior HIV Status and Exploring Possible Solutions

Room: Kennesaw (Hyatt Regency Atlanta)

Abstract 1577 - Monitoring “Newly identified” HIV Positives: Examining Measurement Issues with Self-Reported Prior HIV Status and Exploring Possible Solutions

Author(s): *Lisa Belcher, Guoshen Wang*

Issue: Client misreporting of HIV status has implications for the measurement and interpretation of indicators that are based on self-reported status questions. Historically, CDC has relied on two variables to assess client’s self-reported HIV status (previous HIV test and results of the test). In 2012, CDC launched a new variable in its HIV testing data collection system to help distinguish between newly and previously identified HIV-positive persons. This variable assesses whether an HIV-positive case was reported to the jurisdiction’s surveillance system prior to the current positive test. Health department grantees have different capacities and challenges for completing the surveillance variable. This roundtable discussion will incorporate specific programmatic examples and data to provide in-depth information on measurement issues related to establishing prior HIV status and explore possible solutions.

Key Points: In 2013, 61 health departments reported 3,343,633 CDC-funded HIV testing events; 28,682 (0.9%) were positive. Of all testing events, 17,426 (0.5%) were identified as new positives using only self-report data, 9,970 (0.3%) using only surveillance data, and 10,324 (0.3%) were identified using a hierarchical method in which surveillance data were used if available (and prioritized), and self-report data were used if surveillance data were missing. Completeness of the surveillance variable was 76.2% at the national level, ranging from 0.0% (5 grantees) to 100.0% (22 grantees) at the grantee level; it was more than 85.0% for 37 grantees. Completeness of previous HIV test was 97.2%, and completeness of self-reported HIV status was 97.3%, when the person reported a previous HIV test. Completeness of both self-reported variables was more than 85.0% for 59 grantees.

Implications: Accurately monitoring newly identified HIV-positive persons is necessary for HIV testing programs, but different methods of distinguishing newly and previously identified persons can generate conflicting results. To accurately monitor newly identified HIV-positive persons, we need to resolve contradictions and improve data completeness and accuracy. Because HIV prevention programs have different capacities for accessing surveillance information to assess prior HIV status, further exploration with grantees is needed to better understand issues and develop solutions to improve data quality.

Session CR08 - Trauma Informed Approaches to HIV Care

Room: Edgewood (Hyatt Regency Atlanta)

Abstract 1929 - Trauma Informed Approaches to HIV Care

Author(s): *Leah Harris, Vanessa Johnson*

Issue: The Adverse Childhood Experiences (ACE) Study, conducted in 1997 as a collaboration between Kaiser Permanente and the CDC, proved that ACEs are more common than originally thought, and that

these experiences can have profound social, physical, and emotional impacts across the lifespan of individuals. For example, the higher one's ACE score, the more likely a person is to engage in behaviors or make decisions that can lead to HIV infection. Furthermore, past or current traumatic experiences can negatively impact the ability of PLHIV to adhere to treatment and achieve viral suppression.

Key Points: There is wide documentation that adverse childhood experiences (ACEs), including histories of childhood sexual and physical abuse, are far more prevalent among people living with HIV (PLHIV) than in the general population. In addition, PLHIV have significantly higher levels of adult trauma, attributed in part to various forms of stigma, discrimination and the criminalization of nondisclosure of HIV status, sex work, and drug use, all of which are sources of trauma independent of interpersonal violence.

Implications: The high prevalence of childhood and adult trauma among PLHIV, and associated outcomes, challenges health care and human services systems to consider adopting approaches that address the source of trauma in the lives of PLHIV. The use and implementation of trauma-informed care practices across sites where PLHIV receive services is a critical strategy to begin to reduce the widespread impact of individual and community-level trauma. However, most providers are not equipped to provide trauma-informed care to PLHIV. This discussion will introduce the principles of a trauma informed approach developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), which are applicable across sectors, and will provide a framework for providers serving PLHIV to consider introducing these approaches to their agencies and organizations. Virtual Learning Networks (VLNs) are a promising strategy for cross-training among multiple organizations and provide useful suggestions for addressing obstacles to implementation of trauma-informed care.

Session CR09 - Addressing HIV-Related Stigma and Discrimination in HIV Testing Programs and Sessions

Room: Spring (Hyatt Regency Atlanta)

Abstract 1229 - Addressing HIV-Related Stigma and Discrimination in HIV Testing Programs and Sessions

Author(s): *Jen Shockey, Francisco Nanclares*

Issue: “The stigma associated with HIV remains extremely high, and fear of discrimination causes some Americans to avoid learning their HIV status, disclosing their status, or accessing medical care.” This statement was true in 2010 when the White House issued its National HIV/AIDS Strategy and, despite improvements, it remains true today. No policy or law alone can impact HIV-related stigma and discrimination. Agents of change, such as HIV test counselors, can contribute to the effort by offering compassionate, nonjudgmental care, correcting misinformation, and responding to the fear-based messages and biased social attitudes that many of our clients face each day.

Key Points: HIV-related stigma has had a profound effect on HIV prevention. For example, the fear of the negative social consequences of testing HIV-positive may deter people from getting tested or seeking care after diagnosis. In addition, use of harm reduction practices or disclosure of HIV-positive status—and even of the intention to test—may still lead to stigmatizing responses, including rejection,

discrimination, and partner violence. , The likelihood of these consequences varies from person to person, community to community, but the fear of stigma, as well as its manifestation, continues to impede HIV prevention at personal and community levels.

Implications: By the end of this interactive roundtable, participants will be able to:

Define and give examples of HIV-related stigma and discrimination. Counselors who can clearly define stigma and identify stigmatizing situations will be better prepared to productively address it when it arises in their work;

Discuss various ways to assess and respond to HIV-related stigma in their HIV testing programs using specific counseling techniques and tools to empower clients so that they can confront stigma in everyday situations;

Understand the impact stigma has on different populations in order to better equip counselors to respond to and counteract their clients' specific concerns about stigma and stigmatizing situations, and support clients in moving forward;

Help participants recognize their own feelings around being stigmatized and stigmatizing others, counselors will be more effective at addressing stigma if they can understand how it relates directly to their lived experience both as people who at some point have felt the effects of stigma and people who might have stigmatized others.

This roundtable is designed to improve the abilities of HIV testing programs and counselors to assess and respond to HIV-related stigma in the lives of preliminary HIV-positive clients. Through small group activities, presentations, and discussions, participants will learn about stigma and its effects, learn how to help prepare clients for potential stigmatizing experiences, and share ways to create less stigmatizing environments for their clients. Since the dialogue around HIV stigma starts with providers recognizing their own experience of stigma, in order to fully be present for clients, the workshop will also allow participants to explore their feelings of being stigmatized or of stigmatizing others.

Session CR10 - ENGAGING TRADE: Men who sleep with men (MSM) of Color Culture and Behaviors within an Mmpowerment Project

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1502 - Engaging Trade: Men Who Sleep With Men (MSM) of Color Culture and Behaviors Within an Mmpowerment Project

Author(s): *Socorro Moreland, Derron Johnson*

Issue: This roundtable aims to provide a space to discuss the role of MSM of color culture within an Mmpowerment project. Specifically, the roundtable will provide a focus on how organizations approach recognizing sexual behaviors and focusing on creating and maintaining a successful program without creating a divide based on sub-cultural differences and labeling.

Key Points: In Oakland California heteronormative cultural stigma and sexual behaviors shape MSM communities of color. These persons within the MSM community live life with a sense of ambiguity,

which in itself creates an underlining stigma towards safe sexual practices and lack of seeking preventative care to protect those within certain sexual groups.

Historically people of color have been researched and dissected, which prevents us from seeking medical care and other resources due to a lifetime of oppression and uncertainty. When colonization, history and religion are added to this equation, it creates a bigger situation concerning social and economic survival.

The roundtable facilitators will share with participants an approach to addressing these regional issues. This approach, Men of Color Health Alliance of Alameda County MOCHAA was derived from the Mmpowerment model encouraging cross cultural support systems and networks to bridge the gap against HIV stigma and MSM behaviors.

Implications: The roundtable facilitators will share six (6) key considerations for organizations looking to navigate MSM of Color culture within their Mmpowerment programs. These six key considerations are:

- An open space for people who don't often seek support services within the community due to MSM being a behavior and not an identity.
- Infusing sexual health and referral services in collaboration with local community organizations to de stigmatize sexual identities and encourage positive sexual health within MSM communities of color through an open support system of peers.
- Monthly events held at different places i.e.: parks, restaurants, coffee houses, and other locations that are welcoming to all people.
- Focusing not only on "Out" gay and bisexual men of color gaining support but, also those who display MSM behaviors within a community.
- Hosting a multicultural group where Positive, Negative, Queer, and Straight identified people come together for monthly events.
- Encouraging members to bring their partners, friends and casual sex partners to the events regardless of race and gender.

Because of the above-mentioned revisions regarding MSM behaviors and labeling within an Mmpowerment program, we are seeing more and more people of color involved with MOCHAA events and their sexual health as well.

Session CR21 - Ensuring your Organization's HIV Prevention and Care Staff are Culturally Competent Providers

Room: Fairlie (Hyatt Regency Atlanta)

Abstract 2381 - Ensuring your Organization's HIV Prevention and Care Staff are Culturally Competent Providers

Author(s): *Brenda Cruz Scotton, Sarahjane Rath, Gisele Pemberton*

Issue: In today's struggle to reduce the transmission of HIV while meeting the demands of High Impact HIV Prevention and the goals of National HIV/AIDS Strategy, non-profit organizations are facing multiple challenges including a rise in the cultural and ethnic groups they serve. An "Institute of Medicine report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care states that "racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are taken into account." (n.d.) (Retrieved

from <https://npin.cdc.gov/pages/cultural-competence#7>). These findings are not considered new information to persons living with HIV and AIDS or current HIV health and human service providers but further emphasizes the need that changes are crucial. These disparities not only affect persons of a specific race or gender but also affect other groups such as transgender individuals, injection drug users and commercial sex workers among others. PROCEED, Inc. – National Center for Training, Support and Technical Assistance has created a series of tools and trainings focused on Cultural Competence to prepare the HIV prevention and care workforce as they face challenging cross-cultural encounters in service delivery.

Roundtable attendees will discuss cultural competence in the context of its essential connection to building and sustaining relationships and responding to others in a multicultural context. Participants will gain a deeper understanding of their own cultural identities, and their individual power to prevent discrimination by learning from, respecting, and accepting diverse world views.

Key Points: To begin to appropriately address the disparities experienced by specific races, genders and groups providers must recognize that cultural competence requires humility in how they bring into check the power imbalances that exist in provider/client relationships. It also involves the dynamics of provider/client communication by using client focused interviewing and care. The roundtable will underscore cultural competence as an essential aspect of effectively responding to others in a multicultural context. Strategies that help providers respond to the needs, preferences, beliefs, behaviors and perceptions of individuals both in and outside their organization will be explored. The session will also emphasize life-long learning and critical self reflection as part of a providers ongoing cultural competence ongoing development.

Implications: To support providers in attracting and retaining culturally and linguistically diverse clients the session will seek to assist providers in the following; understanding how one’s worldview, biases, and assumptions impact relationships with others, including co-workers, clients, and community stakeholders, exploring the Cultural Competence Continuum as a personal and organizational evaluation tool and discussing strategies for enhancing cultural competence to improve relationships and perform better in the work setting .

Track D

Session DR05 - PrEParing for an Evolution: PrEP and Its Potential to Generate Community Engagement Among Gay Men and Transgender Women of Color

Room: Piedmont (Hyatt Regency Atlanta)

Abstract 1319 - PrEParing for an Evolution: PrEP and Its Potential to Generate Community Engagement Among Gay Men and Transgender Women of Color

Author(s): *alex garner*

Issue: Pre-Exposure Prophylaxis is a highly effective prevention strategy that could have a significant impact on the epidemic but currently gay men of color, young gay men, and transgender women face significant barriers when accessing PrEP. Barriers to basic healthcare – costs, provider bias, documented

status- and cultural issues, such as stigma, are preventing the most severely impacted communities from realizing the benefits of PrEP. Employing social media and stimulating community dialogue are key tools for engaging the community. Utilizing the potential for community engagement around PrEP could significantly improve the access to care, increase understanding of HIV prevention options, and strengthen community support for health and wellness.

Key Points: While gay and bisexual men represent about 2-5% of the general population, as of 2011 they were 63% of all new infection in the U.S. and also represent the majority (57%) of those living with HIV in the U.S. African Americans represent about 12-14% of the U.S. population but account for 44% of new HIV infections. Latinos represent 16% of the general population but account for 21% of new infections. Young Black gay and bisexual men represent the highest of new infections among all gay men while Black transgender women have the highest percentage of new HIV positive test results. Though significant strides have been made in regards to access to affordable healthcare, marginalized communities still experience severe health disparities. Additionally there is a lack of community dialogue about the latest advancements in HIV prevention and how to improve access. Presenters will review the ongoing efforts to educate and engage gay men and transgender women of color about PrEP and facilitate a discussion about employing multi-media efforts and social media networks to increase access and awareness around PrEP. Additionally participants will have the opportunity to exchange ideas around how best to utilize social media to educate and mobilize the community around PrEP and sexual health issues.

Implications: Great advancements have been made in regards to healthcare access but some of the most vulnerable communities continue to fall through the cracks – the undocumented, youth, and trans people. Effective community engagement and mobilization are critical parts of assuring culturally competent, quality care for all parts of our communities. PrEP is an excellent vehicle for engaging people in care, fostering a relationship with the health care system, and empowering the individual. Social media and community engagement efforts can shape the narrative around PrEP and its impact on sexual health and the quality of life for LGBT people.

Session DR09 - Setting a PrEP Advocacy Agenda from LGBT and HIV Consumer Perspectives

Room: Roswell (Hyatt Regency Atlanta)

Abstract 2464 - Setting a PrEP Advocacy Agenda from LGBT and HIV Consumer Perspectives

Author(s): *Christopher Cannon, Julio Fonseca*

Issue: PrEP utilization has been very low since FDA approval in 2012. This can be attributed to many barriers that are limiting access to this highly effective prevention tool. Barriers include lack of consumer appreciation, lack of access to providers and to medication, and lack of understanding of reimbursement potential. The consumers that are most impacted by these barriers are MSMs, MSMs of color, young MSMs, and transgender individuals.

Key Points: There are an estimated 1.2 million people living with HIV/AIDS in the United States. Although the incidence of HIV infections have remained consistent at approximately 50,000 new HIV infections diagnosed each year, gay and bisexual men are the only group to show an increase in rate of

infection for the last 10 years. The majority of these infections disproportionately occur among gay and bisexual black men between the ages of 13-24. Rates of HIV incidence among transgender individuals are limited due to lack of standardized data collection. It has been further shown that an estimated 92% of those testing HIV positive in 2009 were directly attributed to high-risk behavior with individuals whom were unaware of their status or were not receiving medical treatment for their HIV at the time. Stall et.al. extrapolated the burden of HIV disease in MSM and African American MSM, demonstrating an unacceptable percentage of HIV burden in MSM communities as they age. Thus, an African American MSM at age 40 is 59.3% likely to have HIV disease, compared to 41.2% of MSM in general. CDC estimates that the positivity rate among the transgender community is higher at 2.9% than men or women. These numbers demonstrate an increased need for PrEP as a prevention option, but overall utilization as reported by Gilead, since FDA approval, shows just over 3,000 individuals. There is great need to identify the barriers that are keeping MSMs, in particular MSMs of color, young MSMs and transgender individuals, from accessing an effective prevention intervention. This roundtable will give participants an opportunity to comment on identified existing barriers and identify potentially new ones for these particular populations at greater risk, and prioritize the advocacy strategies needed to effectively increase access and utilization of this effective prevention tool.

Implications: Identifying advocacy needs and setting priorities help consumers and consumer based organization working on these issues to more effectively program, create a framework to remove barriers, and align resources to PrEP utilization.

Session DR11 - Regional Institutes -- Stepping Stones to Building a Sustainable Condom Distribution Structural Level Intervention

Room: Lenox (Hyatt Regency Atlanta)

Abstract 2471 - Regional Institutes – Stepping Stones to Building a Sustainable Condom Distribution Structural Level Intervention

Author(s): *Oscar Marquez, Miguel Chion*

Issue: In 2011, the U.S. Centers for Disease Control and Prevention (CDC) released official guidelines for Condom Distribution as a Structural-level Intervention (CDSI). Given that CDSI is a relatively new public health strategy, there is a lack of standardized models and tools available to organizations to operationalize CDSI in their communities. Often, CDSI is implemented without comprehensive community assessments, adequate partnership development, and/or quality assurance activities. Most importantly, the different stakeholders within a region, especially for any structural intervention, do not have the same understanding CDSI and of how to accomplish a coordinated implementation of it. This could represents major barriers for a successful implementation of CDSI in a given community.

Key Points: There are three Capacity Building Assistance (CBA) providers who were funded specifically to provide CBA services for Condom Distribution as a Structural-level Intervention under CDC's PS: 14-1403 Capacity Building for High Impact HIV Prevention. These CBA programs have formed a working group to increase understanding nationwide of CDSI and address the implementation barriers to implementing CDSI among health departments (HD) and community-based organizations (CBO). The foundational building blocks to implement structural interventions is to bring the stakeholders to same place to:

understand CDSI, secure the critical elements of CDSI and develop indispensable partnerships. Regional institutes can be a very effective tool to create the first and most important building block for a structural intervention. Using a strengths-based model, a regional institute will use a 3 Ps approach (planning, partnership and promotion) to help integrate recommendations for structural-level interventions into new or existing condom distribution programs. During 2015, the condom Distribution Workgroup (CDW) started piloting the regional institutes for CD and will present the evaluation results: number of participants, type of stakeholders, increase of knowledge and self-efficacy and what is the ripple effect of these institutes. If accepted the presenters will invite the members of the Condom distribution Workgroup to participate and share their experience (NYC DOHMH, API Wellness Center and Center for Disease Control and Prevention).

Implications: Many health departments and community-based organizations (CBOs) require increased support in implementing the critical components that make up a structural-level intervention, including a high level of planning and assessment, partnerships, and promotion. The regional institutes for Condom Distribution will create the foundational knowledge and understanding to plan, communicate and create important collaborations to implement a successful condom distribution program that will affect a jurisdiction/region in a positive direction. Most important, this session will present the model and tools to replicate this capacity building methodology as well as the opportunities to replicate this initiative in other jurisdictions. This new approach to build capacity of regions will support the implementation of High Impact HIV prevention in alignment to the National HIV AIDS Strategy.

Session DR12 - Collective Impact Utilizing Community Partnerships

Room: University (Hyatt Regency Atlanta)

Abstract 1491 - Collective Impact Utilizing Community Partnerships

Author(s): *Eileen Loughran, Paul Harkin*

Issue: Proper disposal of sharps is a shared responsibility among a number of stakeholders including community clinics, community-based organizations, local government, injection equipment users, local businesses, pharmacies, and community members. San Francisco Department of Public Health (SFDPH) plays a leadership role in the development of such partnerships and is proactive in working with partners to promote community awareness and engagement in the implementation.

Promoting safe disposal of used needles and syringes is a key component of SFDPH funded syringe programs. All programs have written disposal plans approved by SFDPH, including a plan for conducting street sweeps of the areas in which the Syringe Program operates to pick up improperly discarded syringes and other injection equipment. The plan also includes information about the maintenance of publicly available sharps disposal boxes and kiosks.

Key Points: Community input is an important component of the comprehensive syringe disposal plan. The SFDPH participates in community meetings to respond to any concerns about discarded syringes. Additionally the SFDPH, in partnership with one of our funded syringe providers, Glide Prevention Services, regularly attends Police Department community meetings to respond to concerns about discarded syringes and to discuss possible solutions with the community. If a syringe disposal box is

approved to be placed at a potential site, the community, residents, and businesses in the area are engaged to ensure knowledge and understanding about the pilot proposal.

Community engagement efforts are strengthened by regular communication with the local Board of Supervisors member and community groups located in affected neighborhoods. If local businesses, schools, or community members have been identified as having concerns about disposal box placement, SFDPH attends community meeting to address concerns.

In San Francisco, the Mission, Tenderloin, and South of Market neighborhoods have been identified as areas where a high volume of improperly disposed syringes accumulate. To prevent a public health risk to the general community, as well as City maintenance workers, permanent disposal boxes are recommended. Community members, law enforcement, and government officials have expressed support of piloting syringe disposal boxes in these areas.

Implications: As part of our coordination effort, SFDPH convenes a quarterly meeting of City and community partners that provide syringe disposal to develop and sustain a coordinated and collaborative response through City and community partnerships in order to decrease improperly discarded syringes. We've learned that through engaging unlikely partnerships the collective impact on community is successful.

Track E

Session ER01 - Health Department Changes in Response to the National HIV/AIDS Strategy and High-Impact Prevention

Room: Inman (Hyatt Regency Atlanta)

Abstract 1967 - Health Department Changes in Response to the National HIV/AIDS Strategy and High-Impact Prevention

Author(s): *Holly Fisher, Kristina Cesa, Tamika Hoyte*

Issue: The field of HIV prevention has changed significantly in response to the National HIV/AIDS Strategy (NHAS). CDC's High-Impact Prevention (HIP) approach supports NHAS by aligning cost-effective and scalable interventions geographically with the burden of HIV. Health departments have to make decisions about how to maximize reductions in HIV infections and operationalize HIP in their jurisdictions, combining prevention and care strategies in the smartest, most efficient way possible. Additionally, field staff and others are not routinely asked to provide their own perceptions of the most critical changes they have undergone.

Key Points: "Changing Landscapes" is a two-year CDC-funded project (October 2014-September 2016) that aims to identify major changes in health department HIV prevention planning and implementation since NHAS and HIP. During Phase I (October 2014- January 2015), CDC staff conducted in-person interviews with 8 AIDS Directors and HIV prevention staff at 5 CDC-funded health departments to get their perspective on change. Five CDC project officers assigned to these jurisdictions were also

interviewed, as their perspectives may be somewhat different from health departments' perspectives. Interview transcripts were analyzed for themes of changes.

Key themes that emerged from Phase I relate to: 1) partnerships and collaborations; 2) data sharing, use, and reporting; 3) funding decisions and budget management; 4) federal messaging and the federal role in providing program guidance; and 5) concerns for HIV prevention practice. Examples of positive change included leveraging existing relationships to expand program reach; improving client-level documentation and data integration to improve linkage to care among people living with HIV; and increasing program integration across diseases to improve long-term client outcomes. Interviewees also shared practical examples of how they have operationalized HIP including aligning local funding to the highest-risk populations (with less emphasis on low-risk groups). Barriers to implementing HIP included structural barriers that impeded data sharing across prevention and surveillance groups; heavy reporting burden to federal agencies; and, while many community-based organizations (CBOs) tried to adapt to the new treatment-as-prevention approach (e.g., to remain relevant under NHAS), many CBOs with less capacity have either merged with other organizations or closed. Interviewees also expressed concern that NHAS and HIP are perceived in the community as not supporting a holistic approach to HIV prevention. Building on Phase I findings, Phase II (February- September 2015) and Phase III (October 2015-September 2016) of the project will further explore changes since NHAS and HIP through the following types of activities: interviewing staff from CDC-funded CBOs, holding a consultation with health departments from additional jurisdictions, conducting a survey with health departments, and/or interviewing grantees who provide training and technical assistance to CDC grantees.

Implications: During this roundtable, facilitators will discuss Phase I and Phase II themes of change and how these changes could affect federal- and health department-supported HIV programs. Additionally, we will discuss how these findings could inform program monitoring and evaluation, capacity building, provision of technical assistance, program implementation, and engaging audience members on how CDC can better support health departments.

MONDAY, DECEMBER 7 | NGO VILLAGE POSTER SESSION | 6:00 PM – 8:00 PM

BP13

Abstract 1718 - Prevention Research and Implementation Science

Author(s): *Elby Katumkeeryil, Silvana Mazzella, Clayton Ruley, Jennie Coleman*

Issue: People with HIV are more at risk for an overdose due to the combined stigma of having HIV and actively using and having compromised immune systems. Co-morbidities, such as Hepatitis C, only increase this population's risk for overdose. In 2012, Philadelphia experienced 497 drug overdose deaths, with over 50% of them being due to opioid overdose. An overdose poses the risk of theft, hospitalization, police-involvement, and death for the average user. For people with HIV, the risks increase due to interruption of drug regimens during hospitalization. There was an increase in opioid deaths with the release of fentanyl into the market in 2013. Twenty opioid overdose deaths were announced in a five-week period in March through April 2014.

Setting: The project took place in Prevention Point Philadelphia's (a syringe exchange program) drop-in center, street-side health clinics, and Infectious Disease clinic.

Project: Prevention Point Philadelphia made several structural changes to revitalize our Overdose Prevention Intervention & Treatment Education (OPIATE) program. These changes included incorporating Naloxone training into the street-side and HIV clinics and training all staff members on overdose prevention and Naloxone administration.

Results: Although the program began in 2006, low uptake of education sessions, lack of overdose risk awareness, and only syringe exchange staff offering trainings resulted in only 81 participants being trained in six months. After structural changes were implemented in 2014, however, the number of participants trained increased to 387 in six months.

Lessons Learned: Effective strategies included training all staff members to offer trainings and conducting outreach to families and partners of those who use opioids. Additionally, targeted trainings for people who are using together, people recently released from incarceration or hospitalization, and those currently participating in a drug treatment program. For the purpose of expansion and replication, we hope to share the strategies we used to effectively expand the services we offered to our HIV positive participants via the expansion of the OPIATE project.

BP16

Abstract 1944 - Prevention Research and Implementation Science

Author(s): *William Johnson, Nhan Truong*

Issue: The pandemic of HIV continues to negatively affect many persons living with the disease both socially and cognitively, which in turn has led to continued high-risk sexual behaviors that perpetuate the spread of the illness. CDC recommends specific evidence-based interventions, such as Healthy

Relationships, to assist those living with the disease in development of skills and building self-efficacy to promote healthy sexual decision-making. Through utilizing small group discussions, role playing, and skill-building exercises, the intervention helps persons living with HIV develop necessary skills to cope with HIV-related stressors and risky sexual situations. The intervention design is based on social cognitive theory to build expectations which encourage practicing new skills to minimize unprotected anal or vaginal intercourse, increase use of condoms, and mitigate pressure of stigmas related to disclosure, to reduce HIV spread.

Setting: Throughout the 2014 calendar year, the Healthy Relationships intervention was implemented in Jackson, MS among African-American men-who-have-sex-with-men (MSM) living with HIV or AIDS. Intervention sessions were conducted over a period of 3 days in casual settings which encouraged unity and discussion among participants.

Project: The intervention consisted of five-sessions conducted in small-group settings focusing on 5 core elements: 1) Defining stress and reinforcing coping skills in 3 areas – disclosure to family/friends and partners, and building safer relationships; 2) Utilizing modeling, role-play, and feedback teaching; 3) Teaching decision-making skills regarding disclosure; 4) Provision of personal feedback to change risky behaviors to protective; and 5) Video clips to stimulate scenario discussions. Initial & post assessment survey tools assessed changes in attitudes and behaviors.

Results: During February through June of 2014, a total of 35 African-American MSM living in Jackson, MS completed the Healthy Relationships intervention. Initial assessments showed the most stressful situations for participants were "money problems" – 62.9%, "loneliness/abandonment" – 57.10%, and "infecting a partner/depression" – at 51.4%. Pre-assessment also revealed participants were more comfortable disclosing to friends versus family members (4.8 to 6.1 respectively). Initial results also showed participants were more likely to disclose positive HIV status to mothers or siblings than other family members (57.1% & 60% respectively). Further analysis displayed that friends of participants who responded well far outweighed the family members who responded well nearly two-fold (5.8 friends vs. 3.2 family members). After completing the intervention, pre & post-assessment comparison of results revealed participants increased in surety or confidence of telling a new partner, family member, or friend about their HIV status, with data showing the highest change was a significant increase in surety of participants to disclose their HIV status to a family member or friend ($p < 0.01$). Full comparison analyses showed vast increases in confidence, disclosure comfortability, attitudes towards safer sex, and condom negotiation with new partners.

Lessons Learned: There are benefits to HIV-positive persons completing the Healthy Relationships intervention. These results indicate that completion of the intervention increases in confidence regarding disclosure, safer sex, and recognition of healthy behaviors which reduce HIV spread. A more thorough report in the future, using a larger sample of participants, will be comprised to gauge statistically significance changes in confidence.

BP67

Abstract 1753 - Prevention Research and Implementation Science

Author(s): *Jesse Wilkinson, Kalyani Sanchez, Jasmine Major*

Issue: HIV care providers consistently report low patient demand for use of Pre-Exposure Prophylaxis (PrEP); however, providers have also reported hesitations in initiating conversations about PrEP for a number of reasons including adherence concerns and lack of agreement about which clients are appropriate. This is problematic, as several studies have revealed that when high-risk populations learn about PrEP's potential for HIV prevention, acceptability and intent-to-use is high (e.g., Underhill, Operario, Mimiaga, Skeer, et. al, 2010). It is paramount that challenges in implementing PrEP are addressed in combination with the development of successful education efforts tailored to reach specific high-risk populations. One potentially fruitful approach is the integration of PrEP education into existing services. The current study aims to evaluate the preliminary effectiveness of using a standardized tool to initiate conversations about PrEP between providers and men who have sex with men (MSM) in post-STI/HIV test counseling sessions.

Setting: GMHC's testing center located in the Chelsea neighborhood of New York City provides HIV/STI testing and subsequent counseling on-site. If appropriate for PrEP, clients are referred to the Mount Sinai Comprehensive Health Clinic.

Project: Testing Counselors at GMHC were trained to discuss the existence of PrEP as a prevention option prior to the current study; however, it was observed that few referrals were made. In order to address this, we developed a knowledge-based PrEP assessment to be completed by HIV-negative MSM during post-test counseling sessions. The assessment included multiple choice and true/false questions and content included: goals of taking PrEP, the relationship between PrEP and sexual risk behavior, and access to PrEP. MSM completed the assessment; counselors reviewed their responses and addressed gaps in knowledge. We then examined the number of referrals made and subsequent PrEP adopters for a period of two months before and after the tool was implemented.

Results: For the months of December 2014 and January 2015, before the current study began, 439 MSM presented for STI/HIV testing; we made 7 PrEP referrals (1.6% of testers); and 4 became adopters (0.9% of testers). In February 2015 and March 2015 after the assessment tool was implemented, 263 MSM presented for STI/HIV testing; we made 55 PrEP referrals (21.0% of testers); and 13 became adopters (4.9% of testers). Though these are preliminary results, which are limited by the small sample size, they do indicate that there was a marked increase in referral rate following use of the standardized tool, and an increase in the frequency of clients who ultimately adopted PrEP. Data will continue to be collected for this project through January 2016.

Lessons Learned: The use of standardized tool to initiate conversations about risk-behaviors relevant to PrEP showed promise in increasing both PrEP referrals by providers and utilization by clients. Integrating PrEP education into other medical services may successfully increase PrEP usage for high-risk clients, particularly when a standardized approach for initiating discussions is utilized. STI/HIV testing provides a particularly opportune setting to identify high-risk clients. The strategy proposed is extremely cost-effective and has potentially large implications for reducing seroconversion rates.

BP74

Abstract 2019 - Prevention Research and Implementation Science

Author(s): *Guy Weston, Beth Tadesse*

Issue: While, Affordable Care Act and the National HIV/AIDS Strategy national guidelines set priorities and resources to facilitate becoming an AIDS free generation, there are educational gaps that exist among healthcare and support service providers that need to be addressed in order to assist implementation of best practices and strategies within their own communities. For these reasons, it is essential that a routine capacity building workshop focusing not only on HIV knowledge, but on workforce development topics such as change management, sustainability planning and cultural competency be provided not only for staff members new to the HIV field. Moreover, these trainings are essential for experienced staff members that often do not have the opportunity to update their HIV knowledge and skills within a rapidly evolving HIV landscape.

Setting: DC CARE provides comprehensive HIV/AIDS trainings for frontline staff in the Washington, D.C. Metropolitan Area.

Project: We will be highlighting results from a needs assessment that we provided to over 258 healthcare providers within the DC Metropolitan Area. The survey was developed and implemented in order to better understand the experience, knowledge, skills, and attitudes of potential training participants. The survey was conducted via a pre and posttest exercise implemented at case manager trainings. Findings indicated there was a deficiency on a broad range of knowledge about basic HIV information among DC Department of Health staff, including a significant number of credentialed social workers and program managers with critical knowledge gaps on very basic HIV science and treatment information, as well as surprising number of peer educators that scored higher on a pretest than their “credentialed” counterparts.

Results: There were several salient findings that will be discussed in the workshop presentation. For example, of the case managers surveys, more than half of respondents (55.6%) have fewer than two years’ experience providing medical case management or treatment adherence services. Further, nearly one-fourth (22.3%) reported basic or intermediate knowledge of HIV/AIDS science, prevention, and treatment issues. In addition, comorbidities such as Hep C diagnosis, mental health diagnosis, substance abuse, and homeless/unstable housing are reported for substantial proportion of patients. Very few case managers have received training in assisting clients in managing their comorbidities.

Lessons Learned: A substantial proportion of persons with HIV infection do not access and/or adhere to treatment that could facilitate this goal. Some studies describe non-adherence as a psychosocial phenomenon, involving issues such as lack of self-efficacy, lack of perception of vulnerability, inadequate treatment readiness, stigma, and fear of disclosure. In this context, the role of social workers, case managers and other health professionals that work outside clinical settings becomes paramount, as they are typically best equipped to address psychosocial issues in healthcare. This poster presentation will discuss the gaps in knowledge case managers in the Washington D.C. Metropolitan area report in addition to effective strategies DC CARE has implemented to train and provide essential skills for HIV providers to assist HIV positive persons in reaching viral suppression and contributing to ending the epidemic.

BP93

Abstract 1147 - Prevention Research and Implementation Science

Author(s): *Miriam Vega, Emily Klukas, Erik Valera, Judith Montenegro*

Background: As of 2014, Latinos are recognized as the nation's largest minority and one of its fastest growing. Latinos are rising in significance both numerically and culturally in many parts of the US Deep South which encompasses seven states: Alabama, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee. As the size of the Latino population has expanded in the South a wave of state-level anti-immigration legislation were also introduced. With the recession, expression of anti-immigrant sentiment through legislation, and the roll out of the Affordable Care Act, Latinos have often been left in very tenuous relationships with institutions in the south while HIV incidence rates in the region have also been steadily increasing.

Methods: From 2012-2014, we conducted an environmental scan with regards to five key areas: health, leadership, community organizing, educational attainment, and political power. The mixed method assessment entailed interviews, meetings and discussions with more than 350 stakeholders across the Deep South representing nine key sectors: AIDS service organizations, community based organizations, academia, media, health care organizations, government, law, communities at large, and activists. Furthermore, the assessment included both a media analysis of over 150 news articles from the seven Deep South states, as well as a survey of more than 100 key stakeholders (representing the sectors listed above) as to the current state of the Latino population in the South.

Results: There are five key findings: (1) Latinos in the South, though settled, are at times invisible. Health institutions struggle to connect with the realities faced by Latinos in cities, counties and states in the South. As a result, Latinos face many health challenges; (2) Latinos are subjected to pervasive institutionalized stigma that impacts their ability to access healthcare services; (3) Due to state and institutional policies, Latinos are living under great fear and highly stigmatized identities on a daily basis that leads to a trauma-filled life; (4) couple the fact that access to mental health providers is a key overriding health concern for Latinos in the Deep South with the often-pervasive feeling that they are living on the margins, HIV is not a high community concern; and (5) HIV prevention behaviors are not a common cultural health script for Latinos in the Deep South.

Conclusions/Implications: As we look towards the future where we want to reach a world without AIDS through the implementation of biomedical models, it is of utmost importance that we begin to address the gaps for Latinos in health coverage. Recognizing that each local Latino community is different and faces unique challenges, it is important that we acknowledge this diversity and work towards positive policy and community solutions to breaking down the stigma walls that constrict the day-to-day movement of Latinos as well as their mental and physical well-being and access to healthcare. As Past UNAIDS Executive Director Peter Piot noted: "tackling stigma & discrimination is 1 of 5 key imperatives for success."

BP97

Abstract 1368 - Prevention Research and Implementation Science

Author(s): *Kristi Gamarel, Amy Conroy, Samantha Dilworth, Torsten Neilands, Jonelle Taylor, Mallory Johnson*

Background: In the United States, the HIV epidemic has evolved over the past 30 years and is now largely concentrated within traditionally socially marginalized groups, which represents a significant public health disparity. Over the past decade, there has been a burgeoning body of literature documenting the effects of relationship dynamics in HIV prevention and treatment outcomes among gay, bisexual, and other men who have sex with men (MSM). However, structural factors which drive the HIV epidemic have yet to be well-integrated into couples-based HIV prevention research. According to the family stress model, economic hardship places strain on intimate relationships, which offsets the positive effects of relationship quality and leads to poor health outcomes. In this study, we examined the extent to which the associations between relationship quality and adherence to antiretroviral therapy (ART) varied by socioeconomic status.

Methods: A sample of 266 male couples completed baseline assessments for a cohort study examining relationship factors and HIV treatment. A computer-based survey was used to assess self-reported socioeconomic status, age, race/ethnicity, relationship length, relationship satisfaction (Dyadic Adjustment Scale; $\alpha=0.84$), depressive symptoms (Center for Epidemiological Studies Depression Scale, $\alpha=0.91$), couple HIV status, time living with HIV, and 3-day ART adherence (AIDS Clinical Trials Group, ACTG). We fit Actor-Partner Interdependence Models (APIM) via generalized estimating equations (GEE) with an exchangeable correlation structure and robust standard errors to account for the correlated nature of the couple data. We aimed to examine whether socioeconomic status moderated the association between relationship satisfaction and 100% perfect 3-day ART adherence, adjusting for other covariates.

Results: The majority of the participants were HIV-positive (78%), over half were Caucasian (56%), and the average male was middle-aged ($M = 45.8$ years, $SD = 10.4$). Approximately 51% ($n = 135$) earned less than \$20,000 annually. Average length of current primary relationship was 6.6 ($SD = 6.8$) years and a little over half of the sample (56%) were in HIV-positive seroconcordant relationships. Of the men on ART ($n = 414$), 45% reported 100% adherence in the prior 3 days. We found a significant interaction between relationship satisfaction and socioeconomic status ($p < 0.01$) such that greater relationship satisfaction was associated with an increased odds of perfect ART adherence among those of higher income (AOR = 1.12, $p < 0.05$), but no association between relationship satisfaction and perfect ART adherence among those of lower income (AOR = 0.93, $p = 0.23$).

Conclusions/Implications: These findings suggest that the positive effects of relationship quality among MSM couples may be reduced for lower income MSM couples. A lack of opportunity to fully benefit from the positive effects of relationship quality represents an additional health disparity experienced by lower-income MSM. Structural factors related to low socioeconomic status (e.g., homelessness, food insecurity) driving the HIV/AIDS epidemic may help to explain this disparity. Couples-based HIV prevention efforts must attend to structural and economic conditions – including environmental resources, constraints, and access to care – to adequately intervene on HIV disease management and prevention among MSM couples and, more broadly, improve quality of life for all MSM.

BP100

Abstract 1707 - Prevention Research and Implementation Science

Author(s): *Ricky Bluthenthal, Charles McWells, Charles Hilliard, Derek Dangerfield, Jeffery Williams, Nina Harawa*

Background: Based on the most recent data collected by the CDC, Black/African American men who have sex with men (AAMSM) account for 39% of all HIV infections diagnosed in 2013. HIV testing rates among AAMSM are not high enough to ensure that a sufficient proportion of new infections are identified early in disease and linked to care. Hence, efforts to redress the racial disparity in HIV incidence require new interventions that address existing motivations and barriers, and facilitate more frequent HIV testing and linkage to care among AAMSM. This abstract provides results from the formative phase of our effort to refine a proposed intervention – Passport to Wellness - to address this need.

Methods: AAMSM were recruited to participate in five distinct focus groups (n=30): newly HIV diagnosed; 3 age cohorts, 18-29, 30 to 49, and 50 years and older; and former LA Centers for Alcohol and Drug Abuse (LACADA) Peer Educators, who were all AAMSMs. Focus groups included a short quantitative survey, followed by a directed conversation that covered the following domains: 1) words and identity labels used by AAMSM; 2) motivations and barriers to preventive care and treatment; 3) identification of reliable and unreliable providers/agencies; 4) attitudes about different incentive schemes to promote preventive care and treatment seeking; 5) preferences for Peer Mentors, and 6) community strengths among AAMSM. Transcripts were coding using Atlas.ti software and thematic analysis was conducted to provide guidance on the intervention components and details.

Results: Differences and similarities by age cohort of focus group members are reported below. Self-labeling preferences differed, with newly diagnosed preferring 'gay,' men ages 18 to 29 and 30-49 preferring 'Brothers loving brothers,' and men ages 50 and over preferring 'Black men who kick it with men.' On the other hand, across groups, men felt that HIV testing was related to self-acceptance of sexual orientation and that HIV testing frequency improved with age as self-acceptance increased. Preferences for incentives included using rechargeable gift cards to retailers that provided a wide range of goods such as Target. Perhaps most importantly, we found that all age cohorts preferred peer mentors who has gone through many of the trials that AAMSM may experience, including homelessness, substance abuse, and being "out" as gay, but who now had achieved stability and a measure of life success. Other components revised due to this feedback include types of services identified, specific organizations to use as referrals (some were promoted and others removed based on feedback), and the development of group activities to support participants.

Conclusions/Implications: The avoidance of testing among young AAMSM is particularly troubling given that incidence is highest in this group. Age differences in high-need populations have rarely been taken into account in intervention development schemes. We found important age group preferences that we have been able to accommodate in this newly created intervention.

BP101

Abstract 2170 - Prevention Research and Implementation Science

Author(s): *Jacob van den Berg, Kimberly Dong, Alice Tang, Christine Wanke, Elsa Larson, Ashley Robinette, Faith Nwaoha, Michelle Lally*

Background: Prior international research indicates that food insecurity or lack of regular access to healthy and nutritious foods increases depression and HIV risk behaviors among people living with HIV. However, few studies in the United States have investigated the relationships among food insecurity, depression, and HIV risk behaviors among vulnerable populations who are at high risk for HIV infection. This study examined the relationships among food insecurity, depression, and HIV risk behaviors among substance users who are homeless living in the Providence metropolitan area.

Methods: Participants were eligible if they were 18 years of age or older, reported substance use [defined as one or more occasions in which they had 4 or more drinks (if female) or 5 or more drinks (if male) and/or used any other drugs in the past 12 months], reported unprotected anal or vaginal sex in the past 12 months, and reported being homeless (living on the street or in a shelter) in the past 12 months. Persons who were intoxicated, incoherent, or unable to give informed consent at the time of participation were excluded from the study. Questionnaires administered to 197 male (51%) and female (49%) adults assessed demographics, food insecurity, depression, and perceived vulnerability to HIV. Sexual and substance use behaviors were also assessed using a 90-day Timeline Follow-Back interview administered by trained research staff. Descriptive statistics and logistic regression analyses were conducted in Stata.

Results: The majority of participants were white (68%), 15% were African American, and 12% were Hispanic. The mean age was 41 (SD=9.1). The prevalence of severe food insecurity among the study participants was 70% (n=135). Significant associations were found between food insecurity and perceived vulnerability to HIV ($r=0.16$, $p<0.05$), and between food insecurity and depression ($r=0.22$, $p<0.05$). Those who were severely food insecure were more likely to have had sex with a partner who had injected drugs within the past month (OR 2.35; 95% CI [1.09, 5.09]) and to have had severe depression (OR 2.26; 95% CI [1.26, 4.07]) in comparison to those without severe food insecurity.

Conclusions/Implications: Our findings suggest that there needs to be increased efforts to ensure that severely food insecure populations have access to, are linked into, and are retained in mental health and HIV prevention and treatment services. Future research is needed to determine the degree to which food insecurity predicts depression and HIV risk behaviors and to investigate if intervening on food insecurity might reduce depression and/or HIV risk behaviors among substance users who are homeless.

BP102

Abstract 2237 - Prevention Research and Implementation Science

Author(s): *Allyson DeLorenzo, Patrick Wilson, Nathan Hansen, Anita Radix, Kathleen Sikkema*

Background: Epidemiological data indicate that the HIV/AIDS epidemic remains a significant health concern among men who have sex with men (MSM). In New York City, MSM account for more than half of new HIV infections (CDC, 2010). The results from the National HIV Behavioral Surveillance Study estimate that 40% of MSM who tested positive were unaware of their status (CDC, 2010). These alarming statistics demonstrate the need for prevention interventions to concentrate on this population

and undergo additional tailoring in order to effectively interrupt the further transmission of HIV within the MSM population. Determining the optimal point after an HIV diagnosis but before re-engaging in sexual activity could be critical to the effectiveness of delivering positive prevention behavioral interventions. However, little is known about this “intervention window,” the period of time from date of confirmatory diagnosis to first sexual event post-diagnosis.

Methods: Timeline follow back data from the Positive Choices (PC) intervention were analyzed to explore sexual activity among newly diagnosed HIV-positive MSM during the first three months post-diagnosis. Of the 102 participants enrolled in PC, 85 (83%) engaged in sexual activity sometime after confirmatory diagnosis but before exposure to the study intervention (an approximately 3 month window). The data presented here describes the first sexual event reported by participants that took place within this time period.

Results: During the 3 months following diagnosis, 40 (47%) participants reported engaging in condomless anal intercourse (CAI). The average length of time from diagnosis to first CAI was 24 days, with a minimum of 0 days and a maximum of 85 days (SD=21.1 days). Twenty-two described their sexual partner as a secondary partner. Most reported that their partners was HIV+ (n=24) or of unknown status (n=12). Sexual positioning was most often reported as versatile (n=16), followed by receptive (n=13), and insertive (n=11). Slightly more than half (53%) of these sexual events included substance use. In addition, 45 (53%) participants reported protected anal intercourse (PAI) within three months of a confirmatory diagnosis. The number of days from diagnosis to PAI averaged 28, with a minimum of 1 day and a maximum of 92 days (SD=27.57 days). A majority (80%) of the sexual partners were described as secondary (n=36), and participants indicated having HIV- (n=14) or unknown status (n=21) partners. Sexual positioning during first PAI post diagnosis was most often reported as receptive (n=20), followed by versatile (n=13), and insertive (n=12). Slightly more than half, 53%, of the participants reported substance use during their sexual encounter.

Conclusions/Implications: These data may prove vital to informing future secondary prevention efforts. Knowing that the window of time between diagnosis and first sexual event is often less than one month, it is imperative that risk reduction interventions be delivered soon after diagnosis, if not at the time of diagnosis. In order to effectively interrupt the transmission rate of HIV, of utmost importance is understanding how to tailor such interventions specifically for MSM who continue to engage in CAI post-diagnosis.

BP103

Abstract 2276 - Prevention Research and Implementation Science

Author(s): *Brian Thoma, David Huebner*

Background: HIV incidence continues to increase each year among young men who have sex with men (YMSM) in the United States. Parents of YMSM are an untapped resource in addressing this epidemic, given their role in socializing adolescents’ sexual attitudes and behaviors. Although effective parent-adolescent communication about sex is associated with fewer sexual risk behaviors among heterosexual adolescents, little is known about how parent-adolescent communication about sex functions within families of YMSM.

Using the theory of planned behavior as a framework, we examined how facets of parent-adolescent communication about condoms and HIV were associated with determinants of condom use behavior among YMSM. Drawing from qualitative data from YMSM and their parents, we developed a measure that assessed multiple facets of parent-adolescent communication about condoms and HIV (i.e., frequency of communication, perceived knowledge and trustworthiness of parents, and negative parental emotionality). Information was collected separately for participants' mothers and fathers. Facets of communication predicted YMSM condom attitudes, subjective norms, perceived behavioral control, and intentions.

Methods: Data were collected from YMSM via a cross-sectional online survey. YMSM were recruited through Facebook ads served to males ages 14-18 with interests in LGBT issues. Eligible participants identified as either gay or bisexual and indicated one of their parents was aware of their sexual orientation (n=531). Sixty percent identified as White, 15% as mixed, 13% as Latino, 7% as Black, and 5% as another race/ethnicity.

Results: Sixty-two percent of participants had discussed condoms with their mother, and 49% with their father. However, fewer discussed specific topics related to condom use with their parents, such as how to properly use a condom (18% and 12%, respectively). Participants discussed most topics with their mothers more frequently than with their fathers, with the exception of discussing how to use a condom, which occurred at equal frequency.

Facets of communication predicted determinants of condom use behavior in multivariate regression models (while controlling for participant age, subjective social status, and sexual orientation). In models containing mother's communication only, perceived knowledge/trustworthiness was positively associated with condom attitudes ($B=.118, p=.003$), subjective norms ($B=.247, p<.001$), perceived behavioral control ($B=.107, p=.002$), and intentions ($B=.130, p=.018$). In models containing father's communication only, knowledge/trustworthiness was positively associated with subjective norms ($B=.146, p=.005$) and perceived behavioral control ($B=.174, p<.001$), and frequency of communication was positively associated with attitudes ($B=.220, p=.005$) and intentions ($B=.289, p=.008$).

Conclusions/Implications: Among YMSM, mothers communicate most frequently with their sons about condoms and HIV, and the perceived knowledge and trustworthiness of both parents about these topics are pivotal in shaping condom-use determinants among YMSM. Fathers communicate about these topics less frequently, but increased frequency of these discussions is associated with more positive condom attitudes and higher condom-use intentions. Parents have the potential to influence determinants of YMSM condom use before YMSM are sexually active, positioning them as a uniquely powerful force in HIV prevention efforts for YMSM. Family-focused HIV prevention interventions for YMSM and their parents should aim to increase parental knowledge about, and augment parental comfort with, discussing condoms and HIV.

BP104

Abstract 2279 - Prevention Research and Implementation Science

Author(s): *Timothy Frasca, Javier Lopez-Rios, Theresa Exner, Marcia Kindlon, Arismendi Jimenez, Patricia Warne, Yvette Calderon, Anya Spector, Richard Cotroneo, Robert Remien*

Background: Acute HIV infection (AHI), the period before HIV antibodies are produced but when viral load is highest, plays a critical role in HIV transmission, yet the diagnosis is frequently missed in primary and urgent care settings. Although most newly infected patients experience a flu-like syndrome and may seek medical care, providers may be unfamiliar with AHI symptoms and fail to screen for HIV risk or to order appropriate diagnostic tests. Also, patients unaware of AHI and its symptoms may not associate flu-like illnesses with the possibility of HIV infection and thereby contribute to the lack of AHI screening and appropriate testing.

Methods: Data were collected in the course of evaluating a multi-level, multi-component structural intervention for AHI screening and detection in 20 primary healthcare clinics and 2 urgent care facilities in New York City. A total of 151 prescribing providers (physicians, nurse practitioners and physician's assistants); 195 non-prescribing providers and staff (nurses, medical assistants, social workers, health educators, receptionists); and 220 clinic patients were surveyed for AHI-related knowledge and attitudes.

Results: Two-thirds (66.5%) of providers surveyed had never received training on AHI. Mean AHI knowledge scores were 3.55 (maximum=6) for prescribing and 3.06 for non-prescribing providers. Approximately three quarters of providers (prescribers: 77.7%, non-prescribers/staff: 70.7%) correctly identified rash, candidiasis, fever and swollen lymph nodes as indicators of AHI. However, more than half of prescribers (57.5%) incorrectly identified coughing, sneezing and runny nose as AHI-related symptoms whereas only 23.5% of non-prescribers/staff made this error. Only half of providers (prescribers: 56.2%, non-prescribers/staff: 51.9%) knew the timeline for the appearance of AHI-related symptoms. Patients answered general HIV-related knowledge questions accurately (median correct responses: 6 out of 7 true/false questions). However, they did poorly on AHI-related questions (median score: 2 out of 7). Only 20% (n=44) said they had ever heard of acute or early HIV infection, and only 8% (n=16) volunteered correct information about it while others had no knowledge or expressed misconceptions (e.g., "It's when you have sex and are infected at a younger age.")

Conclusions/Implications: Many providers in primary care settings in high-prevalence areas of New York City are unfamiliar with key diagnostic information about AHI. Prescribing providers showed only slightly more accurate knowledge than other providers and support staff and were more likely to misidentify symptoms. Patients surveyed in these areas were almost entirely unaware of AHI, its symptoms, and its relevance to HIV transmission. Limited public and provider knowledge about this crucial phase of the illness may be impeding timely identification of AHI in the primary care setting. Appropriate training for medical personnel and community education initiatives could enhance AHI screening and diagnosis.

BP105

Abstract 2301 - Prevention Research and Implementation Science

Author(s): *Sabeena Sears, Sylvia Odem, Jonathon Poe, Michael Wu, Osaro Mgbere, Mamta Singh, Melanie McNeese*

Background: In Texas 16,699 women and 59,922 men were living with HIV as of 2013. This analysis examined gender-related differences in socio-demographic, behavioral and clinical characteristics among HIV+ persons receiving outpatient medical care in Texas. These data are critical for program planning and resource allocation at the state level.

Methods: The Medical Monitoring Project (MMP) is an ongoing surveillance system that assesses behaviors and clinical characteristics of HIV-infected persons who are receiving outpatient medical care. The MMP uses a three stage cluster sampling method to randomly select 23 city/state project areas, healthcare facilities within those areas, and patients within facilities. From the Texas and Houston MMP facilities, 458 of 800 sampled persons participated in the 2011 cycle. Behavioral and clinical data were collected using an in-person interview and medical record abstraction (MRA). Weighted interview and MRA datasets were analyzed to assess gender differences in key variables using SAS 9.3. Gender differences within characteristics of interest were assessed using Rao-Scott chi-square tests and significance level was determined at $p < 0.05$.

Results: Among participants, 78% were male and 22% were female. Among females and males, 57% and 31% were Black, Non-Hispanic; 25% and 33% were Hispanic, and 18% and 33% were White, Non-Hispanic, respectively. A higher proportion of females (44%) than males (26%) were in the 18-39 age group ($\chi^2 = 8.23, p < 0.05$). Fifty-nine percent (59%) of males completed higher education compared to 38% of females ($\chi^2 = 16.08, p < 0.001$). More females (62%) than males (37%) ($\chi^2 = 15.18, p < 0.0001$) reported an income below the 2010 federal poverty level. Females (69%) were less likely to have a suppressed viral load (VL) than males (82%) ($\chi^2 = 4.21, p < 0.05$). Females were also less likely to have at least two viral load tests conducted in the past 12 months (22% compared to 26% for males) and more likely to not have had a test in the past 12 months (14% compared to 6% for males) ($\chi^2 = 8.73, p < 0.05$). According to PHQ-8 depression scale responses, 35% of females compared to 18% of males ($\chi^2 = 9.15, p < 0.01$) were depressed. Females were more likely than males to agree with statements indicating feelings of stigma: "...hiding HIV status (76% vs 57%) ($\chi^2 = 20.76, p < 0.0001$), "...feeling dirty", (39% vs 26%) ($\chi^2 = 6.84, p < 0.05$) and "...feelings of worthlessness" (37% vs 22%) ($\chi^2 = 9.13, p < 0.01$) Fewer females (12%) than males (23%) reported drug use ($\chi^2 = 6.84, p < 0.01$).

Conclusions/Implications: Texas MMP data suggest there are significant differences between HIV+ males and females in care. In addition to using these data for program planning and resource allocation, these results illustrate the need for HIV care and social services with a gender based focus that addresses barriers to care and empowerment. These efforts may enhance better outcomes and reduce the current health disparities among women. Additional analysis should be conducted to further assess the degree to which socioeconomic factors, depression, and stigma might influence retention in care and clinical outcomes.

BP108

Abstract 2484 - Prevention and Care Programs

Author(s): *Myriam Hamdallah, George Gates, Cornelius Baker*

Issue: Minority participation in HIV prevention research is essential; nearly two-thirds of people diagnosed with HIV in the United States are African American or Hispanic/Latino. In spite of these trends, historically, the recruitment of racial/ethnic minorities in biomedical research has been a challenge for medical researchers. There is a need for clear and effective biomedical HIV prevention research information to increase understanding of and support for research among populations most affected by HIV/AIDS.

Setting: The Be The Generation (BTG) project was created as one of NIAID's educational and outreach initiatives to support and facilitate biomedical research. It was designed to foster relationships with highly impacted communities in the U.S. to promote dialogue and understanding of biomedical prevention research, and increase support for research participation.

Project: One of the goals of the BTG project was to create materials to inform communities about biomedical HIV prevention modalities – pre-exposure prophylaxis (PrEP), microbicides, treatment as prevention (TasP), and vaccines. Formative research to develop and test materials consisted of key informant interviews (KIIs) with health care providers (HCP) (who can be influential in the decision to participate in clinical trials) and focus groups with priority populations – African American MSM and heterosexual women and men; Hispanic/Latino MSM and heterosexual women; transgender persons of any race; and White MSM. The research, conducted in two phases with a total of 106 focus group participants and 12 KIIs, assessed current HIV prevention research awareness and attitudes, feedback on key messages and brochure, formats and dissemination, and behavioral intentions after reviewing the materials.

Results: Focus group participants found the terminology to be complex – especially the terms “biomedical” and “microbicides.” There was interest in how prevention modalities worked and specific questions about each, such as who should take PrEP, and the window of time to apply microbicides. The brochure format, images and flow of information were well received. Many stated they would pick it up if they saw it, and suggested modes of dissemination ranging from doctor's offices to pizza delivery boxes. Many transgender and African American MSM participants would not be likely to read it. The brochure did not make most participants more supportive of a friend or family member participating in HIV prevention research due to concern about “unknown risks” and mistrust of the scientific community.

HCPs were willing to bring up HIV prevention research with patients, but were concerned about side effects, risks, length of studies, interactions, pre-existing conditions, and influence of incentives. They had positive reactions to the brochure and would provide it in their offices, but suggested more sources of information and less medical jargon.

Lessons Learned: Input from priority populations and HCPs was critical in developing educational materials on biomedical HIV prevention research and understanding the challenges in conveying information in an effective way. While participants are interested in learning about new prevention technologies, knowledge per se does not impact behavioral intentions. Further follow up with communities after materials are disseminated is necessary to assess if the information influences intentions and attitudes toward support for HIV prevention research.

CP31

Abstract 1705 - Prevention and Care Programs

Author(s): *Elby Katumkeeryil, Silvana Mazzella, Elvis Rosado, Nidia Flores*

Issue: Self-reports and data from the testing program show that 20% of newly identified HIV positive participants from Prevention Point Philadelphia (PPP) never make it to care in the first year. Reasons for being out of care include active addiction, lack of transportation or stable housing, incarceration, and fear of being “outed.”

Setting: PPP, a syringe exchange program, in conjunction with Philadelphia FIGHT, a comprehensive AIDS service organization, established an HIV clinic called Clinica Bienestar. The clinic takes place at Prevention Point Philadelphia weekly.

Project: Until the establishment of Clinica Bienestar, there were no culturally sensitive HIV clinics for active users. In incorporating an infectious disease clinic within a syringe exchange program, we faced several challenges, including maintain confidentiality, continuing to provide harm reduction education, and attracting a population that has resisted care for various reasons.

Results: These services have resulted in 45 patients being referred to the clinic and 41 being enrolled. Of these, 28 have attended at least 3 appointments, 19 are on ARVS, and 10 have undetectable viral loads. In addition, several new measures, including block scheduling and escorts to specialty care, have been implemented in the clinic to ease access to and improve retention in medical care.

Lessons Learned: An effective harm reduction HIV provider needs to supplement treatment with a comprehensive package of specialty medical care, case management, and outreach services. Additional factors that increase retention rates include providing patient-determined care and collaborating on innovative strategies for medication adherence. We present the challenges we faced in establishing a harm reduction HIV clinic and the strategies we employed to overcome these challenges for the purposes of expansion and replication.

CP35

Abstract 1934 - Prevention and Care Programs

Author(s): *Jeffrey Roberson, Silvana Mazella, Champagnae Smith, Jasmine Santos, Jennie Coleman*

Issue: Beginning in January 2014, the Hepatitis Epidemiology Program (HEP) at the Philadelphia Department of Public Health (PDPH) began a collaboration with Prevention Point of Philadelphia (PPP) to increase HCV confirmatory testing of clients. Given the high prevalence of HCV among people who inject drugs (PWID) and the development of interferon-free medication, on-site confirmatory testing was piloted as a method of assisting individuals in accessing high quality and specialized care.

Setting: PPP is a multi-service, non-profit organization that serves Philadelphia’s most at-risk populations, including those identifying as drug users/abusers and sex workers. Services offered include

a needle and works exchange for drug users, on-site clinical care, health education, mail services, and support groups.

Project: While HCV rapid antibody (Ab) testing has been offered since 2011, clients testing Ab positive were being referred out to partner clinics to receive the confirmatory RNA test, and PPP was unable to track whether the testing actually occurred. To actively support the movement of PPP clients through the HCV care continuum, HEP began offering free, on-site confirmatory testing once a week. In addition, PPP clients began receiving education about HCV and the actions required to prevent transmission. HCV Ab positive RNA negative clients also received education about their exposure and risk of reinfection. The success of this program has inspired PPP to get its own staff phlebotomy trained in order to offer confirmatory testing more than once a week. In August 2014, PPP added an on-site HCV care coordination component for individuals previously identified as or currently tested HCV positive

Results: In CY2014, 737 people were tested for HCV Ab, and 206 were reactive for HCV Ab. Of those 206, 168 received on site HCV confirmatory RNA testing through PDPH staff, and 38 people received off site HCV confirmatory testing at an external provider. Of the 168 confirmed internally through PDPH at PPP, 84 people tested RNA positive, and 84 tested RNA negative. Of the 36 confirmed at an external provider, 6 made it to a first hepatology appointment post RNA testing. Data is being obtained on how many of the 36 were RNA positive. Of the 84 RNA positive individuals tested internally, 44 kept their first and subsequent appointments. Of the 36 confirmed externally, only 6 made it to a non-lab appointment. All of these clients were enrolled in on site HCV Care Coordination. Over 40% of enrolled clients were uninsured at the time of enrollment, and over 50% were either currently or imminently homeless. A total of 20% were co-infected.

Lessons Learned: This project has huge implications for organizations working with vulnerable populations, active drug users, and co-infected individuals, and has implications for how to successfully mobilize those most affected by HCV and HIV through the HCV care continuum.

CP44

Abstract 2153 - Prevention and Care Programs

Author(s): *Juan Oves, Victor Gonzalez, Eric Fenkl, Sandra Jones*

Issue: South Florida and the city of Miami continue to be an epicenter of the HIV/AIDS epidemic in the U.S. Miami-Dade County continues to rank number one in the U.S. for its rate of new HIV infections in 2013; 16% of new Florida HIV infections in 2013 occurred among adolescents and young adults and 49% among gay, bisexual, and other men who have sex with men (MSM). Most new infections in Florida are among African-Americans and Hispanics. South Florida's university and college settings provide windows of opportunities for high impact prevention compliant programs for YMSM. While conventional wisdom might hold that college students are shielded from the risk behaviors of their peers with lower educational attainment, risk taking on campus and / or amongst college students has fueled local HIV outbreaks in many regions.

Setting: This session will describe how Florida's most diverse university partnered with the state's only gay HIV agency to launch the Mpowerment intervention in Miami-Dade County.

Project: Mpowerment is an adaptable community-level intervention, in order to increase HIV/AIDS and STDs education and prevention, increase HIV testing, decrease sexual risk behavior, and provide a welcoming and safe environment for YMSM. Mpowerment is a theory-based intervention based on the empowerment theory and diffusion of innovations to mobilize YMSM to reduce sexual risk behaviors and educate their peers. The local project, called Panther Mpower, is developed from a core group of volunteers who participate in small group discussions, outreach, events, and a community campaign on campus. Intervention components provide opportunities for YMSM on campus to connect with their community and increase awareness of HIV prevention.

Results: This community-level intervention has established partnerships with the university's student health services, student organizations, and local community-based organizations. HIV testing has increased significantly among YMSM on campus through the use of geosocial social networking apps and social media such as Facebook, Grindr, and Yik Yak. Program activities have increased HIV/AIDS knowledge including topics such as pre-exposure prophylaxis (PrEP), condom use, and stigma. **Conclusions:** This innovative community-level intervention has shown to be effective in reducing sexual risk behaviors including HIV risk reduction among YMSM. Participants in this session will learn how to implement a High Impact Prevention-compliant EBI with limited resources. They will see how the Panther Mpower project leveraged social media and networking tools to reach YMSM and increase HIV testing on campus. Facilitators will describe the baseline HIV knowledge, the perceived barriers to testing or service access, and the peer-driven strategies that engaged high risk YMSM into services. Small-group discussions or M-groups provided safer sex workshop opportunities for YMSM to increase sexual health knowledge and risk reduction skills.

Lessons Learned: Adaptation of this intervention in a university/college setting allows reaching YMSM, a specific high-risk population. In closing discussion, participants will develop an action plan to bring scalable EBIs to their own minority YMSM at historically black colleges and universities, community colleges, and other settings.

CP45

Abstract 1904 - Prevention and Care Programs

Author(s): *Tina Radin, Jules Buchanan, Jen Mainville, Juliet Fink Yates*

Issue: Young PLWHA account for 26% of new HIV infections and continue to be disproportionately impacted by this epidemic, yet the barriers for young people needing HIV treatment are many. They range from developmental issues, socioeconomic impediments, lack of family support, and most critically, health literacy. According to the American Academy of Pediatrics, successfully transitioning youth to adult HIV clinics is dependent on their ability to gain the skills needed to manage their own health care.

Setting: Based in Philadelphia, PA and operating out of Philadelphia FIGHT, a comprehensive HIV/AIDS Service organization, in partnership with adolescent HIV programs at two area hospitals. Target population is low income youth of color who are newly diagnosed or transitioning from youth to adult care.

Project: Youth TEACH (Treatment Education Activists Combating HIV), is a targeted adherence intervention for young people living with HIV/AIDS. It is modeled after Project TEACH, a unique HIV Treatment Education program grounded in popular education and designed to build capacity, promote healing, and reduce transmission at the community level among marginalized PLWHA. Youth TEACH aims to provide extensive digital health literacy and treatment education training to vulnerable youth living with HIV who are transitioning to adult care.

Specifically, we offer replicable interactive lessons on self-advocacy in entering adult care, understanding HIV treatment, and managing the social and emotional impact of an HIV diagnosis. Lessons are created for and by young PLWHA to enable and empower them to build the critical health literacy skills needed to transition successfully, engage in their health care, and succeed as adults living with HIV

Results: Youth TEACH is a new program in 2015. Since 1996 more than 100 people have graduated from Project TEACH annually. Our reach has extended significantly beyond the classroom through our peer education program which trains TEACH graduates share HIV information with thousands throughout Philadelphia each year.

We have considerable anecdotal evidence of the positive and powerful impact Project TEACH has on the lives participants. Preliminary data analysis from a recent formal evaluation study of 5 cohorts of TEACH students has shown a statistically significant increase, at the $p < 0.05$ level, of HIV knowledge from pre- to 1 year post-class. Youth TEACH is too new to have specific evaluative data, but cohort 1 had a 100% retention rate, and final evaluation scores indicated increased confidence in scheduling medical appointments, asking medical providers questions, and searching for accurate HIV information on the internet.

Lessons Learned: Interventions grounded in the knowledge that treatment alone will not end the epidemic are necessary to intensify HIV prevention in the communities where HIV is most heavily concentrated. Programs designed to complement medical care and reinforce adherence should providing cutting edge HIV treatment information along with emotional support and resources needed to become empowered HIV educators, activists, and advocates. Most importantly, we must educate participants in a manner that shifts the status quo to concentrate power in the community, where the wisdom garnered from the lived experience of HIV can fuel creative and efficacious solutions to the problems that perpetuate the epidemic.

CP74

Abstract 2343 - Prevention and Care Programs

Author(s): *Stephanie Cornwell, Samantha Feld, Nikia Harris, N. Dietz, Cynthia Carey-Grant*

Issue: The HIV epidemic in Alameda County, California is one which takes a disproportionate toll on low-income persons and persons of color, especially those who are women. The percentage of women living with HIV/AIDS is higher in the Oakland TGA than in any major metropolitan area in the western U.S., at 19.3%. In 2010, over 54% of female non-AIDS HIV cases in Alameda County were out of care. Indeed, women living with HIV/AIDS often experience significant barriers to quality care, including poverty,

substance abuse, experiences with violence and social and cultural factors limiting women's power in sexual decision making.

Setting: 2nd CHANCE is part of the Kaiser Permanente National HIV Test and Treat Initiative. The goal of 2nd CHANCE is to implement a new, peer-based model which significantly expands the number of low-income, women of color living with HIV in Alameda County, California who are effectively engaged in HIV care and who are adherent to HIV medications, both to enhance their quality and length of life and to achieve undetectable viral load levels that virtually eliminate the risk of passing HIV to others.

Project: 2nd CHANCE is an innovative linkage and retention initiative targeting women living with HIV/AIDS who are tenuously in care or who have fallen out of care. WORLD Outreach and Linkage Specialists (OLS) conduct street and community outreach, in addition to partnering with local clinics to identify, link, and help retain in care low-income women of color who are either out of care or precariously retained in care, including women with co-occurring behavioral disorders and women with complex family or life situations that threaten their long-term retention in care. WORLD's OLS will work as an integrated team to implement a new model of peer-based, women-centered HIV patient linkage and retention. OLS provide individualized services tailored to each client's needs and life circumstances, including personally contacting and communicating with women at least once each week; driving women to medical and support service appointments; and organizing client-centered educational and supportive events that directly respond to client needs.

Results: Data collection is ongoing, but preliminary analysis of baseline data have been analyzed (n=59 of 100) to describe barriers to care including homelessness (22%), incarceration in the past 12 months (19%), involvement in sex trade in the past 90 days (13%), substance use in the past month (42%), and injection drug use in the past 30 days (5%). By the end of 2015, data will be analyzed to show the effect of contact frequency with clients as a health outcome determinant.

Lessons Learned: A major barrier to linking and retaining women into care has been twofold: Despite having proper documents in place which protect our community partner clinics from violating HIPAA by releasing client information, local clinics have been reluctant to refer their patients. Additionally, efforts to contact clients who would be candidates for this initiative, including clinic referrals, have been challenging because contact information on file at both WORLD and our clinic partners is often not current.

CP76

Abstract 2027 - Prevention and Care Programs

Author(s): *Donald Wood*

Issue: CDC seeks ways to reduce HIV infection within the gay and bisexual Black and Latino population (MSM). Within this demographic, amongst the subset of men ages 18-24 it is estimated that nearly one in three persons do not know they have HIV and over 50% of them have it. In 2010, black youth accounted for an estimated 57% (7,000) of all new HIV infections among youth in the United States, followed by Hispanic/Latino (20%, 2,390) and white (20%, 2,380) youth.

Setting: S.N.A.P. desires to become a teaching module in an interactive workshop format accompanied by a film. This workshop can either be taught in HIV prevention programs or the film can be viewed in sex education classes, either of which work with young gay men of color.

Project: S.N.A.P. will be taught and/or shown to HIV prevention organizations that serve young MSM of color. The workshop/film is an attempt to empower them to make healthier choices by: 1) identifying their sexual triggers so they can avoid risky situations; 2) connecting impulsive in-workshop choices with real life-like consequences; 3) pretending that they have received a HIV+ diagnosis and the challenges that come with it (revealing to family, friends and partners; costs of medication and its side effects; sticking to a daily regimen; issues with housing, religious and employment); 4) discovering and challenging hidden assumptions about who has HIV, how one is infected and how they can consciously or unconsciously propagate the stigma; 5) choosing the right HIV test (the window period); 6) discussing the differences between PEP and PrEP and the usage of other HIV medications; 7) listening to HIV+ persons whose lives debunk the "automatic death sentence" stereotype; and 8) emphasizing the need for testing, counseling and ongoing medical care (irrespective of HIV status results).

Results: The success of the program depends on the level of exposure which will result in more initial HIV testing, linkage to gay-friendly Primary Care Physicians (PCPs), continual HIV/STI screenings for HIV- persons and routine monitoring and maintenance for HIV+ persons. The workshop will also aid MSM in connecting with various programs that help defray the costs of HIV medication while also factoring in possible insurance coverage.

Lessons Learned: In the end, S.N.A.P. will help to empower young MSM to mature into confident men who are vital, connected parts of their communities while navigating the world of gay sex, dating and relationships. They don't have to wait for government programs or societal changes to take place — they can start taking action now and be the change they want. While there are unique obstacles for young MSM of color, those outside forces do not have to dictate what goes on in their bedrooms. S.N.A.P.'s ultimate goal is to shift the locus of control from external stimuli to an internal mechanism.

CP77

Abstract 1949 - Prevention and Care Programs

Author(s): *Stephen Fallon, Jose Javier, Victor Gonzalez*

Issue: The High Impact Prevention approach seeks scalable, cost effective interventions and services. Strongly motivated clients engage in health-seeking behaviors, such as accessing HIV testing at fixed locations during specific hours. However, many of the most at-risk members of a target population do not engage in these proactive behaviors. How can community-based organizations find, reach, and serve these community-members with HIV rapid testing, and "sticky" linkage to care services that help clients who test HIV-positive to achieve viral suppression?

Setting: Miami-Dade County, FL, currently ranking #1 in new HIV incidence. Late diagnosis and low rates of viral suppression lead to poor health outcomes for the target population. Gay Latinos live only half as long as their non-minority gay male counterparts in this region.

Project: The presenters represent a gay, Latino organization that expanded its services to a neighboring county within a high-prevalence MSA, and sought to serve the population of Latino Men Who Have Sex with Men most effectively and efficiently. Barriers that the agency sought to overcome included: Latino MSM reluctant to test, due to a mistaken belief that a reactive result would trigger deportation; poor public transportation, making it difficult for Latino MSM to access testing at fixed locations; high numbers of potential clients juggling two jobs, making it difficult to schedule times for the initial test and, if needed, the confirmatory result counseling; fatalism common to some Latino cultures, leading some community members to believe that nothing can be accomplished by knowing one's status; low socioeconomic status precluding HIV testing amongst those gay Latinos who are unaware of Ryan White funded services.

Results: The presenters will describe the outcomes yielded through three strategic approaches: mobile HIV testing in late night outreach where Latino MSM socialize; leveraging GPS-based "hook up" apps to motivate "impulse" testing; and the addition of Couples HIV Counseling and Testing. The presenters will describe unexpected lessons, and how staff adapted their strategies to yield more tests, while maintaining high rates of positives, indicating the most at-risk were served. Next, the presenters will describe linkage strategies and the outcomes realized when clients were linked to care at HIV clinics with provider staff who were bilingual, and/or with providers were also MSM.

Lessons Learned: 1. Mobile testing vans are more accessible when they do not have signage indicating that HIV testing occurs inside. Clients also reported preferring van interiors that are not partitioned, both due to privacy concerns (sound carries through thin walls), and because the larger space allows for couples HIV counseling and testing.

2. The most at-risk clients tend to access a testing van at the end of a night socializing, not on their way in. Testing staff needed to move some shifts to end at 3:30 a.m. GPS apps drew more walk up tests;

3. Even clients who are fully bilingual benefitted from linkage specialists accompanying them to medical appointments. Linkage specialists served as strong advocates when some providers acted in ways that seemed dismissive, or even outright disrespectful (homophobic, transphobic, classist) in their interactions.

CP89

Abstract 1234 - Prevention and Care Programs

Author(s): *Ken Levine*

Issue: As the number of patients being prescribed PREP continues to rise, it becomes impractical to conduct EHR chart reviews of every PREP patient to extract information relevant to their adoption of PREP and management of their care. A standardized method of collecting this data needs to be developed and adopted by clinicians.

Setting: Fenway Community Health (FCH) is a Federally Qualified Health Center with a mission to serve the LGBT community. In 2014 alone, FCH provided primary care services to over 2000 HIV positive individuals, as well as to many thousand HIV negative individuals who may be at risk for HIV. In this

setting, prescription of PREP has risen dramatically. Through calendar year 2014, over 650 patients had initiated PrEP, with well over 500 having initiated in 2014 alone.

Project: The compilation of much of the data regarding patients prescribed PREP at FCH has often required extensive chart review. This includes prior PREP history in a clinical or research setting, prior PEP history (and why they stopped), initiator of PREP discussion (patient, provider), how patient heard about PREP (media, provider, forum), setting of initial PREP discussion (email, phone call, visit specifically for PREP, etc) primary motivation for going on PREP (partner HIV+, high risk activity, PEP follow up, recent STI)sexual preference, gender identity, relationship status, HIV status of partner(s), and risk behaviors. Even the manner in which PREP usage was documented needs be standardized so that it is easy to tell when the patient started and stopped, and why they did so.

Results: A pilot is underway to collect the information required in discrete EHR data items via a clinician friendly forms interface. This will allow more aggregate results can be reported and so that prior patient history is more reliable and easier to extract, and allows for real-time monitoring. The pilot involves developing a form or forms that represent the continuum of PREP use, from initial contact through to adoption, discontinuation and re-adoption.

Lessons Learned: PREP usage has only been FDA approved in the last few years, and adoption among clinicians for their patients began very slowly, but is now growing very rapidly, resulting in a need for more efficient capture of any data that might be relevant to each case. While some of these data requirements cannot readily be anticipated before the program gets underway, many data elements could have been determined ahead of time and kept the necessity for extensive chart reviews from growing as fast as the number of patients. In a Health Center such as FCH, with such a large population that could benefit from PREP, being proactive about capturing information around PREP adoption is a necessity, as part of an iterative process to improve data quality and patient care.

CP90

Abstract 1248 - Prevention and Care Programs

Author(s): *June Holmes, Joyce Poole, Peggy Simonette, Dulce Dones-Mendez, Ramon Rodriguez-Santana*

Issue: The Centers for Disease Control and Prevention (CDC) estimates that 14% of individuals living with HIV infection in the United States are unaware of their status (1). In September, 2006, the CDC revised their HIV testing guidelines and recommended testing for persons 13 years of age to 64 years of age in all health care settings. The consent parameters include opt-out testing, inclusion of HIV testing consent as part of general medical consent forms, and permission to give consent orally. The counseling parameter does not require prevention counseling prior to testing (2). On January 1, 2009, the CT Department of Public Health (CT DPH) enacted Public Act 09-133 to encourage opt-out routine HIV testing in the health care setting.

Setting: In January 2013, Yale-New Haven Hospital (YNHH) was awarded funding from CT DPH to develop an Expanded HIV Testing Initiative (ETI) in our Primary Care Center for the adult and adolescent population, and Women's Center. In September 2013, YNHH acquired the Hospital of Saint Raphael (SRC); ETI was expanded to include the SRC Adult Primary Care and Women's Center.

Project: Our project is consistent with CDC and CT DPH guidelines, and the National AIDS Strategy. Routine HIV testing is provided in the context of a new patient appointment and/or annual exam; also for patients with clinical indications, e.g., STIs, and for those at high risk for HIV infection. The patient is informed that HIV testing will occur as part of their health care visit; the patient can opt-out if desired. If the patient does not opt-out and result is positive, linkage to comprehensive multi-disciplinary HIV care is immediate. If the patient is in a sero-discordant relationship, PrEP is introduced at the HIV care site.

Monthly lists of all patients tested, including demographics and test results, are generated through our Electronic Medical Record (EMR) system. These lists are used to enter data that is required by CT DPH and CDC.

Results: Since January 2013, 6518 patients have been tested. Thirty-six (.06%) new diagnoses have been identified. Of the 36 people with new diagnoses, 34 have been linked to medical care and are actively in care. One patient remains lost to follow-up from medical care and CT DPH has put a tracer on that patient. The other patient expired.

Lessons Learned: • Transparency and Integration: It was apparent early on in the process that ETI needed to be transparent within the patient visit. It could not involve additional responsibilities for staff or disruption of clinic flow. We decided to integrate HIV testing as part of routine blood-draw, and as clinically indicated, with Rapid Testing as an option for patients.

- Physician and Nursing Champions: It is important that medical and nursing leadership believe in the concept of ETI and champion the initiative to administration, faculty, staff, and students.
- EMR: This tool was extremely useful for generating patient information and test results
- Reimbursement: One annual test is reimbursable by Medicaid, Medicare and most commercial insurers. Appropriate ICD-10 coding is needed for reimbursement.

CP93

Abstract 1578 - Prevention and Care Programs

Author(s): *Maureen Scahill, Patricia Coury-Doniger, John Hamiga, Susan Kegeles, Greg Rebchook, Scott Tebbetts, Robert Williams, Benjamin Zovod*

Issue: Despite 2012 FDA approval of HIV PrEP, uptake in the U.S. has been suboptimal. Diffusion of PrEP could be enhanced through integration into HIV prevention programs provided by health departments (HDs) and Community Based Organizations (CBOs) throughout the U.S. Current HIV prevention programs include various effective behavioral interventions (EBIs) developed for men who have sex with men (MSM), injection drug users (IDU), and high-risk heterosexuals which have been successfully implemented by the HIV prevention workforce. Adaptation of these EBIs by integrating PrEP and engagement-in-care messaging and services could significantly increase PrEP uptake as well as engagement in the HIV care continuum.

Setting: The Mpowerment Project (MP) is a model community-level intervention that specifically addresses the needs of young adult gay and bisexual men, ages 18-29. Many Men, Many Voices (3MV) is a proven effective, group-level HIV/STD prevention intervention for Black MSM. The intervention consists of 7-sessions addressing behavioral determinants such as knowledge, attitudes/beliefs, skills and intentions as well as the social determinants of dual-identity, stigma, racism, and homophobia. Since 2004, MP and 3MV have been diffused and implemented by HDs and CBOs nationally.

Project: MSM, including Black MSM who experience significant HIV disparities, are a priority population for HIV PrEP. The 3MV intervention developers worked with the Centers for Disease Control (CDC) to integrate PrEP awareness and motivations into 3MV group sessions. The MP intervention developers incorporated both HIV PrEP and engagement in the HIV care continuum messages into MP Core Elements.

Results: MPs have begun promoting public forums and discussion groups that highlight PrEP as a prevention option along with outreach and educational materials. Other MPs have collaborated with PrEP trials in their cities, allowing MP participants to enroll in studies and obtain PrEP at no cost. Still others have created guides including information about PrEP safety, efficacy, access to providers, and financing. MP sessions now include information on Treatment as Prevention (e.g., meaning of ‘undetectable’, correcting misinformation around treatment, increasing social support for staying in care, and medication adherence). 3MV is designed to decrease risky sexual and substance use behaviors and increase health promotion behaviors, thus providing a structure for the insertion of information and experiential methodologies to increase PrEP awareness, influence attitudes and beliefs, and increase self-efficacy and skills in seeking HIV PrEP services. Specifically, 3MV sessions are focused on discussion of a Menu of HIV/STD Prevention Options which lists a variety of options for decreasing sexual/substance use risk and increasing HIV and STD testing. HIV PrEP was added to the Menu and subsequent experiential methodologies. The HIV PrEP-adapted sessions were incorporated into the national 3VM TOT curricula.

Lessons Learned: A variety of strategies can be used by the HIV prevention workforce to increase the diffusion of HIV PrEP services to high priority populations they are already reaching. Integrating HIV PrEP into existing EBIs designed for those priority populations, represents a value add-on without requiring significant new resources. Training and capacity building assistance (CBA) services are available to assist in the adaptation of PrEP into MP, 3MV and other existing EBI programs.

CP94

Abstract 1635 - Prevention and Care Programs

Author(s): *Pedro Carneiro, Melanie Martinez, William Nazareth*

Issue: Operationalizing the access and delivery of Emergency HIV Prophylaxis (nPEP) is a considerable challenge for Community Health Centers (CHC) given high patient volume, limited staff and space. Callen-Lorde Community Health Center has explored a variety of techniques to increase our community’s access to nPEP resources while minimally affecting both the standard of care and healthcare providers’ workflow

Setting: Community Health Center

Project: In 2013, the clinic offered 571 nPEP interventions to 519 clients from a variety of socioeconomic backgrounds. Initially the link to nPEP was offered upon expressed need by the patient during Counseling and Testing (CT) or medical appointments. Upon establishing eligibility, patients were directed to follow procedural requirements to access medication such as insurance approval, public funding paperwork, phone calling/faxing third parties. The navigation of these systems coupled with the clinic's own interdepartmental approach to nPEP – nursing, physicians, and HIV counselors- severely increased the time of visits, indirectly affected non-nPEP seeking patients and added work to already overburdened staff. In efforts to create a standard of care that would facilitate patients' navigation through these systems and alleviate staff participation in this extensive process, we were prompted to reformat our delivery of nPEP. We redirected an HIV counselor to serve as the "nPEP liaison" during clinic hours, responsible for providing customized follow up services to clients and serving as a direct contact between patients, clinical staff and outside parties.

Results: Implementation of a system to deliver nPEP in CHCs requires a multidisciplinary approach allowing the navigation of medical, behavioral and social services. CHCs should not rely on adding nPEP to standard medical or social services appointments. There is a need for better policies that consolidate the delivery of nPEP, especially for the uninsured and underinsured, assuring that clients are not overburdened by bureaucracy and irregularity.

Lessons Learned: Prior attempts to streamline nPEP delivery through standard appointments were unsuccessful. Our reformatting project reduced patient wait time, freed staff of unnecessary burden and connected clients to a point person for navigating the system and receiving follow up support. Given the multilateral aspect of delivering this intervention, it was fundamental to centralize the system around the nPEP liaison.

CP95

Abstract 1808 - Prevention and Care Programs

Author(s): *Terry Stewart, Miguel Chion, Oscar Márquez, Deryk Sanchez Standring, Katie Langland, Erin Hobbs, Kendra Barker, Heather Gotham, Kimberly Carlson, Alex Barajas-Munoz*

Background: HIV Navigation Services (HNS) is a CDC's required strategy in the newest funding cycle PS15-1502: Comprehensive High-Impact HIV Prevention Projects for Community-Based Organizations. In the field of HIV, HNS seeks to enhance HIV prevention services delivery including linkage, retention and re-engagement to support clients who are living with HIV to reduce the gaps in the continuum of care and support viral suppression and assist high risk negative individuals to remain HIV negative. To prepare professionals to meet this growing need, the Denver Prevention Training Center, AIDS Project Los Angeles, and Capacity Provider Network (CPN) Resource Center, members of the CPN Network, developed a dual-delivery course titled HIV Navigation Services. The course is comprised of a 45-minute online pre-course module, as well as a 3 day face-to-face training. By the end of the training, participants will be able to: increase capacity to implement navigation services aligned to High Impact Prevention (HIP); demonstrate an increase understanding how navigation services support HIP; explain a

protocol for conducting HIV Navigation Services (HNS); identify the required core skills and knowledge of HNS; and, apply the skills and knowledge of HNS to their work.

Methods: The CBA Provider Network conducted a four-part pilot of the training in the Spring and early Summer of 2015. The dates of the pilots were: March 16-18 in Chicago, IL; April 14-16 in New York City, NY; May 12-14 in New Orleans, LA; and May 27-29 in Los Angeles, CA. Participants of the pilot were invited to complete the survey post-training that covered satisfaction with the course, its design, and materials; knowledge and skills acquisition; intention and readiness to implement; degree of “buy-in”; and intention and expectation to adopt and maintain HNS.

Results: Nonparametric statistical analyses using medians and the Wilcoxon Signed Rank Test were performed to test significance of changes in knowledge and skills from pre-course to post-course. Significance was tested at the $p < 0.05$ level. Poster will illustrate the highlights of our evaluation efforts and key learnings on blended learning approach with the HIV workforce. At the time of this submission results were not yet available.

Conclusions/Implications: At the time of this submission, pilots were not yet complete.

CP96

Abstract 2114 - Prevention and Care Programs

Author(s): *Alton King, Gerlinda Somerville, Sherrye McManus, Kimberly Thierry, Ed Craft*

Issue: Behavioral health (substance use and mental disorders) remains a highly fragmented health delivery service within the overall continuum of care. This reality is further exacerbated as 1 in 4 Americans experience some form of substance use disorder (SUD) and/or mental illness each year. Racial/ethnic minority populations are acutely impacted by disjointed care in the continuum for behavioral health prevention and treatment, HIV and Hepatitis testing and referral services.

Setting: Behavioral health providers funded under SAMHSA's Targeted Capacity Expansion Program: Substance Abuse Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (TCE-HIV; and TCE-HIV: Minority Women) aim to facilitate the development and expansion of culturally competent and effective community-based behavioral health treatment within racial/ethnic minority communities that have substance use or co-occurring disorders and are living with or who are at risk for HIV/AIDS.

Project: TCE-HIV program grantees provide coordinated behavioral health services. Several grantees are highlighted to discuss their innovative approach to health awareness campaigns; community relationship-building engagements; screening and treatment of HIV, Hepatitis, SUDs, and mental disorders; linkages to and referral services; and client engagement through the lens of a patient-centric focus.

Results: In the first year of the TCE-HIV: Minority Women program 2,859 clients were screened using a trauma-informed approach showing a net reduction in risky behavior profiles in several stratifications including injection drug use (IDU, 32.0%) and unprotected sexual contact with an individual intoxicated

on some substance (25.9%). Likewise, TCE-HIV grantees (FY2012) facilitated risky behavior reductions such as IDU (57.1%) for 5,581 clients.

Lessons Learned: Behavioral health providers can deliver innovative and culturally appropriate services that promote collaboration between behavioral and physical health clinicians. Together they can design and implement integrated behavioral health and HIV care plans for patients. Linkages to and referrals for wrap-around and/or complementary services are necessary components to enabling patients to enjoy a quality of life supported through patient-centered care instead of their maladies.

CP97

Abstract 2177 - Prevention and Care Programs

Author(s): *Daniel Uhler, Lori Jones*

Issue: In 2010, as social media flourished, the County of San Diego (COSD) HIV prevention providers began using Facebook to engage and recruit participants for services. In 2012, to align with the National HIV/AIDS Strategy (NHAS) and CDC's High Impact Prevention (HIP) approach, prevention services shifted to target people living with HIV/AIDS (PLWHA). The COSD and prevention providers were challenged with redirecting efforts and posed questions related to the use of social media and technology: What is the best way to use social media and technologies and which venues are preferred (Twitter, Instagram, You Tube, etc.)? How to best reach PLWHA? Are smart phone applications (app) viable means to engage MSM? How to best track, evaluate and report efforts? What capacity do providers have and what were their concerns in using technology regionally?

Setting: The COSD is one of 61 local health jurisdictions (LHJs) in California. It is the 3rd largest county in CA and the 6th largest county in the US. The county stretches 65 miles from north to south and 86 miles east to west. The county consists of diverse populations, a large military presence and is located on the US/Mexico border, sharing the world's most active international border crossing (40 million crossings per year) with Tijuana, Mexico. The county includes a mixture of urban and rural communities, from coastal beaches to mountains and desert.

Project: The COSD contracted with Family Health Centers of San Diego who employs an in-house social media specialist to provide technological and ecological prevention (T&EP) services, including technical assistance to HIP providers throughout the county. The T&EP provider focused on: increasing provider capacity to employ technology to inform, engage and recruit participants into services; develop brand identity of providers specific for the diverse populations in each region; market agency websites using smart phone apps; and conduct search engine optimization for regional websites. John Snow Inc. provided assistance to assess provider capacity to use technology and provided training to HIP providers and community members active on social media to deploy videos of storytelling along the HIV continuum of care.

Results: Smart phone app banner ads yielded over 60,000 visits to HIP websites in 2014 with 25,873 in the 4th quarter of 2014 of which 48% were new users. These results were driven by banner ads on MSM networking smart phone app. Coordinating Facebook boosts to promote online sexual health assessment (oSHA) targeting MSM in each region yielded an increase in reach from 95 to 14,393 with

121 completing the assessment. Data will be presented to show how online activities contributed to recruitment of participants to individual and group level interventions

Lessons Learned: Coordination, county-wide, across agencies and target populations are essential to successful use of social media. Regular review and understanding of metrics and use of these metrics to drive what, where, when and how to use social media, is necessary. Also, it is important to engage active and visible community members. Tacking mechanisms were developed locally and will be shared for consideration for replication by other health jurisdictions.

CP98

Abstract 2211 - Prevention and Care Programs

Author(s): *Dongwen Wang, Monica Barbosu, Terry Doll*

Issue: With 154,000 individuals infected with HIV, NYS continues to have the highest cumulative HIV/AIDS cases in the nation. Among these, only 131,000 (85%) were tested and diagnosed as HIV positive, 85,000 (55%) were linked to care, 74,000 (48%) were under continuous care, and 60,000 (39%) were virally suppressed. Addressing the challenges in HIV care linkage, retention, and treatment adherence is critical to improve clinical processes and outcomes.

Setting: The NYS HIV LRTA program aims to link the newly diagnosed patients to healthcare system, to increase care retention, to promote adherence to antiretroviral therapy, and to achieve viral suppression. In the current five-year program period starting from July 2014, 12 clinical sites (Albany Medical Center, Anthony Jordan Health Center, Arnot Ogden Medical Center, Erie County Medical Center, Evergreen Health Services, Middletown Community Health Center, Nassau Health Care Foundation, North Shore University Hospital, SUNY – Stony Brook, SUNY – Upstate Medical Center, Trillium Health, Westchester Medical Center) and 1 data coordinating center (University of Rochester Medical Center) are awarded.

Project: The initial set of LRTA program measures include: 1) linkage – scheduling of the first visit for newly diagnosed patients within 30 days of confirmative HIV test; 2) linkage – completion of the first visit for newly diagnosed patients within 30 days of confirmative HIV test; 3) retention – new patients having a visit every 4 months over the 12 months measurement period; 4) retention – all patients having a visit every 6 months over the 24 months measurement period; 5) viral suppression – all patients being virally suppressed for over 3 months; and 6) viral suppression – Tier II patients being virally suppressed for over 3 months. With these standardized definitions of program measures, each clinical site queries its own local data systems, obtains the denominators and numerators for each measure, and submits them to a web-based data reporting system for the LRTA program.

Results: We have found a wide variety in the 12 clinical sites' data systems, ranging from the latest generation of electronic medical records to paper charts with data extraction to spreadsheets. Using the first 4 reporting periods as the baseline measures and pooling all clinical sites' data as the state-wide benchmark, we have found: 1) linkage – scheduling of the first visit is in the range of 67.65% - 88.46%; 2) linkage – completion of the first visit is in the range of 58.82% - 80.77%; 3) retention of new patients is in the range of 52.36% - 61.86%; 4) retention – global is in the range of 60.75% - 70.12%; 5) viral

suppression – all patients is in the range of 55.12% - 65.36%; and 6) viral suppression – Tier II patients is in the range of 27.05% - 59.22%.

Lessons Learned: The initial experience seems to indicate the feasibility for clinical sites to query the different data systems and to submit the standardized program measures. We will continue to work with all clinical sites to ensure data quality, to validate the program measures, and to analyze correlations with program activities/interventions.

CP99

Abstract 2229 - Prevention and Care Programs

Author(s): *Kim Peifer, Suzanne Cohen, Tina Penrose*

Background: Routine HIV testing in health care settings requires collaborative effort, including the ability to use Health Information Technology (IT) systems to document and report on testing. Under a grant with aims to support providers in the successful adoption and practice of routine HIV testing, an informative questionnaire focused on the electronic health record (EHR) was developed based on the experience of HIV routine testing implementation in various healthcare organizations.

Certified EHRs meet the standards for the user (hospital or practice) to be able to achieve Meaningful Use. Clinical quality measures (CQMs) are defined by CMS for providers and hospitals to collect, track, and report, and thus, certified EHRs are theoretically capable of tracking and reporting these measures in their “out-of-the-box” form. [2]

The offer rate and the acceptance of/consent to routine testing require fields that are not traditionally available in the “out-of-the-box” EHR. There are no CQM measures related to routine screening, therefore most EHRs have limited ability to capture and report these data without customization.

The goal of this project is to increase understanding in how the respondent’s EHR and change management processes can either support or hinder routine HIV testing.

Methods: Qualitative information was collected through semi-structured interviews with current and previous partners of the grant. Interviews focused on general practice information, technology systems (EHR and any reporting systems), capabilities of staff and consultants in relation to the EHR, and the workflow specific to routine HIV testing. Interviews were conducted with 9 sites, and across 5 EHRs, including primary care clinics as well as hospitals (ED and Inpatient). The EHRs included in case studies are: NextGen, WellSoft, eClinicalWorks, Cerner, and Centricity. Additionally, a healthcare technology consultant was interviewed regarding the ability to configure, customize, and collect the data of interest on the EHRs studied.

Results: Information collected from interviews was used to develop, an annotated assessment tool to identify the ability of the practice to implement routine HIV testing. The assessment and related case studies direct providers in understanding and planning infrastructure changes necessary to accurately document and track routine testing offer rates and acceptance rates.

Conclusions/Implications: The intended use of this tool is to guide healthcare organizations through assessment of their capabilities in tracking routine HIV testing offer and acceptance rate, and to understand their ability to make technology supported changes in workflow. The scope of this understanding includes a combination of factors, including the policy landscape, the EHR system used, the infrastructure of the EHR system, workflow, staff capacity, and change management processes. These factors contribute to the effective implementation of routine HIV testing, and the effective use of the EHR as a tool in clinical decision support, workflow, and reporting. Given the encompassing findings, use should not be limited to only the EHRs studied, as the questions asked and implications of responses are pertinent to making effective changes in any organization.

 

CP100

Abstract 2273 - Prevention and Care Programs

Author(s): *Marlene Matosky, Emily Chew, Michael Hager, Clemens Steinbock, Lori DeLorenzo*

Issue: The National HIV/AIDS Strategy and HIV Care Continuum Initiative provide frameworks to assess progress toward achieving viral suppression and reducing disparities. Additionally, the Ryan White HIV/AIDS Program (RWHAP) Moving Forward framework identifies the critical tools needed in order to reach zero new infections. Despite these frameworks, many jurisdictions experience gaps at each stage of the HIV care continuum.

Setting: Based on the Institute for Healthcare Improvement Breakthrough Series Collaborative, the Health Resources and Services Administration HIV/AIDS Bureau funded a collaborative in 2014 to reduce gaps along the HIV Care Continuum through the implementation of evidence-based quality improvement projects. This collaborative, called the HIV Cross-Part Care Continuum Collaborative, engaged RWHAP grantees across Parts A-D in 5 states. Leveraging work in all five domains of the RWHAP Moving Forward framework (service delivery, policy, assessment, capacity development and quality), state teams aim to increase statewide retention and viral suppression and to decrease disparities in performance for key demographic groups.

Project: The HIV Cross-Part Care Continuum Collaborative has 3 aims: 1) build regional capacity for closing gaps across the HIV Care Continuum; 2) align quality management goals across all RWHAP Parts to jointly meet legislative quality management mandates; and 3) implement joint quality improvement activities to advance the quality of care for people living with HIV and to coordinate HIV services seamlessly across the state.

Collaborative participants include all RWHAP grantees within 5 states, reaching 33,905 people living with HIV. Each state established a leadership team to implement activities and received professional coaching to accelerate implementation. Performance data on key HIV measures, including stratification by demographics, are analyzed routinely. Each state developed an HIV care continuum and performed analyses to determine similarities and gaps compared with RWHAP data. Each state also identified a cohort of clients not achieving viral suppression to be followed over the course of the collaborative. Evidence-based improvement strategies are collected and discussed at learning sessions. To ensure longevity of the initiative beyond 2015, sustainability plans are being drafted by each state team that

will include the collection and dissemination of data, sharing of evidence-based improvement strategies, regional trainings, and virtual learning sessions.

Results: Across the 5 states, there have been improvements in antiretroviral therapy prescription and viral load suppression. Successful improvement strategies implemented by each state team will be discussed. By the initiative mid-point, one state met its viral suppression cohort goal (88%, n=602 additional people living with HIV achieved viral suppression). Overall, the Collaborative has already met key national aims and facilitated communication and sharing across federally funded HIV providers. Differences in performance between demographic groups have been steadily narrowing over time.

Lessons Learned: Collaboratives are effective models to address gaps in the HIV Care Continuum and to create statewide momentum for advancing HIV care. It is important to assess state-specific data quality and communication issues ahead of implementation. Coaching of the state teams is most intensive at the initiation of the collaborative and with the roll out of new tasks.

CP101

Abstract 2277 - Prevention and Care Programs

Author(s): *Jomar Lopez, Kirsty Gutierrez, John Faber*

Issue: Hot, healthy & keeping it up, renamed Impac+, is the core curriculum for a one-time facilitation designed for HIV+ men who have sex with other men (MSM). Its goal is to promote sexual behaviors that prevent the spread of HIV within Hillsborough and Pinellas counties in Florida. The intervention has been in place since March 2013 and continues to serve HIV+ MSMs today. Since its implementation and multiple recruitment efforts IMPAC+ has assisted in strengthening linkages of all its participants to medical care, mental health and/or case management. Despite its successes, IMPAC+ requires additional strategic planning to reduce disparities that limit an HIV+ MSM's desire to continue care.

Setting: All program facilitations occurred on-site at Metro Wellness and Community Centers

Project: Participants were recruited through multiple methods: social media, client referrals, and HIV+ peer advocate networking. Due to the different lifestyles of all clients, the facilitators tailored the intervention towards factors that encouraged enrollment and participation like time, vocabulary change, and incentives. All HIV+ MSMs in Impac+ completed a Behavioral Risk Assessment prior to participation. The facilitator made the necessary linkages based on the participant's history of leadership, mental health, medical care, and case management as indicated on the assessment. A brief follow-up was done with staff in each department to check on a client's progress.

Results: The discussion's quality within group meetings was strengthened after incorporating an HIV+ peer advocate. Outcomes such as recruitment increased once the benefits of social media were recognized. Vocabulary was changed so participants did not feel they were attending a support group. Examples of new vocabulary include: social, meetup, and get-together versus group, meeting, and seminar. However, several participants stated hesitations to attend group because the community perception is that Metro is an HIV agency. Participants who were encouraged to recruit friends were

successful in bringing additional people living with HIV, and later incentivized for their dedication. Finally, the trust built during meetings motivated clients to continue care and access services.

Lessons Learned: A peer advocate enhances the discussion's quality and provides a relatable individual that acts as a role model for HIV+ MSMs. Additionally, dating apps such as Grindr are an effective recruitment tool. However, recruitment is limited to the application's terms and agreements. Incentives are an effective motivator for enrollment. Frequent meetings in public settings may increase enrollment; nonetheless public settings may inhibit effective communication since some participants fear their status will be publicly disclosed. As previously described, the participants expressed interest in returning to the group. As it stands, the intervention currently allows for previous participants to return and continue expressing their thoughts about living with HIV, which has displayed positive outcomes. Furthermore, because young MSMs do not interact well with older MSMs additional strategic planning must tailor the intervention to young MSMs. Moreover, perhaps age differences contribute to a young MSM's apprehension in attending Impac+. Overall, within the gay and bisexual community exists different issues that lie among the stigma spectrum and hinders the progression of preventative efforts.

CP102

Abstract 2402 - Prevention and Care Programs

Author(s): *Michele Keogh*

Issue: The need exists to fast track Young Minority MSM (YMSM) and other men who have sex with men (MSM) that are ready into substance use disorder treatment, and to provide pre-treatment services for those not yet ready to enter treatment. Moreover, the need exists for these clients or potential clients to receive HIV and HCV testing, and to assure those testing positive are both referred for medical services, and to have their treatment adherence monitored.

Setting: The Long Island Association for AIDS Care, Inc. (LIAAC) Project Safety Net's (PSN) mission is to strengthen its capability of providing culturally competent and effective treatment systems for substance use disorder within racial and ethnic minority communities. PSN has an ongoing goal of preventing and reducing the transmission of HIV, viral hepatitis and other infectious diseases through prevention education and testing services.

Project: YMSM and other MSM who are ready for treatment immediately receive an appointment with a substance use disorder treatment program. Those individuals who are not ready for treatment are enrolled into the Brief Strength Based Case Management (BSBCM) program. PSN provides HIV and HCV testing. All clients who test HIV-positive are linked to a medical provider and referred to LIAAC's Ryan White case management program. Program staff monitor HIV-positive clients' treatment adherence. LIAAC is currently partnered with Economic Opportunity Council (EOC) of Suffolk, a CBO serving low-income and minority individuals. LIAAC is also partnered with Seafield Services, the leading provider of substance use treatment across Long Island.

Results: The program encountered 2,443 YMSM and other MSM within the first two-and-a-half years. For these individuals, 25,323 condoms were distributed, 660 HIV, 284 HCV and 247 HBV tests were administered; and 1359 community referrals were made to substance use disorder treatment, social

services, medical care, mental health programs, local public assistance, Medicaid, housing, and legal services. A total of 322 GPRA baselines were completed, while 44 individuals were fast-tracked into treatment, and 120 clients were enrolled into BSBCM program.

Lessons Learned: Out of 284 YMSM individuals tested for HCV, 13 were positive, a 4.6% positivity rate. Out of 322 assessments, 44 clients were fast-tracked into treatment. Program staff report barriers such as lack of motivation, familial issues and housing stressors prevent individuals from receiving substance use disorder treatment.

CP103

Abstract 2424 - Prevention and Care Programs

Author(s): *Randal Leggett, Yue Huang, Seema Gai*

Issue: Retention in care has remained a pivotal aspect in preventing an AIDS diagnosis among people living with HIV (PLWHA). Poor adherence to scheduled primary care appointments has been associated with negative health outcomes among HIV patients. One such outcome is viral load suppression, which is also a primary focus for preventing the spread of HIV.

Setting: The HIV Continuum of Care is a model for assessing the care and treatment of PLWHA. The model has been adopted by many prominent state and federal agencies for its ability to quickly convey five important measures of HIV care: HIV diagnosis, linkage to care, retention in care, prescription of antiretroviral therapy, and viral load suppression. Individual healthcare organizations and clinics have struggled to apply this tool to their own patient populations. This urban HIV clinic, located in New Orleans, Louisiana, adopted the Continuum of Care for assessing its primary care clinic performance with slight modification to accommodate the clinic population.

Project: The Clinic used a modified Continuum of Care beginning between the second step (linkage) and third step (retention), which is often referred to as engaged in care. Reports were built using business intelligence software that tap into real-time data generated by the Clinic's Electronic Health Record. The data were used to create the Clinic's Continuum of Care and assess the relationship between retention rates and specific demographic factors, such as age, gender, race and ethnicity, federal poverty level, and health insurance status. These data were used to design a performance improvement project with the goal of improving retention rates among a specific subset of the population.

Results: At the time of analysis, 81.1% of all primary medical care clients were retained in care and 70.3% met every step in the Continuum and achieved viral load suppression. The Clinic identified patient age group ($p = 0.01$), race and ethnicity ($p = 0.01$), and health insurance status ($p < 0.01$) as being strong predictors of retention in care rates. A notable finding was patients between ages 12 and 24 were 2.15 (90% CI: 1.02, 4.53) times as likely to not be retained in care as compared to patients age 45 and older. Therefore, youth patients were targeted for a currently-ongoing intervention project with the goal of improving retention in care rates. Clinic staff are also collaborating with state and local AIDS Service Organizations through the Louisiana Clinical Quality Group to re-engage patients that have fallen out of care.

Lessons Learned: Adoption of the HIV Continuum of Care by healthcare agencies and clinics is beneficial in many ways. Its application at this HIV Clinic assisted in gap analysis and elucidated areas for targeted care interventions. The tool can be used by clinics to compare their efforts against national averages as well as other healthcare organizations and clinics. Continued utilization of the tool is also useful in identifying emerging trends and monitoring the impact of ongoing improvement projects.

DP08

Abstract 1710 - Partnerships, Community, Communication, and Mobilization

Author(s): *Eric Wagner, Melissa Howard, Juliette Graziano, Michelle Hospital, Staci Morris*

Issue: Hispanics experience serious health disparities related to HIV/AIDS; a lack of culturally appropriate, evidence-based prevention may contribute to this disparity. Growing evidence supports the effectiveness of social media to influence health behaviors; little is known regarding social media impact on HIV prevention among Hispanic young adults.

Setting: South Florida rates of HIV infection are alarmingly high; the Miami metropolitan area ranks first in the nation in HIV diagnosis and AIDS case rates (CDC, 2014). In Florida, 17% of all new HIV infections reported in 2012 were among persons under the age of 25. Miami has an active nightlife and is consistently voted as the #1 party city in the US (US News and World Report, Maxim).

Project: The “Miami-Dade Partnership for Preventing Health Risks among Young Adults” brings together (a) Florida International University (FIU)-a large Hispanic serving institution (b) two CBOs- Union Positiva, and Spectrum Programs, (c) Mixto Music- a high visibility Hispanic market media production company, and (d) Dieste- the largest Hispanic market advertising company in the US. The project’s goal is to reduce HIV/AIDS among Hispanic young adults in Miami-Dade through culturally-tailored, integrated HIV prevention. One strategy includes a media advocacy/awareness campaign to increase point-of-care HIV/HCV testing. The first phase of the social media campaign was launched during the Miss Universe contest where our spokesperson, Miss Hivaria, representing a fictitious country symbolizing the 35 million people with HIV worldwide, created meaningful and engaging social conversations on Twitter, Instagram and Facebook.

Results: In one week, the #MissHivaria campaign received 1,300 Facebook likes, reached 800 people on Instagram and 80 people on Twitter. Miss Universe contestants showed support for the campaign by promoting the hashtag and retweeting messages. Timing coincided with FIU’s HIV testing Valentine’s Day outreach. In 2015, after the campaign’s launch, 320 students were tested, representing a 43% increase from 2014 and a 592% increase from 2013. In September, 2014 FIU, HIV testing outreach resulted in 91 students tested. The 320 students tested in February 2015 represents a 352% increase.

Lessons Learned: Numerous lessons were learned regarding collaboration with production and marketing companies in the design, launch, impact, and evaluation of social media campaigns. Marketing and production companies bring a level of creativity, technical expertise, and networking capacity typically outside the realm of expertise of HIV researchers and CBOs. Regarding the evaluation of social media campaigns, the project provides opportunities to better develop and understand social media indicators and metrics, and develop benchmarks for success. The goal of using social media was

to increase exposure and extend messaging reach in order to increase HIV testing; results reveal a high degree of success.

DP26

Abstract 5133 - Partnerships, Community, Communication, and Mobilization

Author(s): *Jacqueline Coleman, Kimberly Parker*

Issue: Despite advances in prevention, care and treatment, the overall rate of new HIV infections in the United States continues to impact several at-risk groups. The National Minority AIDS Council (NMAC) strives to end the HIV epidemic through its mission to educate, advocate, collaborate and compel –with urgency- for dramatic progress to close health gaps in communities of color in a tireless quest to end HIV. The Youth Initiative Program was developed as a way to engage future scholars in effective community engagement by implement evidence-based, sustainable programmatic efforts. This presentation will discuss the development and implementation of the Youth Initiative Program as a HIV prevention strategy.

Setting: The Youth Initiative Program brings together a national cohort of future leaders, or Youth Scholars to participate in a 12-month comprehensive program. Scholars complete professional development and educational activities, and implement HIV prevention programs within their respective cities and states.

Project: The goal of the NMAC Youth Initiative Program is to develop future leaders among a cadre of Youth Scholars to take action to end HIV/AIDS in their communities through educational trainings, and professional development and networking opportunities. Youth Scholars also cultivate skills needed to formulate a research proposal and community oriented activities rooted in evidence-based and best-practices strategies, and explore funding and career opportunities to sustain these efforts. Youth Scholars attend the US Conference on AIDS to commemorate the start of the program, and are then paired with previous scholar and professional mentors for guidance. Youth Scholars are also required to create, implement and evaluate a project for World AIDS Day. Process and impact evaluation components are embedded throughout the program and included pre/post assessments, digital storytelling and journaling.

Results: Evaluation and assessment activities are used to asses demonstrated measures of increased knowledge among HIV/AIDS prevention strategies, research concepts and program planning and evaluation. The evaluation also assesses self-efficacy towards utilizing social media techniques in reaching over 70,000 additional peers within the Youth Scholar’s social networks.

Lessons Learned: The NMAC Youth Scholar’s Program provides information on effective techniques and methods for how to develop and augment educational programs with leadership implications among a cohort of youth. Program participants also engage in community mobilization activities targeting HIV prevention for youth across the US.

DP27

Abstract 5116 - Partnerships, Community, Communication, and Mobilization

Author(s): *Ronald Braithwaite, Cassandra Collins, Rhonda Holliday, Tiffany Zellner, Tiffany Aholou, Nzinga Harrison, Stephanie Lee, Jean Bonhome, Fahruk Akinleye*

Issue: A significant barrier to HIV prevention among African Americans is the lack of awareness of HIV status. According to the 2013 Georgia HIV/AIDS Surveillance Summary, 68% of individuals living with HIV identify as African-American, there were 1,294 persons newly diagnosed with HIV in 2010 and up to half of new infections were in youth and adults aged 16-24.

Setting: Zip codes 30314, 30310 and 30318 were in the top ten zip codes in Georgia for HIV infection. These zip codes encompass the Atlanta University Center (AUC) where six Historically Black Colleges and Universities (HBCUs) are clustered, and serve as the emphasis population for the College and Community HIV and Addiction Prevention (CCHAP) program, a collaborative HIV service and prevention project between Morehouse School of Medicine (MSM) and Recovery Consultants of Atlanta (RCA) that utilizes targeted community outreach as a method of promoting HIV testing and addiction prevention.

Project: CCHAP established partnerships with college campuses and the surrounding community to implement HIV testing and substance abuse prevention activities. Well trained staff and peer specialists canvass locations where young adults, 18-24 frequent, including college campuses, fraternities/sororities, malls, churches, community centers and health centers. During testing sessions, counselors identify risk for HIV and substance use disorders using standardized screening tools and motivational interviewing to discuss personal risk behaviors, identify safer goal behaviors and develop action plans with participants. CCHAP employs environmental strategies including hosting college and community events in celebration of national HIV awareness activities and provision of condom machines placed throughout the college campuses.

Results: Within 14-months of launching our HIV testing initiative, CCHAP conducted 1,435 HIV tests. Of those tested, 49% were from the colleges and 51% from the community. The ages ranged from 14y-74y (M=29) with 56% between the ages of 18y-24y. The majority identified as non-Hispanic African Americans (98%); male (56%); and as heterosexual/straight (82%). Although, over 80% of clients were classified as high-risk (reporting 2 or more sexual risk behaviors), 26% had never been tested for HIV. The most common risk behaviors in the past 12 months were unprotected sex (66%), unaware of partner's HIV status (48%); 25% used marijuana use (25%); and binge drinking (16% and 20%, respectively for females and males). Twelve tested positive, seven were newly diagnosed and linked to HIV treatment.

Lessons Learned: The CCHAP project has been successful at reaching high-risk individuals in both the college and community settings by targeting a high-risk geographic area and employing a three-prong model which includes educational, peer and environmental strategies. Uniquely, CCHAP strategy aims to link college students to the surrounding community by inviting them to serve as peer educators both for college peers and for age-matched community peers. At the conclusion of the three-year project, CCHAP seeks to use comparative data-analysis to evaluate the effectiveness of collaborative college and community prevention strategies for increasing awareness of HIV and addiction risk.

EP04

Abstract 2003 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Shamir Gates, LaDaryl Watkins, Deja Abdul-Haqq, Henry Fuller*

Background: In March 2011, the enactment of Mississippi House Bill 999, a dual-option (abstinence-only or abstinence-plus) sex education mandate required all Mississippi public school districts to implement either Abstinence-Only or Abstinence-Plus (comprehensive) education, beginning in the 2012-13 academic year.

Methods: When identifying the adoption and implementation of state-mandated abstinence-only or abstinence-plus (comprehensive sex education) policies in school districts across the nation, My Brother's Keeper, Inc. conducted a policy scan of state and national policy briefs, reports, peer-reviewed journals and news articles, telephone requests, and online resources from a variety of sources. These include sexual health researchers and centers and organizations such as: State Department of Education, State Department of Health; National Campaign to Prevent Teen and Unplanned Pregnancy; Sexuality Information and Education Council of the United States (SIECUS); Social Science Research Center of Mississippi State University; National Association of State Boards of Education; National Conference of State Legislatures; and National Coalition to Support Sexuality Education.

Results: Of the 155 Mississippi school districts, 81 have adopted an abstinence-only sex education curriculum, 71 adopted Abstinence-Plus, and the Mississippi Board of Education chose abstinence-plus for the three specialty schools it governs.

Conclusions/Implications: The passing and implementation of Mississippi House Bill 999 was a big step in the right direction to improve the health of young people in Mississippi. Unfortunately, a limited number of Mississippi School Districts adopted an Abstinence-Plus policy that allows instruction to address a broader range of sexual health topics, such as contraceptive methods, sexually transmitted diseases (STDs), and STD/HIV prevention. Curriculum-based, comprehensive sex (abstinence-plus) education, which involves instruction that includes a focus on abstinence, as well as inclusive information about contraception and sexually transmitted diseases, has been shown to delay sexual activity, improve contraceptive use among sexually active teens, and/or prevent teen pregnancy.

EP12

Abstract 1965 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Allison Vertovec, Alex Leigh*

Issue: Louisiana has continuously ranked at the top of state infection rates for HIV and AIDS as well as Syphilis, Chlamydia and Gonorrhea, with New Orleans having the highest rates statewide. Three years ago the Office of Public Health rolled out a demonstration project to support Community Based Organizations, including the NO/AIDS Task Force (NATF) d.b.a. CrescentCare, to provide comprehensive STD testing and treatment for Men who have Sex with Men (MSM) and Transgender clients at a Wellness Center (WC).

Setting: The WC operates out of two satellite offices of NATF where other MSM focused prevention programs are housed. One of the sites, the CAN office, has been in existence for 15 years and is a known

and trusted source for HIV testing and other services, specifically amongst MSM. STD testing is offered M-Th between the two sites over a variety of times.

Project: The project started on a small scale with an average of 5 clients per week, during limited hours. STD tests are offered on an opt-out basis, with site-specific Chlamydia (CT) and Gonorrhea (GC) testing highly encouraged (rectal, pharyngeal and urethral). Electronic Medical Records are used for all elements of the clinic, which has improved record keeping and follow-up.

Results: The program has seen continuous growth in the number of clients it has seen since its inception. During 2012-2013, the agency saw just over 100 clients for the WC. In the 2013-2014 year, a total of 350 clinic visits were documented. The most recent report from the Office of Public Health notes that a total of 414 clinic visits occurred between 7/1/2014 and 3/31/2015 (75% of the contract year). HIV testing was performed with the least frequency because many clients were referred to the WC from HIV testing services. There were 227 HIV tests performed, with 6 (3%) identified as positive. The agency performed 360 syphilis tests, with 49 (14%) reactive tests. There were 394 oral CT/GC tests performed with 48 (12%) positives, 379 rectal CT/GC tests with 73 (19%) positives, and 372 urine CT/GC tests performed with 21 (6%) coming back positive. The agency works closely with its primary care department and DIS to offer partner notification and quick access to treatment for identified infections.

Lessons Learned: By offering services that are comprehensive, yet non-judgmental in a community based setting, the WC has become a trusted resource for MSM who are at-risk for STDs and HIV. Operating outside of traditional hours meets the needs of many clients. Furthermore, had most of these clients only receive a 'standard' urine test for CT/GC, the majority of infections would have gone undiagnosed and untreated, thus increasing biological risk for HIV contraction. Additionally, many of the clients indicate they are on private insurance plans, so while the community appreciates getting free services, it is likely in the agency's and state's best interest to investigate ways to implement third party billing in order to sustain the program.

EP16

Abstract 5033 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Dulce Dones-Mendez, Andee Krasner*

Issue: Public funding for HIV and STD clinical services has been flat or in decline over the past five years, making it more difficult for traditional safety net providers to ensure access to HIV and STD services. Provisions in the Affordable Care Act, including increased insurance coverage and ensuring essential community providers are included in qualified health plans, may make billing third-party payers a viable complement to grant funding for essential community providers, including STD clinics.

Setting: The Connecticut (CT) DPH funded JSI, a non-profit public health consulting firm, to provide billing training and technical assistance (TA) to seven CT local health departments providing free clinical STD services. The Clinics were approached to consider initiating billing third-party payers for HIV and STD services.

Project: JSI worked with seven small (<1000 annual visits) CT STD Clinics to do a forecast revenue projections for billing third-party payers. For STD clinics that were interested, JSI also provided training and TA to develop billing systems, such as development of a superbill and billing policies, coding support, third-party contracts, and changing clinic flow to accommodate billing.

Results: From January 1, 2015 through June 30, 2015, JSI did revenue projections for seven CT STD clinics who agreed to do them. Clinics were asked to provide payer mix information about their patients, including the percent that had Medicaid, private third-party payers, and uninured. They were also asked to provide the number of annual visits and the percent of new and established patients. Because these STD clinics did not bill, JSI estimated the distribution of patients by Evaluation and Management CPT Codes. National averages for Medicaid reimbursement were used to estimate Medicaid reimbursement, and national average Medicare reimbursement rates were used to estimate private third-party payer reimbursement.

N=7

Range of annual visits: 400-737

Range of reported Medicaid coverage: 13%-37%

Range of reported private third-party payer coverage: 17-25%

Range of expected revenue in year 1 (billing Medicaid only): \$4,782- \$11,438 +/-20%

Range of expected revenue in year 2 (billing Medicaid and other third-party payers): \$5,503- \$16,927 +/-20%.

Lessons Learned: The first year projected revenue, of less than \$12,000, was not sufficient for the majority of clinics to decide to initiate billing. The low numbers of annual visits, reimbursement, and coverage rates resulted in a small amount of income from third-party billing. Only two of the seven clinics decided to consider billing. The other five clinics did not find the revenue projections compelling enough to request billing TA, but this does not preclude them from billing in the future. While projected revenue was not remarkable to the personnel of the STD clinics, the circumstances of CT local health department STD clinics may not be representative of other small STD clinics in other settings; others may find that revenue from third-party payers will offset costs and be a compelling reason to initiate billing.

TUESDAY, DECEMBER 8 | ROUNDTABLE SESSIONS | 7:30 AM – 8:15 AM

Track B

Session BR05 - Social Determinants of HIV Risk & Treatment Outcomes: Is It Possible to Design, Implement, and Sustain Structural Interventions?

Room: Edgewood (Hyatt Regency Atlanta)

Abstract 2535 - Social Determinants of HIV Risk & Treatment Outcomes: Is it possible to Design, Implement, and Sustain Structural Interventions?

Author(s): *Chinekwu Obidoa, Tiarney Ritchwood*

Issue: ISSUE: HIV is among the leading causes of death for youth worldwide, with HIV-related deaths more than tripling between the years 2000 and 2012. Over the thirty-year history of HIV prevention efforts, the majority of research studies have focused on modifying individual-level risk behaviors. In recent years, however, there has been a call for research aimed at understanding and addressing the influence of broader contextual factors on soaring HIV rates among vulnerable populations.

Key Points: KEY POINTS: The persistence of the HIV epidemic requires the examination of social determinants of HIV risk and resilience, acknowledging that structural conditions of daily life create social determinants of HIV and are critical to explaining inequities in treatment outcomes. Social determinants include socioeconomic status; access to health care and education; opportunities for work and recreation; condition of housing, communities, and rural or urban settings; and chances of leading a fulfilling life. Structural determinants, on the other hand, govern the manner in which services are provided and accessed thereby shaping HIV outcomes. Understanding social and structural determinants of HIV outcomes may provide insight into why marginalized groups continue to be disproportionately impacted by HIV. The facilitators will review the research on socio-structural determinants of HIV treatment outcomes and provide a summary of recommendations regarding ways to address socio-structural factors in HIV intervention programs. The session will conclude with a discussion on the considerations required in designing multilevel interventions with socio-structural components and the feasibility and sustainability of such methods in a strained funding climate.

Implications: IMPLICATIONS: With mounting evidence showing that HIV knowledge is insufficient to prevent associated risk behaviors; and that individual-level interventions have not effectively curtailed the tide of the epidemic, there is a strong need to understand and identify factors that underlie socio-structural determinants of HIV outcomes in order to design effective and sustainable interventions. Such interventions will call for novel and creative approaches to engaging communities, stakeholders, and governing bodies, particularly in resource-limited settings.

Session BR06 - Reaching Adolescent MSM: How Do we Find and Engage them in Prevention?

Room: Courtland (Hyatt Regency Atlanta)

Abstract 2118 - Reaching Adolescent MSM: How Do we Find and Engage them in Prevention?

Author(s): *Lisa Barrios, Richard Dunville*

Issue: Young MSM, particularly Black and Latino young MSM, carry a significant portion of the HIV burden, suggesting a need to strengthen prevention efforts earlier in the life course, particularly among adolescent MSM (AMSM) (i.e., MSM 18 years old and younger). For reasons including evolving sexual identity, less connection to a “gay” community, greater internalization of sexual minority stigma, lack of disclosure to others, need for parental consent, and lack of transportation, there is little research focusing on AMSM, and existing research focusing on older MSM has limited applicability.

Key Points: Adolescence is a distinct phase of life that is subject to vast changes in physical, cognitive, psychological, interpersonal, and ecological processes. It is a time of increasing identity development, including a more defined sexual identity that is often associated with changes in social relationships and psychological self-perceptions. It is also an important time of transitions in family, peer, and romantic relationships; work; education; and self-autonomy. These coinciding changes make it unlikely that HIV prevention efforts aimed at adult populations will adequately address the unique needs of adolescents. The experience of being adolescent, MSM, and a racial/ethnic minority calls for distinctive set of research questions and programmatic strategies. Little is known about attitudes and behaviors that could aid access to, acceptability of, and adherence to promising biomedical HIV prevention interventions. Further, there are outstanding questions about acceptability of common prevention strategies, such as HIV and STD testing.

The field needs to explore ways to improve reach to this vulnerable, difficult to reach, and understudied population. For instance, could online recruitment, intervention delivery, or evaluation increase the likelihood of participation as compared to other places where this population might be found (e.g., schools or CBOs)? Likewise, increased understanding of the role of protective factors, such as positive attributes (e.g., future goals), family factors, relationship dynamics, and social contexts (e.g., education attainment), could support intervention attempts that move beyond the individual level to address structural, community, network, and dyadic factors.

The facilitators will summarize a recently funded project to increase understanding of how to reach and engage AMSM. The project includes development and pilot testing of a questionnaire to assess how AMSM currently get information and want to get information about sexual health services. The project will also test methods for recruiting AMSM to participate in formative research and will create tools to better serve AMSM. The facilitators will lead a discussion asking roundtable participants to share successes and failures to improve our understanding of how to reach and engage adolescent MSM.

Implications: New tools and guidance are needed for public health practitioners trying to work with AMSM to prevent HIV. This roundtable will open a discussion of ways to build on the unique individual, interpersonal, and social characteristics of AMSM to provide appropriate context to HIV prevention efforts. By sharing their experience, participants will come away with an enhanced understanding of the challenges of recruiting and engaging AMSM and promising methods for overcoming these challenges.

Session BR07 - Trans Women and Pre-Exposure Prophylaxis (PrEP): An In-Depth Discussion

Room: Baker (Hyatt Regency Atlanta)

Abstract 1871 - Trans women and pre-exposure prophylaxis (PrEP): An in-depth discussion.

Author(s): *JoAnne Keatley, Jae Sevelius, Greg Rebchook, Danielle Castro*

Issue: A meta-analysis of 29 studies from 15 countries found that trans women are 48.8 times more likely to be HIV infected than other adults of reproductive age (Baral et al., 2012). Furthermore, the Baral et al. study reported an estimated HIV prevalence of 22% among trans women in the United States. Given the high rates of HIV infection among trans women, the absence of trans-specific PrEP data is a glaring oversight in biomedical HIV prevention. The first comprehensive clinical practice guidelines for PrEP were released by the US Public Health Services in May of 2014, but only briefly mentioned trans women. Additionally, the iPrEx study presented in 2011 at the International AIDS Society Conference included 296 (12%) participants identified as transgender and 29 (1%) participants identified as a woman of 2,499 total participants in iPrEx (Grant et al., 2015). Findings showed no significant difference among trans women who used PrEP compared to trans women not using PrEP, meaning that PrEP had no significant impact on reducing HIV infection among trans women enrolled in the study (Mascolini et al, 2011; Grant et al, 2015).

Key Points: Although trans women continue to be disproportionately impacted by HIV, there is little to no guidance available for the use of PrEP. CBOs and clinics have been encouraged to advocate for the use of PrEP for high-risk trans women throughout the United States, even in the absence of data. This seminar will increase the capacity of CBOs and clinics to better understand the background, current practices, and community perspectives of PrEP for trans women.

Implications: This discussion will provide an opportunity to discuss issues of PrEP acceptability and uptake among trans women in the US through the following:

- The Center of Excellence for Transgender Health (CoE) will present focus group findings of PrEP knowledge and acceptability among trans women.
- Community Healthcare Network (CHN), a federally qualified health center in New York, will discuss barriers and facilitators for PrEP linkage and adherence among trans women in their clinical practice.
- A panel of HIV positive trans women and trans people at risk for HIV will provide current community perspectives regarding the use of PrEP with an opportunity for Q&A by seminar attendees.

Track C

Session CR11 - License to Bare-back: PrEP, Pleasure, and the Politics of Risk

Room: Kennesaw (Hyatt Regency Atlanta)

Abstract 2200 - License to Bare-back:PrEP, Pleasure, and the Politics of Risk

Author(s): *Michael Diaz*

Issue: Over the course of 30 years, research and science have transformed the HIV landscape. High Impact Prevention, biomedical interventions, and continuum of care are buzz words which have flooded public health discourse and prevention messaging. Among these waves of conversation and frameworks exists risk compensation. Risk compensation in the field often manifests as the negation and policing of behaviors deemed high risk, i.e. “always use a condom,” “don’t use substances,” “don’t have sex,” “have less sex.” These messages often omit the role of desire and pleasure; powerful components of human experience and interaction making it at times difficult to treat the whole person instead of just parts of them. As Providers, it is important to be critical of existing public health paradigms and the role they play in overall health outcomes. Accordingly, how do we shift from continuing centering discussions on pathology to incorporating discussions on pleasure as socially responsible practice that is client-centered?

Key Points: Among Latino MSM, bare-backing (condom-less anal intercourse) is a reality and the choice of many, a part of the arsenal of pleasurable sexual activities despite individual’s knowledge, awareness, and intentions to practice safe sex. Furthermore, research has shown that even though Latino MSM are well aware of prevention strategies they still engage in behaviors deemed high risk (Diaz, M.R. Ayala, G., 1999). Although current CDC guidelines stipulate PrEP should be part of a comprehensive prevention plan, science tells us it works regardless of a condom not being present. This roundtable discussion will explore ideas regarding socially shared meanings and subjective experiences of PrEP consumers who may dissent from dominant discourses and definitions of safe sex (i.e. condoms every time in conjunction with PrEP) as the only acceptable form of prevention for high risk negatives. Knowing the importance of holistic approaches to improve and sustain positive health outcomes, how do we create spaces for Providers and the communities they serve to support and engage collaboratively in conversations inclusive of sex, pleasure, desire, and safety? These spaces can serve as platforms to assess community values and needs to inform the interventions designed and delivered with them in mind. Additionally, these spaces may serve as conduits for social change as we think about nuanced and strength-based perspectives to address pervasive health disparities and inequities of vulnerable populations.

Implications: As service providers, it is imperative to think critically about the approach, the language, and messages we are using to inform the communities we serve about PrEP. Recognizing, empathizing, and validating diversified sexual expressions and interrogating static notions of risk is vital to the role of establishing client-provider relationships and part of the client-centered approach. Through a ‘HIP’ lens participants will explore and discuss culturally competent, cost effective and scalable interventions that shift the focus of structural interventions from pathology to practicing pleasure and wellness. Participants will also unpack the role of pleasure and desire in prevention messaging in addition to exploring intimacy and connection as values of priority populations.

Session CR12 - Implementing PrEP in the Real World: From Theory to Practice through Community-Based Pilot Initiatives

Room: Inman (Hyatt Regency Atlanta)

Abstract 1878 - Implementing PrEP in the Real World: From Theory to Practice through Community-Based Pilot Initiatives

Author(s): *Barry Callis*

Issue: In Massachusetts, gay and bisexual men and other men who have sex with men (MSM) represent 60% of HIV cases diagnosed among men between the years 2011 and 2013 and 43% of all HIV cases diagnosed during this same period. Gaining momentum to prevent new HIV infections will require careful selection of the right mix of high-impact and evidenced-based prevention and care approaches.

Key Points: PrEP unites the goals of the National HIV/AIDS Strategy (NHAS) and our local Massachusetts State HIV/AIDS Plan, including promoting health equity. PrEP is a gateway to engage gay and bisexual men in primary care and as a way to advance a broader approach to behavioral and sexual health through a network of 6 community health centers and 2 urban safety net hospitals. Pilot PrEP implementation activities included an assessment of funded provider capacities, data collection, identifying supports and responding to challenges, ongoing community engagement, and learning from real-time experience. Pilot sites identified a physician lead and primary prescriber, a patient support team (including a nurse, social worker, health navigator, and/or case manager), and agreed to develop and share protocols to offer PrEP in primary or specialty care.

Implications: This session will focus on lessons learned from a PrEP implementation pilot to increase capacity in the field to deliver this intervention. It will also focus on efforts to build awareness, promote education, screening, and enrollment in PrEP services in 8 community-based medical settings. PrEP is an important new tool for HIV- gay and bisexual men to consider with ongoing risk behavior.

Session CR14 - Use of a Point of Care HIV Rapid-Rapid Testing Algorithm for Partners in a Ryan White Clinic Will Facilitate Linkage to Care

Room: Piedmont (Hyatt Regency Atlanta)

Abstract 2272 - Use of a Point of Care HIV Rapid-Rapid Testing Algorithm for Partners in a Ryan White Clinic Will Facilitate Linkage to Care

Author(s): *Anndrea Rogers, Arif Sarwari, Jeannette Southerly*

Issue: The CDC currently recommends an HIV testing algorithm utilizing a fourth generation test followed by an HIV differentiation assay/RNA testing for diagnosis of HIV infection. This process increases sensitivity in identifying those individuals with acute retroviral infection. The recommended algorithm can be implemented in traditional HIV testing sites where individuals seek care or request an HIV test, however, those individuals that test positive must then be referred to an HIV care provider (typically outside the testing site) where they must keep their medical appointment to access antiretrovirals and eventually achieve viral suppression. According to CDC's National HIV Care Continuum data (MMWR 63:1113-17, 2014) the greatest impact on the ultimate goal of viral suppression is at the point of diagnosis and linkage to care.

Key Points: In 2006 we established a non-traditional HIV testing model by offering free, confidential, rapid HIV testing to partners of our HIV infected patients in the Ryan White Clinic. We now propose to establish a modified algorithm when testing these high risk individuals to facilitate diagnosis of HIV infection and linkage to care at the time of testing (point of care). Current HIV positive patients and their

partners are asked to participate at the point of care during regularly scheduled appointments in the WVU Positive Health Clinic using a single finger stick whole blood sample. Testing is performed using three CLIA-waived rapid HIV tests: Alere Determine™ HIV 1/2 Ag/Ab Combo (4th generation), Oraquick Advance® HIV 1/2 Ab, and Insti™ HIV-1 Ab. An algorithm was developed using the 4th generation combination assay as the primary test with reflex testing using a 2nd generation test for Ab only or Ag/Ab reactive specimens and RNA testing for Ag only reactive specimens.

Implications: Since Ryan White / HIV Care Clinics are uniquely positioned to offer HIV testing to partners and contacts of HIV positive patients, we can expedite the linkage to care of new positives using the same team of healthcare professionals who have established a rapport during testing. Having the ability to identify a new HIV infection in a single testing visit and offering immediate support and entry to care in the same location should not be underestimated.

Session CR16 - Identifying Best Practices and Effective Strategies to Confirm Linkages of High-risk HIV-negative Clients to Services

Room: Fairlie (Hyatt Regency Atlanta)

Abstract 2369 - Identifying Best Practices and Effective Strategies to Confirm Linkages of High-risk HIV-negative Clients to Services

Author(s): *Sam Stallworth*

Issue: While much guidance and resources have been allocated to ensuring that health departments and community-based organizations (CBOs) are able to successfully link persons living with HIV (PLWH) to medical care, there have been fewer efforts to help organizations confirm linkages for high-risk HIV-negative clients to prevention and essential support services, such as screening for sexually transmitted diseases (STD), housing, and pre-exposure prophylaxis (PrEP). With shifting funding priorities, questions remain for how to provide the same level of service for HIV-negative clients and ensure they remain negative.

Key Points: Many CBOs and health departments have informal processes in place to confirm referrals for HIV-negative clients. These informal procedures run the risk of ending when contacts change within referral networks or there is staff turnover. While activities to confirm referrals may represent programmatic best practices, the informal procedures could be immeasurably strengthened by establishing formal agreements between agencies and partners within their referral networks. Agencies may need guidance in identifying the components and steps to initiate formal agreements, including obtaining proper consents, establishing needed data sharing agreements, and maintaining systems for data collection and reporting. Increased monitoring and reporting of referral activities will help agencies gauge the effectiveness of the referrals being made, and assist them to better identify gaps in services for high-risk HIV-negative clients.

Implications: As the HIV prevention and care landscape continues to change, and agencies are increasingly held accountable to report new performance measures, staff must be able to better monitor and track all services and referrals provided. During this discussion, participants will identify activities and best practices already in place at their agencies to help ensure high-risk HIV-negative

clients are receiving needed services, as well as identify what additional tasks may be needed to formalize their processes. Participants will also discuss the services and referral networks they have in place to address barriers for HIV-negative clients, to help improve their overall health, and decrease their chances of becoming HIV-positive. Supporting high-risk HIV-negative clients aligns with the first goal of the National HIV/AIDS Strategy (NHAS), as well as the Centers for Disease Control and Prevention's (CDC) High-Impact Prevention (HIP) approach.

Track D

Session DR08 - Road to Integration

Room: University (Hyatt Regency Atlanta)

Abstract 2311 - Road to Integration

Author(s): *Oscar Macias, Eileen Loughran*

Issue: This round table will address the barriers, successes and lessons learned by local HIV prevention and Ryan White planning bodies on their road to integration.

Key Points: Efforts to fully integrate HIV prevention and care planning in San Francisco have been challenging. Engagement and treatment adherence in HIV care have improved the health outcomes for people living with HIV and dramatically decreased infectiousness. These factors have blurred the distinction between HIV care and prevention efforts making the case for the notion of "treatment as prevention." Moreover, funding and policy pressures have drastically changed the delivery of HIV prevention and care services. To facilitate an improved collaboration effort between HIV prevention and care planning reflective of the local priorities and national policy.

Based on the San Francisco experience, this round table will focus on the barriers, successes and lessons learned by the HIV prevention and care planning bodies on their road to integration. The processes implemented to increase collaboration for HIV prevention and care community planning bodies will be discussed, in the context of aiming to increase the collective impact of HIV prevention and care efforts – an essential step in achieving the goals of the National HIV/AIDS Strategy. The facilitators will illustrate various ways for collaboration and lead a discussion on the strengths and weaknesses of models presented.

Implications: After attending this round table, HIV prevention and care planners, local health jurisdictions and other stakeholders will have first-hand insight and knowledge in the efforts to: develop a collaborative planning work group to identify and assess areas of collaboration among both councils and negotiate priorities of the two leadership committees into one coherent vision for the two separate councils.

Session DR13 - Meth, Gay Men, and HIV: An Addict's Story and a Clinician's Perspective

Room: Spring (Hyatt Regency Atlanta)

Abstract 1636 - Meth, Gay Men, and HIV: An Addict's Story and a Clinician's Perspective

Author(s): *David Fawcett, Mark King*

Issue: The resurgence of meth use among gay men is an enormous contributing factor to both new HIV infections and poor adherence among those living with HIV. To illustrate the personal toll of meth abuse and its impact on HIV risk, this interactive roundtable will feature a substance abuse specialist explaining the trajectory of addiction while a recovering addict candidly shares his drug abuse history.

Methamphetamine today is cheaper and of higher purity than ever before. In one study, the CDC, in collaboration with the San Francisco Department of Public Health, concluded that men using meth were more than twice as likely to be HIV infected, have more than double the number of sexual partners, and were 4.9 times more likely to be diagnosed with syphilis. Other studies have similar findings. Cathy Reback at UCLA, for example, has found that 1 in 4 gay men in Los Angeles use crystal meth. This roundtable discussion, presenting both the clinical and the user perspectives, will present a unique and informative perspective on meth use as well as best practices and interventions from several programs around the country.

Key Points: Physiological changes in brain function play a key role in understanding how casual drug use becomes addiction, and why HIV safety becomes secondary to supporting the addiction. Meth activates the limbic system, dramatically increasing sexual desire while numbing uncomfortable feelings such as shame and stigma. It also destroys the dopamine transporter system, a process requiring 12-18 months to restore, during which mood disorders persist. These factors, presented from both user and clinical perspectives, will form the basis for discussing best practices for both prevention and treatment.

Implications: By understanding the course of drug addiction and its effect on HIV prevention and treatment adherence, we can more effectively design interventions that address the needs of gay men at high risk for, or already struggling with drug addiction. These interventions must incorporate significant psychological risk factors such as shame, low self-esteem; breaking sexual taboos, and most significantly, the perfect storm created by HIV, heightened sexual desire, and disinhibition.

Session DR14 - Harnessing the Power of Social Media

Room: Greenbriar (Hyatt Regency Atlanta)

Abstract 1396 - Harnessing the Power of Social Media

Author(s): *Sharita Ambrose*

Issue: Social media campaigns are an innovative way to expose large segments of specific populations to health promotion messages. Social media campaigns play a vital role in public health, and is a strong tool for advocacy, communication, and education. Organizations that aim to use social media platforms as health education tools must first have an understanding of the various social media platforms, common terminology, and the social media use patterns of the various targeted populations. Social media based interventions can produce positive health changes on a large-scale by reinforcing positive health behaviors among individuals. It is essential to organization to cultivate the skills needed to develop, plan, implement, and sustain social media campaigns.

Key Points: This workshop will explore how to strategically plan, develop, and implement an effective health campaign using various social media platforms. The use of an effective social media campaign may assist nonprofit organizations and grassroots/ non-501c3 designated community groups in identifying, locating, and mobilizing target populations to seek HIV and STI related services.

Implications: I Am My Sister's Keeper is the Austin branch of the Texas Black Women's Initiative (IAMSK and TxBWI respectively, hereafter). The TxBWI is a community mobilization initiative of the Texas Department of State Health Services (DSHS, hereafter). The overall goal of this initiative is to develop a community driven response to the disproportionate rates of HIV infection among Black women.

In an effort to ensure community level programming would be implemented, IAMSK developed a social media campaign to create awareness of the disproportionate rates of HIV infection among black women. Through collaboration with national, state, and local organization the IAMSK team has developed a successful a crowd funding campaign to provide an opportunity for the community to become aware of the HIV infection rates among African American women in Austin/Travis County. If selected as a presenter the IAMSK team will offer specific guidance and examples from their social media campaign to promote skills building with attendees.

Session DR15 - Creating the Roadmap for Integrating HIV Prevention and Care Planning

Room: Roswell (Hyatt Regency Atlanta)

Abstract 2113 - Creating the Roadmap for Integrating HIV Prevention and Care Planning

Author(s): *Andrea Jackson, Amelia Khalil, Candace Webb*

Issue: As we gain a better understanding of treatment as prevention, and the overlap increases between high priority care and prevention interventions, it becomes increasingly important for Federal officials, along with State, local and community stakeholders, to work together to smartly bring our prevention and care investments more closely in line with each other to increase impact. The Centers for Disease Control and Prevention's (CDC)/Division of HIV/AIDS Prevention (DHAP) and the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) have developed the Integrated HIV Prevention and Care Plan guidance for CDC HIV Prevention grantees and HRSA-funded Ryan White HIV/AIDS Program Part A and B grantees to create integrated HIV prevention and care plans to improve health outcomes along the HIV Care Continuum. The guidance is designed to meet the comprehensive plan requirements for both CDC and HRSA-funded HIV prevention and care grantees. The Integrated HIV Prevention and Care Plan guidance builds upon the Department of Health and Human Services' HIV/AIDS Indicators Implementation Group's (HAIIG) efforts to reduce the reporting burden experienced by CDC and HRSA grantees by streamlining reporting requirements. This guidance also promotes collaboration and coordination through the use of shared data to inform HIV prevention and care program planning.

Key Points: The Integrated HIV Prevention and Care Plan guidance is written in three sections that provide a framework for HIV prevention and care grantees to capture their jurisdiction's (1) prevention and care needs assessment results; (2) comprehensive prevention and care plan; and (3) monitoring and improvement plan. The integrated guidance is framed using the HIV Care Continuum and the goals of

the National HIV/AIDS Strategy. The purpose of the integrated guidance is to: (1) reduce the burden of planning and reporting; (2) align reporting dates; (3) leverage resources for prevention and care; (4) utilize integrated epidemiologic profiles; and, (5) submit a multi-year plan with consistent terms across HIV prevention and care programs. The facilitators will present information on the guidance, obtain feedback from stakeholders, allow participants to discuss issues and concerns around integrated planning, and identify areas where technical assistance may be needed.

Implications: The plan developed from the Integrated HIV Prevention and Care Plan guidance will result in a roadmap which directs how prevention and care services, interventions, and strategies will be delivered in the jurisdiction. The guidance instructs stakeholders to identify existing resources, needs, and gaps in HIV prevention and care services, such as data access, service barriers and HIV workforce capacity. As a result, the Integrated HIV Prevention and Care Plan guidance will increase the efficiency of planning, evaluation, and quality improvement activities within health departments to meet the HIV prevention and care needs in their jurisdictions. The main goal of the discussion is to assist HRSA/HAB and CDC/DHAP with developing resource materials based on the stakeholder feedback.

Session DR17 - GIPA in Motion: Supporting Positive Leaders to Create Advocacy and Action to Address Stigma and Discrimination in Metro Detroit

Room: Techwood (Hyatt Regency Atlanta)

Abstract 2474 - GIPA in Motion: Supporting Positive Leaders to Create Advocacy and Action to Address Stigma and Discrimination in Metro Detroit

Author(s): *Laurel Sprague, Akilah Benton, Jimena Loveluck, Brian Minalga, John Trimble*

Issue: A metro-Detroit community partnership between AIDS Partnership Michigan (Detroit), the HIV/AIDS Resource Center (Ypsilanti), the University of Michigan Center for Sexuality and Health Disparities (Ann Arbor), and the Global Network of People Living with HIV, North America piloted The People Living with HIV Stigma Index to identify the forms and extent of HIV-related stigma and discrimination experienced by different communities of people living with HIV. Based in the principle of the Greater Involvement of People Living with HIV/AIDS (GIPA), the project sought to build community leadership to use evidence and local knowledge to increase the quality of life for people living with HIV, including access to healthcare, employment, and family, faith-based, and social support. This was the first U.S. implementation of the global Stigma Index project.

Key Points: High levels of internalized stigma were identified across all groups, with respondents reporting feeling ashamed (60%), guilty (66%), and self-blame (80%) in the last twelve months. High percentages of respondents reported experiencing gossip (79%), family exclusion (28%), and physical assaults (24%) in the last year. Many respondents (21%) reported avoiding health care when they needed it because of stigma. A range of effects from stigma were reported, including depression and anxiety, reduced self-care, avoiding care and support, and missing doses of medication. Stigma created distrust of health and legal institutions: 88% of respondents did not trust the Michigan courts to give a person with HIV a fair hearing and majorities indicated it was acceptable for a person to avoid getting tested (62%) and to avoid medical care (51%) because of a fear of prosecution. Using the survey data,

the Steering Committee developed action items to address internalized stigma and PLHIV self-empowerment, HIV criminalization, and other institutionalized stigma at local and state levels.

Implications: Five HIV-positive leaders were trained to conduct interviews (n=70) to assess stigma-related needs and barriers in diverse populations of people living with HIV. Focused recruitment resulted in a sample inclusive of people living with HIV who were: young (45%), gay, bisexual, or MSM (44%), transgender (10%), African American (68%), Latino/a (14%), and women (40%). A local Steering Committee of HIV-positive community leaders belonging to various key population groups led the project with support from the community partnership.

The data results provided the Stigma Index Steering Committee with a foundation from which to engage support groups, networks, and community advisory boards of people living with HIV to collaboratively address internalized stigma. Further, these data are providing openings to address HIV-related stigma with community partners, healthcare facilities, faith-based organizations, and state prison/parole systems. For example, the Steering Committee has created infographics about HIV criminalization to share with the community and state legislators to educate them about the vague and overly broad language of our existing laws and the resulting legal perpetuation of stigma around HIV. These strategies are being used to implement the PLHIV Stigma Index in other states.

Session DR19 - Healthcare Capacity-Building Assistance: Unique Opportunities Focusing on Building High-Impact HIV Prevention Capacity Among Healthcare Organizations

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 2258 - Healthcare Capacity-Building Assistance: Unique Opportunities Focusing on Building High-Impact HIV Prevention Capacity Among Healthcare Organizations

Author(s): *Vasavi Thomas, Maria Alvarez, Tony Jimenez, Emily Rebella, Mark Thrun, Terry Stewart, Sarah Blust, Mazdak Mazarei, Dena Quinones,*

Issue: New cases of HIV remain stable at approximately 50,000 a year in the United States. According to Centers for Disease Control and Prevention (CDC), only 40% of those persons living with HIV are currently engaged in care, and, nationally, only 30% have reached our goal in treatment of an undetectable viral load . In 2013, the HIV Care Continuum Initiative was instituted by the White House to ensure priority was placed on addressing the stages of the continuum in order to achieve National HIV/AIDS Strategy (NHAS) goals . After HIV diagnosis, facilitating linkage and retention in care are integral steps to achieving viral suppression and finally significantly reducing the risk of transmission. Healthcare organizations such as hospitals, emergency departments and community health centers not only play a critical role in providing life-saving care for people living with HIV/AIDS, but also an expanding role in HIV prevention services for persons living with HIV and those at highest risk for acquiring the virus. In the current rapidly evolving healthcare environment, healthcare organizations face many challenges in developing and strengthening HIV prevention services that are programmatically and financially sustainable, and which are integrated within existing chronic care initiatives. Hence, more assistance is needed to build sustainable and integrated HIV prevention capacity among these healthcare organizations.

Key Points: To achieve the goals of NHAS and CDC’s High Impact Prevention (HIP) and address the need to enhance HIV prevention skills among clinical staff, CDC launched a new funding announcement in April 2014 entitled “Capacity-Building Assistance for High-Impact Prevention.” For the first time, health care organizations were included as a specific priority target for Capacity-Building Assistance (CBA) providers. This provides a unique opportunity to enhance existing prevention and care services using scalable, cost-effective strategies. The interactive roundtable discussion will emphasize:

1. The benefits to health care organizations of CBA providers in assisting with the implementation of programming and services that would help meet NHAS and HIP goals
2. The significant role that healthcare care organizations, including primary care providers, may play in the provision of HIV prevention services that have the potential to change the landscape of the domestic HIV epidemic
3. Knowledge of the capacity building needs of healthcare organizations providing or interested in providing prevention services for people at risk for HIV, HIV testing, or prevention services for persons living with HIV as they progress along the HIV care continuum

Implications: In order to improve outcomes along the HIV care continuum, the provision of HIV prevention services must partially shift away from historic prevention providers to healthcare organizations routinely seeing patients at risk for or living with HIV. CDC-funded capacity building organizations are working in partnership with these healthcare organizations to improve rates of HIV screening, the provision of prevention services for people at risk for HIV, including PrEP and PEP, and helping persons living with HIV to transition along the continuum to reach an undetectable viral load.

Session DR21 - Disrupting Silos: Cross-Sector Conversations to Strengthen Linkage and Engagement in HIV Care Outcomes

Room: Marietta (Hyatt Regency Atlanta)

Abstract 1504 - Disrupting Silos: Cross-Sector Conversations to Strengthen Linkage and Engagement in HIV Care Outcomes

Author(s): *Ben Cabangun, Adam Viera, BA Laris, Jacob Yang*

Issue: This roundtable will convene HIV Linkage and Engagement in Care strategists from Health Departments, Clinical Settings, Non-Clinical Settings, and capacity building providers to discuss sector specific strategies and to build cross-sector approaches to improve participants’ regional continuum of care outcomes. Numerous interventions targeting populations at risk of HIV care disengagement have been enhanced and adopted by health departments, community based organizations, and health systems throughout the country. Despite innovation in linkage and engagement strategies in each respective sector, often remaining are fragmented approaches—gaps in collaboration and communication across sectors within the same region. Health departments, community based organizations, and hospital/community health centers are still “siloesd”. These challenges indicate the need for regional conversations on linkage and engagement in care in a national setting.

Key Points: 1. Key Point One: Promising Linkage and Engagement in Care Strategies in the United States include cross-sector communication and collaboration. This roundtable discussion will begin with a discussion of promising practices in linkage and engagement in HIV care—including Anti-Retroviral

Treatment and Access to Services (ARTAS)—highlighting national and regional approaches to linkage to care. Part of the discussion will include identifying organizational needs related to effective implementation of linkage and engagement in care strategies.

2. Key Point Two: Cross-Sector Conversations are needed to Strengthen HIV Linkage and Engagement in Care. Roundtable facilitators will then solicit discussion from participants who will self-select into one of the following sectors; Community Based Organization, Health Department, Health Center/Hospital System, and Capacity Building Provider/Consultant. Building on the models and strategies described, participants will explore the unique and shared experiences of the success and challenges of linkage and engagement for each sector. This will provide the opportunity for them to then indicate regional needs for a successful cross-sector HIV linkage and engagement in care strategy for the respective regions each participant represents.

3. Key Point Three: Providers across sectors need to establish stronger relationships to build trust and collaborative commitments. The roundtable will close with participants receiving instructions for a facilitated networking activity at which they will be tasked to find a provider from a different sector within relative geographic distance to their region. They will then engage in rapid facilitated conversations to produce at least one action item they can complete together towards the goal of improving their region's continuum of HIV care outcomes. This will conclude with a closing activity developing desired next steps to sustain a regional and national conversation on cross-sector HIV linkage and engagement in care collaborations post-NHPC 2015.

Implications: In summary, this roundtable will bring cross-sector collaboration challenges to the forefront of conversations in a national setting. This roundtable will convene national thought leaders in Linkage and Engagement in HIV Care to provide promising applications to address gaps in regional continuum of care outcomes. The opportunities of intentional networking between participants from diverse sectors will advance the conversation for NHPC 2015 participants towards fostering cross sector successes in making a national impact on HIV Linkage and Engagement in Care.

Track E

Session ER04 - Case Study Findings on Community-Based Organizations' Sustainability and Readiness to Integrate Care and Preventions

Room: Lenox (Hyatt Regency Atlanta)

Abstract 1703 - Case Study Findings on Community-Based Organizations' Sustainability and Readiness to Integrate Care and Preventions

Author(s): *Earl Pike, Jacob Yang, Ed Tepporn, Nickie Bazell*

Issue: Economic challenges, the implementation of health care reform, and the changing HIV prevention and service provision context—including the National HIV/AIDS Strategy (NHAS) and the Centers for Disease Control and Prevention's (CDC) Community High Impact HIV Prevention initiative—have significant ramifications for the strategic decision-making and sustainability of HIV prevention and care efforts across the country. AIDS Service Organizations (ASOs) and Community-Based Organizations (CBOs), particularly those targeting communities at very high risk for HIV, are presented with unique challenges. What do we know about the emerging context and how CBOs have rethought and retooled

to conduct effective HIV/AIDS- related work? How can CBOs integrate prevention and care work in a way that is sustainable and makes an impact? What practices are CBOs across the county adopting to comply with NHAS and CHIP? How does the sectors' commitment to decreasing disparities in access and outcomes continue in this context?

Key Points: 1. Results of comprehensive, in-depth case studies of approximately 18 ASOs across the country, that build on Capacity for Health's 2013 HIV/AIDS ASO and CBO Stability and Sustainability Assessment Report will be presented and discussed, highlighting different approaches to integration of care and prevention, their requirements, challenges, outcomes and applicability to other CBOs and ASOs.

2. Real time strategic planning, a model for laying the groundwork of implementation through a short but comprehensive planning process will be highlighted an applicable framework to consider. Its use with Capacity for Health CBO and ASO clients will also be discussed. Participants will receive information on the framework and its application.

3. Participants will have an opportunity to ask and learn about the particulars of planning and implementing ASO and CBO sustainability and program integration, and which approaches might hold better promise for their organizations and the contexts in which they work.

Implications: This roundtable discussion advances and expands an ongoing exploration of options and promising practices for ASOs and CBOs seeking to align with NHAS and CHIP. Opportunities for high level examinations and discussions of real life case studies and the resultant promising practices and possible pitfalls are rare. These considerations for capacity builders, funders, organizational leadership, program administrators, and CBO staff are key to success, as they work on sustainability and manage the many moving pieces of prevention and care program integration.

Track A

Session A07 - PrEP: From Estimating Population Size to Knowledge, Acceptability, and Use

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1680 - Using Publicly Available Representative Data to Estimate the Size of Subpopulations at Substantial Risk for HIV Acquisition

Author(s): Dawn Smith, Margaret Lampe, Steven Nesheim, Jonathan Mermin

Background: Daily, oral antiretroviral preexposure prophylaxis (PrEP) is not indicated for all sexually active persons or all person who inject drugs. Its use should be targeted to persons at substantial, ongoing risk of sexual or injection HIV acquisition. To plan for the scale-up of PrEP services, assess intended coverage, and monitor its contribution to HIV prevention at several jurisdictional levels (national, state, city/county), estimating the size of the target populations for PrEP use by transmission risk group is important. Many methods to do this require significant statistical expertise and specifically designed data collections. We developed a simple method to calculate an “order of magnitude” estimate sufficient for planning PrEP scale-up and making preliminary assessments of appropriate levels of coverage. As an example, the calculation method for MSM is presented in the results.

Methods: We developed algorithms to estimate the number of gay, bisexual and other men who have sex with men (MSM), persons who inject drugs (PWID), heterosexual men and women (HET), and persons in heterosexual HIV discordant couples (HDC), with sexual or injection behaviors that are indications for PrEP use. First we obtained the total number of persons in the population of interest from US Census data (HET), the National Health and Nutrition Examination Survey (NHANES) (MSM), or the National Survey of Drug Use and Health (PWID); then restricted to HIV-negative persons with data from other sources (e.g., published meta-analyses, HIV Surveillance System). Finally, we used data from population representative studies (e.g., National Survey of Family Growth, National Survey of Sexual Health and Behavior (NSSHB)) to define populations with behaviors that indicate substantial risk for HIV acquisition.

Results: For MSM, an NHANES analysis estimated 2.2 million adult men who reported sex with a man in the prior year. Multiplying by the 88.2% of MSM who tested HIV negative, and the 59.1% who reported having ≥ 1 male sex partner in the prior year, yields an estimated 1,146,776 HIV-negative MSM with multiple sex partners. Multiplying by the proportion of MSM in the 2010 NSSHB who reported no condom use at last sex (39%) yields an estimated 447,243 MSM nationally at substantial risk for HIV acquisition for whom PrEP may be indicated. For a single state estimate, we started with US census data for men in Missouri ages 15-59, applied the estimated proportion of men who had sex with a man in the prior year (2.9%) from a meta-analysis (Purcell, 2012), subtracted the number of MSM living with HIV in Missouri, applied the NHANES proportion with ≥ 1 male sex partner in the prior year and the NSSHB

proportion reporting last anal sex without a condom. This yielded an estimated 10,600 MSM in Missouri for whom PrEP may be indicated.

Conclusions/Implications: In settings where statistical modelling of relevant populations is not available, simple algorithms can be used to assess the approximate size of MSM, HET, IDU, and HDC populations that may benefit from PrEP.

Abstract 1903 - Knowledge of Pre-Exposure Prophylaxis among Populations at High Risk for HIV Infection: Findings from the National HIV Behavioral System, Long Island, NY

Author(s): *Suzan Walters, Anthony Romano, Bridget Anderson, Jonathan Feelemyer, Lou Smith*

Background: New York State has documented high levels of HIV incidence and continues to experience elevated levels of new diagnoses, particularly among high-risk populations. Ending the Epidemic by reducing new infections in the State by 75% by 2020 is a top priority. Several approaches have been developed to achieve this goal. Research demonstrates that Pre-exposure Prophylaxis (PrEP) can reduce HIV transmission. In order for PrEP to be successful, individuals at high risk of infection need to be aware of and have access to the intervention. We compare high-risk populations including men who have sex with men (MSM), persons who inject drugs (PWID), and high risk heterosexuals (HET) in New York to evaluate levels of knowledge regarding PrEP.

Methods: Data was obtained from the third round of the National HIV Behavioral Surveillance System (NHBS) from high-risk populations (MSM, PWID, HET) living in Long Island, New York. Data collection occurred between 2011 and 2013 with yearly cycles for each high risk population utilizing both respondent driven sampling (RDS) and venue based sampling methods. Interviews were conducted using a standardized questionnaire along with voluntary anonymous HIV testing. Multivariate regression was used to model knowledge of PrEP by risk group. Statistical analysis was conducted using Stata 13.1.

Results: There was wide variation and generally low knowledge by risk group of PrEP: 14.7% of MSM, 5.2% of PWID, and 5.8% of HET had heard of PrEP. Controlling for demographic and testing variables including race, income, education, and HIV status (defined as tested positive or negative), MSM were more likely (OR: 2.17, CI: 1.07, 4.40) to have knowledge of PrEP compared to IDU or HET. Non-Hispanic blacks (OR: 2.95, CI: 0.82 10.53), those with higher education (OR: 1.15, CI: 1.02, 1.30), and those who were HIV positive (OR: 5.813, CI: 2.54, 13.30) had more knowledge of PrEP.

Conclusions/Implications: There are clear disparities in PrEP knowledge among high risk groups on Long Island. Results from this study indicate that overall PrEP knowledge is low and that there is an increased need for awareness of PrEP particularly among PWID and HET populations. Future research should focus on dissemination of information related to PrEP, integrated with current harm reduction programs including syringe exchange and low threshold substance abuse treatment. Outreach efforts on Long Island should integrate PrEP education in order to increase knowledge and access to this intervention.

Abstract 2010 - Utilization of HIV Preexposure Prophylaxis by Commercially Insured Persons—2010–2013

Author(s): *Hsiu Wu, Dawn Smith, Maria Mendoza, Tameka Hayes, Karen Hoover*

Background: Daily, oral use of tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) for preexposure prophylaxis (PrEP) is one of the most effective strategies to reduce the risk for acquiring HIV infection. In July 2012, the US Food and Drug Administration approved an indication for TDF/FTC use in PrEP. In 2014, the Centers for Disease Control and Prevention issued PrEP clinical practice guidelines. We used a health insurance database to estimate the uptake of TDF/FTC prescribed for PrEP among commercially insured persons in the United States during 2010–2013.

Methods: The analysis of commercial insurance databases provided by MarketScan (Truven Health Analytics) included persons aged ≥ 16 years who had National Drug Codes (NDC) for TDF/FTC prescribed in 2010, 2011, 2012, and 2013. Persons who met one of the following criteria were excluded: International Classification of Diseases, 9th revision code for HIV or active hepatitis B; NDC for antiretrovirals or drugs for hepatitis B treatment other than TDF/FTC before or within 30 days after TDF/FTC was first prescribed; Current Procedural Terminology code for CD4, HIV viral load, or hepatitis B viral load tests ordered concurrently with or before TDF/FTC; or prescription of TDF/FTC for ≤ 30 days. The numbers of persons with commercial insurance prescribed PrEP nationwide was estimated by applying MarketScan national weights to the number identified in this analysis.

Results: The numbers of persons prescribed TDF/FTC for PrEP among all those aged ≥ 16 years were 267 (among 34,882,254 total) in 2010, 373 (among 40,408,924) in 2011, 497 (among 41,367,859) in 2012, and 695 (among 34,223,117) in 2013. The number of persons prescribed PrEP increased from 2010 through 2013 ($p < 0.001$). Of the 695 persons who received PrEP in 2013, 608 (87.9%) were male, and the mean age was 43.6 years (standard deviation [SD]: 10.3). In 2013, the geographic distributions of persons prescribed PrEP were 229 (33.0%) persons in the West, 222 (31.9%) in the South, 141 (20.3) in the Northeast, and 92 (13.2) in the North Central; 679 (97.7) were in a metropolitan statistical area. The weighted estimates of persons prescribed PrEP among those with commercial insurance nationwide were 1015 (among estimated total of 125,533,754) in 2010, 1250 (among 125,513,213) in 2011, 1607 (among 124,298,424) in 2012, and 2,750 (among 124,320,042) in 2013.

Conclusions/Implications: Among commercially insured persons, PrEP prescriptions increased from 2010 through 2013. Most TDF/FTC prescriptions for PrEP were for middle-aged men, in metropolitan statistical areas, and in southern and western states. The MarketScan health insurance database and the analytic methodology we used provide a way to monitor PrEP utilization among commercially insured persons in the United States.

Abstract 2187 - Changes in Awareness, Willingness to Take, and Use of PrEP among MSM in Washington, DC from 2011 to 2014: Data from National HIV Behavioral Surveillance

Author(s): *Irene Kuo, Rudy Patrick, Gregory Phillips II, Anthony Rawls, Jonjelyn Gamble, Jenevieve Opoku, Manya Magnus, James Peterson, Michael Kharfen, Alan Greenberg*

Background: In 2010, pre-exposure prophylaxis (PrEP) was shown to be effective in preventing HIV transmission among men who have sex with men (MSM). However, dissemination of information and uptake of this new HIV prevention intervention over time has not been fully studied. To better

understand awareness of, willingness to take, and use of PrEP in the community, we examined knowledge, attitudes, and use of daily PrEP among MSM and factors associated with willingness to take PrEP over time using data from the 2011 and 2014 MSM cycles of National HIV Behavioral Surveillance.

Methods: Between August-December 2011 and July-December 2014 in Washington, DC, MSM were recruited using venue based sampling. Men who were ≥ 18 years old and reported having had sex with ≥ 1 man in the past year completed a behavioral survey and voluntary rapid HIV testing; this analysis only included men who were HIV-negative and men of unknown status at enrollment. Participants were asked about HIV risk behaviors, knowledge and use of PrEP, and willingness to use PrEP if it were available for free or covered by health insurance. We used multivariable logistic regression to assess correlates of being “very likely” to use PrEP as described. All analyses were conducted using 2011 and 2014 data separately.

Results: The samples included 323 in 2011 (42% >32 years old; 28% black, 49% white, 13% Hispanic) and 313 in 2014 (37% >32 years old, 37% black, 37% white, 14% Hispanic). MSM in 2014 versus 2011 were more likely to have some college education, have a higher income, be HIV tested in the past year, use non-injection drugs, and binge drink (all $p < 0.05$). In 2011, 39% had heard of PrEP versus 75% in 2014 ($p < 0.0001$); $< 1\%$ in 2011 versus 10% in 2014 had ever taken PrEP ($p < 0.0001$). A smaller proportion of MSM in 2014 versus 2011 reported being very likely to take PrEP if it were available for free or covered by health insurance (48% versus 61%, $p = 0.005$). In 2011, correlates of being very likely to take PrEP included younger age (≤32 versus >32 ; AOR: 2.1; 95% CI: 1.3,3.5), and being Hispanic versus white (AOR: 3.4; 95% CI: 1.4,8.1); having more sex partners (≥ 6 versus 2-5 partners; AOR: 1.7; 95% CI: 1.0,3.0). In 2014, Blacks/African-Americans versus whites had a higher odds of reporting being very likely to use PrEP (AOR: 1.8; 95% CI: 1.0,3.1). Other correlates included having more sex partners (≥ 6 versus 2-5 partners; AOR: 2.3; 95% CI: 1.3,3.8). Being newly identified with HIV through study testing was associated with a higher odds of being very likely to use PrEP (AOR: 3.1; 95% CI: 0.9,10.5); this was not statistically significant.

Conclusions/Implications: Awareness of PrEP in 2011 was low but significantly increased by 2014. PrEP use increased significantly over time; however, overall uptake was still low in 2014. Willingness to use PrEP seemed to decline over time and was positively associated with minority race and some HIV risk behaviors in both years. Innovative strategies are needed to further inform and educate MSM about this effective prevention strategy.

Track B

Session B02 - Sex Matters: Understanding Unique Associations of Women's Vulnerabilities and Health Behaviors

Room: Embassy E/F (Hyatt Regency Atlanta)

Abstract 1220 - Exploring Sexual Self-Efficacy as a Factor in Reducing HIV Rate Disparities in African American Women

Author(s): *Tameca Harris-Jackson*

Background: Rates of HIV infection and diagnosis remain significantly higher for African American women in the U.S. than women of other ethnicities (Centers for Disease Control and Prevention [CDC], 2012). On several accounts, based on rates of denominational affiliation and participation in religious activities, heterosexual African American women are considered to be amongst the most religious group of people in the world (Galvan, Collins, Kanouse, Pantoja, & Golinelli; Lichtenstein, Hook, & Sharma, 2005; Sherkat, 2002). Because religion is often considered to be a protective factor for a variety of risk behaviors (Elifson, Klein, & Sterk, 2003; Galvan et al., 2007; Morse et al., 2000), when exploring psychosocial factors that could help prevent or minimize HIV-related risk behaviors among African American women, faith-based interventions are often explored (Jarama, Belgrave, Bradford, Young, & Honnold, 2007; Wingood et al., 2013); however, several studies have noted that self-efficacy can also play a vital role in helping to reduce health risk behaviors (e.g., Bandura, 1994; Bowleg, Belgrave, & Reisen, 2000; Gerrard & Gibbons, 1982; Heeren, Jemmott, Mandeya, & Tyler, 2007; Jemmott, Jemmott, O’Leary, 2007). Hence, between 2009 and 2010, this author conducted a quantitative study as part of a dissertation to explore the role of self-efficacy and religiosity on Black American women’s HIV-related sexual risk behavior.

Methods: A combination of convenience and snowball sampling was used to recruit a sample of 102 heterosexually-identified Black American women from Baltimore, Maryland. Participants were between the ages of 20 and 49 with the majority identifying as Baptist or nondenominational (70%). The women completed a confidential, on-line survey on risk, religiosity, and sexual self-efficacy (i.e. the confidence one has in one’s ability to execute various sexual behaviors). Participants were able to enter a raffle to win 1 of 3 gift cards for \$50.

Results: Correlation models were run to analyze the relationship of SSE (moderating variable) and religiosity (predictor variable) on risk (criterion variable identified as frequency of condom use and number of partners). Analysis revealed that while religiosity had a small impact on risk behavior (i.e. high rates of religiosity increased condom use among some women), with the introduction of sexual self-efficacy, much more risk reduction was found. Specifically, results indicated that women with high religiosity scores but low sexual self-efficacy scores were much more likely to report a greater degree of HIV-related sexual risk behavior.

Conclusions/Implications: Not enough empirical research exists to firmly establish connections between risk factors and the unique needs of Black women (Black AIDS Institute, 2008; National Alliance of State & Territorial AIDS Directors [NASTAD], 2008). Though limitations of this study are noted with regard to generalizability, overall, results are promising concerning implications for HIV prevention programming for African American women. Specifically, this study highlights support for the continued exploration of sexual self-efficacy to help broaden the scope of high impact HIV prevention programs for African American women.

Abstract 1333 - Correlates of HIV testing and Health-Seeking Behaviors among Incarcerated Women in North Carolina

Author(s): *Monique Carry, Deborah Gelaude, Jeffrey Herbst, Catherine Fogel, Sharon Parker*

Background: Incarcerated women face disproportionate HIV burden and unique challenges accessing and interfacing with formal healthcare settings relative to their non-incarcerated counterparts. This study examines health-seeking behaviors and individual and social factors associated with HIV testing in a sample of incarcerated women.

Methods: The study sample includes 521 women from two correctional facilities in North Carolina enrolled in a randomized control trial testing the efficacy of an adapted HIV/STI prevention intervention. Women were assessed at baseline for individual risk behaviors (i.e., drug use, previous diagnosis of sexually transmitted infections, number of sex partners, sex work), health-seeking behaviors (i.e., number of days wait to see doctor when sick, reasons for not seeing a doctor), psychosocial factors (i.e., condom barriers, HIV knowledge, health protective communication skills, partner abuse, social support) and HIV testing (i.e., HIV test in 12 months prior to incarceration). Logistic and bivariate linear regression analyses were used to determine associations of individual risk behaviors, health-seeking behaviors, and psychosocial factors with self-reported HIV testing behavior. Age was controlled for as a continuous variable in all analyses.

Results: Participants ranged in age from 18 to 60 years (mean = 33.8 years); 58% were white and 34% black/African American; and 52% were unemployed or on disability prior to incarceration. More than half of the women (n=287, 55 %) did not have insurance to pay for health care. Among women who did have health insurance, 79% (n=185) were insured through Medicaid or other government assistance programs. Women reported waiting an average of 2.61 days when sick before calling a doctor, and less than one day if the problem involved vaginal issues. The top three reasons women reported for not going to a doctor included: 1) symptoms usually go away (30.3%), 2) hate going to the doctor (27.4%), and 3) not having health insurance (26.5%). Results of age-adjusted logistic regression showed that reportedly having an HIV test was significantly associated with being black/African American (adjusted odds ratio [AOR]=2.34, p=.002, CI [1.45, 3.79]), having health insurance (AOR =1.89, p=.004, CI [1.22, 2.92]), and with having two or more concurrent sex partners (AOR =1.56, p=.05, CI [.98, 2.47]). Results of age-adjusted bivariate regression analysis among psychosocial measures showed that reporting an HIV test in the last 12 months was significantly associated with greater health-protective communication skills (β=.11 p=.01), lower levels of reported physical (β =-.09, p=.04) and non-physical partner abuse (β =-.10, p=.03), waiting less time to see a doctor for vaginal related issues (β =-.11, p=.008), and lower number of reported reasons for not seeing a doctor (β =-.15, p=.001).

Conclusions/Implications: These findings suggest that increased perceived barriers to accessing health care can negatively impact HIV testing. Women with fewer health protective communication skills and those reporting partner abuse are less likely to get an HIV test. Prevention programs may consider addressing incarcerated women's actual and perceived barriers to accessing healthcare, including access to affordable health insurance, and the context of intimate partner relationships to increase HIV testing among this population.

Abstract 1558 - DMPA Induces Gene Expression Patterns in the Vaginal Canal of Pig-tailed Macaques Distinct from those Observed during the Late Luteal Phase of the Menstrual Cycle.

Author(s): *Ajay Sundaram Vishwanathan, Steven Bosinger, Gregory Tharp, Katherine Butler, Nirav Patel, Janet McNicholl, Ellen Kersh*

Background: High natural progesterone levels during the menstrual cycle or synthetic progestins like the contraceptive DMPA (depot medroxyprogesterone acetate) may make women more vulnerable to HIV infection. Here, we studied gene expression patterns in the macaque vaginal canal during DMPA use and in the late luteal phase (LLP) when progesterone levels and susceptibility to SHIV infection are naturally high.

Methods: Vaginal pinch biopsies were collected from 9 untreated pig-tailed macaques. The LLP phase (days 25-32) was precisely determined using a combination of progesterone and sex skin swelling measurements, and menses. A microarray analysis was performed using Affymetrix GeneChip® rhesus macaque arrays, and gene expression post-DMPA compared to expression at LLP. To determine differential expression (DE), we used ANOVA; values were corrected for multiple tests. Using similar techniques, we have previously shown differential regulation of 763 genes on days 1-15 compared to days 16-32 of the cycle.

Results: At two weeks following second DMPA dosing, expression of 51 genes was significantly different compared to the LLP. Five out of the 51 were previously reported to be upregulated in the luteal phase; the remaining 46 genes showed DE after DMPA use. Of the 5 genes, we observed further enhancement of tetraspanin (TSPAN1) expression, an HIV-promoting factor. Of the 46 distinct genes, 14 were downregulated during DMPA use, including anti-HIV immune factor, BLIMP-1, and 32 were upregulated including factors that enhance HIV replication/pathogenicity (example: high-mobility group protein, HMG1).

Conclusions/Implications: In this animal model for vaginal HIV infection, DMPA not only induced specific genes distinct from those induced by high levels of endogenous progesterone, but augmented expression of those already differentially expressed in the LLP. This study contributes to identification of biological factors that potentially increases risk of HIV acquisition during DMPA use.

Abstract 1938 - Sex Trafficking is Associated with Sexual Violence and HIV Infection among Female Sex Workers on the Northern Mexico Border

Author(s): *Jay Silverman, Sabrina Boyce, Argentina Servin, Shira Goldenberg, Carlos Magis-Rodriguez, Julie Ritter, Steffanie Strathdee, Kimberly Brouwer*

Background: Adolescents migrating from Central America and Mexico to the U.S. are thought to be at high risk for being trafficked into sex work in Mexico's northern border cities (e.g., Tijuana and Ciudad Juarez). Research from other regions indicates that those entered into sex work as adolescents, relative to those entering as adults, are at increased risk for sexual violence and exposure to HIV risk during their initiation to sex work, as well as being substantially more likely to become HIV infected. However, apart from one study specific to injection drug-users, no empirical studies exist on the prevalence of minors in sex work for any region of Latin America, or their subsequent risk for violence and HIV infection. Such data are vital to inform efforts to prevent adolescent entry to sex work (i.e., sex trafficking), violence against adolescents in sex work, and the related health consequences, including HIV infection.

Methods: Between March 2013 and January 2014, female sex workers (FSWs; N=603) ages 18 years and older were sampled via time-location sampling across the northern Mexico cities of Tijuana and Ciudad Juarez. Computer-assisted surveys were completed to calculate the prevalence of adolescent (16-17 years) and early adolescent (<16 years) entry to sex work, and, via adjusted multivariate logistic regression analyses, associations of entry at these ages with sexual violence, no use of condoms, and high client volume (>10 clients/day) during the initial 30 days in sex work. HIV infection was assessed via diagnostic testing.

Results: Approximately 1 in 4 (25.4%) FSWs in Tijuana and Ciudad Juarez reported entering sex work before age 18; approximately 1 in 8 (11.8%) reported entering under age 16. As compared to those entering sex work at adults, those entering sex work as adolescents were more likely to report violence to force engagement in commercial sex (AOR 2.5, 95%CI 1.2-5.2, entry <16 years; AOR 2.0, 1.0-4.2, entry 16-17 years), having >10 commercial sex clients per day (AOR 2.4, 1.2-5.0, entry <16 years; AOR 2.4, 1.3-4.6, entry 16-17 years), and no use of condoms with sex work clients (AOR 6.6, 3.3-13.2, entry <16 years; ns for entry 16-17 years) during their first 30 days post-entry to sex work. Those reporting entering sex work as adolescents were three times more likely to be infected with HIV as compared to those entering sex work as adults (AOR 3.0, 1.0-8.8, entry <18 years).

Conclusions/Implications: Heightened risk for HIV among those reporting adolescent sex work may relate to the relatively higher risk for violence used to force participation in prostitution, higher numbers of male clients, and condom non-use during initiation to sex work. Consistent with these findings, adolescents remain the single demographic group, globally, for whom HIV prevalence has not declined during the past decade.⁶ Efforts to prevent HIV and sexual violence should include prevention of sex trafficking via protection of vulnerable adolescents, as well as efforts to reach and assist adolescents in sex work.

Session B11 - The Social is Structural: Exploring How HIV-Related Disparities and Determinants Affect Key Populations Along the HIV Care Continuum

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 1461 - Power and Sexual Decision Making in the Context of Male Incarceration and Imbalanced Sex Ratios

Author(s): *Emily Dauria, Lisa Oakley, Danielle Haley, Gina Wingood, Kimberly Jacob Arriola, Kirk Elifson, Hannah Cooper*

Background: Areas with high incarceration rates have high rates of HIV and other sexually transmitted infections (STIs). While a growing body of research has explored the pathways through which incarceration influences HIV/STI transmission, these studies largely focus on the experiences of incarcerated men and/or their sexual partners. Theories of gender and power posit that gender socialization puts women at increased HIV/STI risk because, in heterosexual relationships, men primarily have control over sexual decision-making. Women who perceive themselves to lack power in their relationship may have difficulty negotiating sexual activities and condom use. The goal of this qualitative study is to examine the processes through which local male incarceration rates and imbalanced

male:female sex ratios in a neighborhood influence romantic and sexual partnership power and sexual decision-making among heterosexual Black women living in that neighborhood.

Methods: This qualitative study consisted of semi-structured, one-on-one interviews with 33 heterosexual Black women living in two neighborhoods: one with a high male incarceration rate and an imbalanced sex ratio (Allentown) and one with a low male incarceration rate and an equitable sex ratio (Blackrock). In Allentown, 12 of every 100 adult men were incarcerated, and there were 70 men for every 100 women. In Blackrock, less than one (0.89) man of every 100 was incarcerated, and there were 96 men for every 100 women. Women were eligible if they self-identified as Black/African American; were heterosexual; were unmarried; between the ages of 18 and 39; reported sexual activity with a man in the past 90-days; resided in their neighborhood ≥ 3 years; and spoke English. Interviews focused on perceptions of local male incarceration rates and sex ratios, sexual relationships, condom use, and HIV/STI testing behaviors. Interviews were transcribed verbatim and data were analyzed using grounded theory methods.

Results: Preliminary results suggest that neighborhood-level rates of male incarceration influenced participants' relationship power and sexual decision-making via several mechanisms. In Allentown, a paucity of potentially-available male partners between the ages of 18 to 39 (due, in large part, to incarceration), led many women to engage in primary partnerships with older (≥ 5 years) male partners. Women in these age-discordant partnerships reported being less able to negotiate when sexual activity occurred and condom use during sexual activity. As a result, some participants contracted an STI or had an unwanted pregnancy. Further, given the high neighborhood rates of male incarceration in Allentown, many participants had male partners with a history of incarceration. These participants believed that their partners had been tested and treated for STIs/HIV during their incarceration; this perception influenced condom-use and testing behaviors. In contrast, in Blackrock, many participants reported shared decision-making with their partners regarding condom use; STI/HIV testing by both partners was described as a necessary precursor to ceasing condom use.

Conclusions/Implications: This qualitative study illuminates pathways through which neighborhood male incarceration rates and sex ratios produce vulnerability to STI/HIV among Black women. HIV and other STI prevention programs targeting this group should consider the role of local incarceration rates on relationship power and sexual decision-making.

Abstract 2076 - A Novel Measure of Poverty and its Association with Elevated Sexual Risk Behavior Among Young Black MSM

Author(s): *Richard Crosby, Leandro Mena, Laura Beauchamps, Angelica Geter, DeMarc Hickson, Timothy Brown, Courtney Sims*

Background: To determine whether a novel (single-item) measure of poverty is associated with elevated sexual risk behaviors among a clinic-based sample of young Black MSM who reside in a southern city with high HIV seroprevalence.

Methods: A convenience sample of 400 Black MSM (ages 16 through 29) completed a computer-assisted self interview in a private area of a clinic dedicated to sexual health. The questionnaire included an item

assessing asking whether men, “In the past 12 months have you missed meals because you did not have enough money to eat?” Contingency table analyses and t-tests were used to determine whether those answering yes to this question reported elevated sexual risk behaviors.

Results: Of 398 men providing valid data, 98 (23.1%) had missed meals due to lack of money. These men were more likely to report: 1) having concurrent sex partners (41.6% vs. 27.1%; $P=.009$), 2) engaging in serosorting (61.8% vs. 44.0%; $P=.003$), 3) depending on sex partners for food, money, and shelter (18.5% vs. 5.2%; $P<.0001$), and 4) dealing with gay-related prejudice (mean score on a scale ranging from 1-4 = 2.60 vs. 2.06; $P<.0001$). In addition, these men were more likely to test positive for Chlamydia/gonorrhea (tested in three anatomic sites) at study enrollment (46.1% vs. 33.9%; $P=.037$) and they were more likely to be HIV-positive (36.5% vs. 25.4%; $P=.045$). Of interest, however, differences in frequency of recent (past 90 days) unprotected anal sex as a TOP (30.1% vs. 28.8%; $P=.81$) or recent unprotected sex as a BOTTOM (42.4% vs. 33.0%; $P=.16$) were not found.

Conclusions/Implications: In this clinic-based sample of young Black MSM, a novel method of assessing poverty was associated with a range of risk behaviors, including being dependent on sex partners for basic necessities of living. Consistent with this observation, men who had missed meals due to lack of money were more likely to test positive for STIs and HIV. This measure of poverty, however, was not associated with unprotected sex thus suggesting that the acquisition and use of condoms is disconnected to poverty.

Abstract 2184 - Geographic Mobility, Social Networks and Syringe Sharing Among Young Persons who Inject Drugs from Metropolitan Chicago

Author(s): *Basmattee Boodram, Mary-Ellen Mackesy-Amiti, Carl Latkin*

Background: Injection drug use is a risk factor for HIV and hepatitis C (HCV) infections. In recent decades in the United States there has been a significant shift in the demographic profile of people who inject drugs (PWID), with initiates being increasingly likely to be suburban and non-Hispanic (NH) white. Young NH-white suburban PWID have low rates of HIV and HCV infection, but frequently engage in behavior that places them at risk. We examined the role of geographic mobility and injection network characteristics on syringe sharing among young PWID.

Methods: We conducted a cross-sectional personal (egocentric) network and geographic study of 164 young (18-30 years old) PWID, collecting information on drug-using, sexual, and social support network members. Recruitment occurred at a large syringe exchange program with five locations in major outdoor heroin and cocaine markets in Chicago, Illinois that attract both urban and suburban drug users. We performed univariate, bivariate and multivariable analyses using Stata 13. In multivariable analyses, we used generalized estimating equations (GEE) logistic regression to adjust for clustering of network members on the participant.

Results: Participants ($n=164$) had a median age of 26, were mostly male (65%), NH-white (71%), had been injecting drugs for a median of 6 years (range=0-14). About one-third (37%) reported suburban residence(s), 36% reported urban residence(s), and 27% reported both suburban and urban residences (“crossover”) in the past year. Most participants reported having been tested for HCV (75%); self-

reported HCV prevalence was 13% and HIV was <1%. Among participants who reported injected with others regularly (n=148), the mean network size was 3.8. After adjusting for participant age, race/ethnicity, gender, residence status, and HCV status, homelessness was significantly ($p<.05$) associated with increasing network size. Syringe sharing with network members was significantly ($p<.01$) higher among participants who had multiple residences in the past year, especially “crossover” participants. In a GEE model that adjusted for participant and network characteristics (e.g. age, race/ethnicity), participant characteristics associated with increased likelihood of sharing syringes with a network member included female gender (OR=3.29, 95% CI: 1.36-7.94), “crossover” vs. suburban residence (OR=4.19, 95% CI: 1.69-10.35) and unknown HCV status vs. HCV negative (OR=4.62, 95% CI: 1.79-11.92). In this GEE model, network variables associated with increased likelihood of sharing syringes with a network member included living in the same “household” ($p<.001$), network member having “crossover” vs. suburban ($p<.01$) or urban ($p<.05$) residence, and network member having unknown HCV status vs. HCV negative ($p<.01$).

Conclusions/Implications: Our study on young PWID reports novel data on the behavioral and geographic characteristics of this population and their injection networks. We identified geographic mobility between suburban and urban locations as a significant risk factor associated with syringe sharing, independent of homelessness and drug-using network characteristics. Given that low-income urban populations typically have higher HIV and HCV prevalence than suburban populations, further research is needed to understand the role of geographic factors promoting higher risk among “crossover” PWID and their potential for spreading infections to suburban PWID.

Abstract 2466 - Exploring How Social Determinants of Health Affect HIV-Related Health Disparities along the HIV Care Continuum in Washington State

Author(s): Jason Carr, Lydia Guy-Ortiz, Tom Jaenicke

Background: Understanding how social determinants of health (SDH) influence HIV-related health disparities is important, both to shape policy development and to improve HIV service delivery. Because the National HIV Surveillance System does not routinely collect socioeconomic information about people diagnosed with HIV, other data sources must be considered. One potential source is the U.S. Census Bureau. The methods describe here are very similar to those in a Supplemental Surveillance Report article published by CDC in July 2014 entitled “Social determinants of health among adults diagnosed with HIV infection in 20 states, the District of Columbia, and Puerto Rico, 2010.”

Methods: HIV surveillance staff at the WA State Department of Health (DOH) linked geocoded, residential address information to Census tract-level data collected via the U.S. Census Bureau’s American Community Survey (2009-2013). Based on the state’s HIV Care Continuum, outcomes of interest included HIV diagnosis rates, late HIV diagnosis, linkage to care, engagement/retention in care, and viral load suppression. Census tract assignment was based on either residential address at HIV diagnosis (2009-2013) or current residential address among prevalent cases as of year-end 2013. Three area-based SDH indicators were selected: 1) percent of Census tract residents living below the Federal Poverty Line, 2) percent of Census tract residents who had graduated high school (or equivalent), and 3) median household income among Census tract residents. Using the SDH indicators, Census tracts were ranked from greatest to least, then divided into four equally-sized SDH Tiers (labeled A through D). Each

SDH Tier was based on the relative, aggregated level of social advantage experienced by residents within, as measured by the SDH indicators. Tier A tracts had the lowest level of social advantage, while Tier D tracts had the highest.

Results: Overall, Tier A tracts had significantly higher rates of HIV diagnosis. Also, new cases linked to Tier A tracts were significantly more likely to be diagnosed late in the course of their HIV illness. These findings held true both statewide, and within most demographic and risk populations. In general, linkage to care did not vary greatly between residents of different SDH Tiers. However, prevalent cases residing in Tier C tracts—with median to higher levels of social advantage—often fared the most poorly with regarding to HIV care engagement and care. Again, this finding was consistent both overall and within stratified populations.

Conclusions/Implications: We expected that both HIV rates and late HIV diagnosis would be inversely associated with SEP. However, the finding that cases living in Tier C tracts often had the most difficulty remaining engaged or retained in care was unexpected. Follow-up discussions with program staff and HIV planners indicated that the financial burden shouldered by people who don't qualify for public assistance can be substantial, even among those with health insurance. Hence, DOH program staff are now considering modifying eligibility criteria to certain programs so that more people who need it can qualify for at least some level of care- and/or treatment-related support.

Session B16 - Factors Influencing the Sexual Behaviors of MSM and Their Response to Public Health Messages

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1454 - Sexual Debut and HIV-Related Sexual Risk-Taking among Men who Have Sex with Men in the United States by Birth Cohort

Author(s): *Kimberly Nelson, Kristi Gamarel, David Pantalone, Michael Carey, Jane Simoni*

Background: Early sexual debut is associated with increased HIV risk behavior among men who have sex with men (MSM). The current study aimed to describe sexual debut patterns and relations with sexual risk-taking among MSM in the United States by birth cohort.

Methods: Adult MSM were recruited online for a cross-sectional, Internet-based survey of sexual risk and sexually explicit online media consumption. Analyses were conducted among a subset of participants (n=812, 69%) who reported voluntary sexual or anal sex debut between the ages of 8 and 22. Descriptive statistics and multivariate logistic regression models were conducted in Stata 12.1.

Results: Of the 812 participants, 243 (30%) were born before 1970, 105 (13%) were born in the 1970s, 269 (33%) were born in the 1980s, and 195 (24%) were born in the 1990s. HIV prevalence was 16%. In the three months prior to the survey, 29% reported serodiscordant condomless anal intercourse (COAI), 18% reported serodiscordant insertive COAI, and 21% reported serodiscordant receptive COAI. Mean age of sexual debut differed by birth cohort (14.6, 15.8, 16.2, and 15.9 for pre-1970, 1970s, 1980s, and 1990s birth cohorts, respectively, $p < 0.01$). The youngest cohort was the least likely to report having their sexual debut with a partner who was 5 or more years older (33%, 38%, 27%, and 25% for pre-1970,

1970s, 1980s, and 1990s birth cohorts, respectively, $p < 0.05$). Compared to participants who reported having their sexual debut with a partner of the same age or younger, reporting sexual debut with a partner who was 2-4 years older was associated with an increased odds of engaging in serodiscordant COAI (OR = 1.5, 95% CI: 1.0-2.2) and serodiscordant receptive COAI (OR = 1.6, 95% CI: 1.0-2.5) regardless of birth cohort. Controlling for birth cohort, increasing age of sexual debut, entered as a continuous variable, was associated with a decreasing odds of engaging in sexual risk behavior (serodiscordant COAI: OR = 0.9, 95% CI: 0.8-0.9; serodiscordant insertive COAI: OR = 0.9, 95% CI: 0.8-0.9; serodiscordant receptive COAI: OR = 0.9, 95% CI: 0.8-0.9). Controlling for birth cohort, increasing age of anal sex debut, entered as a continuous variable, was also associated with decreasing odds of engaging in sexual risk behaviors (e.g., serodiscordant receptive COAI: OR = 0.9, 95% CI: 0.8-0.9). Regardless of the reported sexual debut age, compared to those born before 1970, being born in the 1980s and 1990s was associated with an increased odds of engaging in sexual risk behaviors (e.g., 1980s: serodiscordant receptive COAI: OR = 2.0, 95% CI: 1.2-3.4; 1990s: serodiscordant receptive COAI: OR = 2.7, 95% CI: 1.5-4.9).

Conclusions/Implications: Although the prevalence of age-discrepant sexual partnerships and the mean age of sexual debut appear to vary by birth cohort, study findings suggest that age-discrepant sexual partnerships and earlier sexual debut are critical risk factors for HIV regardless of birth cohort. Sexual risk reduction strategies should consider addressing sexual debut characteristics among MSM.

Abstract 1786 - Substance Use and HIV Serodiscordant Partnerships among a Cohort of MSM with New HIV Diagnosis

Author(s): *Marjan Javanbakht, Robert Bolan, Pamina Gorbach*

Background: We examined substance use and sexual risk behaviors one-year following HIV-testing in a cohort of men who have sex with men (MSM) who were newly HIV-diagnosed or HIV-negative.

Methods: Between February 2009 and May 2012 we enrolled participants from a community-based organization providing sexual health services to the gay, lesbian, and transgender community in Los Angeles, CA. Clients were eligible for inclusion if they were at least 18 years of age, male, and reported sex with a male partner in the past 12 months, and not previously known to be HIV-positive. At baseline, participants were classified as HIV-negative, newly HIV-diagnosed, or newly HIV-infected based on nucleic acid amplification test (NAAT) with negative HIV serology or detuned assay. Demographic, behavioral and other data were collected via computer-assisted self-interview at baseline and 1-year follow-up. Differences between groups were examined using chi-square methods and the association between ongoing substance use and sexual risk behaviors was assessed using logistic regression analysis.

Results: A total of 328 men were enrolled: 125 men recently HIV-infected, 113 with new diagnosis of chronic HIV infection, and 90 HIV-negative. The participants were mostly young (59% < 30 years of age), minority (50% Hispanic, 15% African American), and educated (80% had > high school education, 30% graduated college). At baseline, the prevalence of substance use with sex was 50%, which was highest among the newly HIV-infected (61.8%) as compared to those newly HIV-diagnosed (39.1%) or HIV-negative (45.9%; p value < .01). Based on follow-up data available on 215 participants, substance use

with sex remained high: 41.1% recently HIV-infected, 30.4% newly HIV-diagnosed, and 24.4% of HIV-negatives (p value=0.11). Condomless anal intercourse (CAI) was reported by 59.1% at 1-year follow-up with 26.5% reporting CAI with serodiscordant partners. After adjusting for age and race/ethnicity ongoing substance use was not associated with CAI with a serodiscordant partner (adjusted odds ratio (AOR)=1.1; 95% confidence interval (CI) 0.4-2.6), while newly HIV-diagnosed were nearly 5-times more likely to report CAI with a serodiscordant partner (AOR=4.7; 95% CI 1.8-12.1) and the recently HIV-infected were 3.6 times as likely (AOR=3.6; 95% CI 1.4-9.0) as compared to HIV-negatives at 1-year post-diagnosis. Furthermore, at 1-year follow-up being newly HIV-diagnosed was independently associated with condomless insertive anal intercourse with a serodiscordant partner (AOR=4.1; 95% CI 1.4-12.4 compared to HIV-negatives), though this association was not seen among the recently HIV-infected (AOR=1.6; 95% CI 0.5-5.2). Although the numbers were too small for inclusion in the model, no bivariate association with being on antiretroviral therapy was seen by practice of CAI.

Conclusions/Implications: Among MSM in Los Angeles substance use declines in the year following HIV-diagnosis though the prevalence remains high. Of concern is that behaviors having the greatest risk of transmission to HIV serodiscordant partners continue throughout the first year of diagnosis, independent of substance use. Furthermore, differences in risk behavior by duration of HIV-infection suggest that targeted prevention strategies may be useful in limiting these risk behaviors.

Abstract 2056 - HIV Prevention Responsibility Beliefs Vary Widely Among MSM

Author(s): *Hong-Ha Truong*

Background: Beliefs about where the responsibility lies for preventing HIV transmission within a sexual partnership may differ between an individual and his partner. While some studies have examined responsibility beliefs among persons living with HIV with regards to preventing transmission, there is little research from the perspective of HIV-negative individuals. We assessed the relationship between individuals' beliefs regarding HIV prevention responsibility and discussion of HIV serostatus with sexual partners.

Methods: HIV-negative ($n=875$) and HIV-positive ($n=188$) men who have sex with men (MSM) were recruited in San Francisco using time-location sampling. We examined participants' beliefs regarding responsibility for HIV prevention and discussion of HIV serostatus prior to sex within their five most recent male sexual partnerships in the previous six months ($n=3,364$).

Results: A higher proportion of HIV-negative MSM compared to HIV-positive MSM agreed with the following statements: "A man who is HIV-positive should discuss his status before having anal sex with new partners" (87% vs. 78%, $p=0.01$), "Men who are HIV-negative should always make sure they are safe with HIV-positive or unknown status partners" (89% vs. 81%, $p<0.01$), and "It is the responsibility of HIV-negative men to make sure they don't get infected" (87% vs. 78%, $p<0.01$). Within the five most recent sexual partnerships, agreement with the statement, "A man who is HIV-positive should discuss his status before having anal sex with new partners" was associated with increased likelihood of discussion of HIV serostatus prior to sex among HIV-negative MSM ($p<0.01$) and HIV-positive MSM ($p<0.01$). There was no association between agreement with the statement, "Men who are HIV-negative

should always make sure they are safe with HIV-positive or unknown status partners” and likelihood of serostatus discussion prior to sex among HIV-negative or HIV-positive MSM.

Conclusions/Implications: HIV prevention responsibility beliefs varied widely among both HIV-positive and HIV-negative MSM. Overall, the majority of participants believed both HIV-positive and HIV-negative men share responsibility for preventing transmission. Prevention responsibility beliefs, however, did not always correspond with discussion of HIV serostatus. This finding suggests further research is needed to examine the differential discrepancies between individuals’ responsibility beliefs and discussion of HIV serostatus with sexual partners.

Session B28 - Reaching and Understanding Latino/Hispanic Communities

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1544 - Home HIV Test: Assessment of Community Readiness Among Hispanics/Latinos in New York City

Author(s): *Emily Klukas, Miriam Vega, Gustavo Morales*

Background: About 40% of Latinos who test positive for HIV develop AIDS within one year. Earlier diagnosis and treatment improves quality of life and reduces further transmission by 96%. The FDA approved the Rapid At-Home HIV Test in 2012, a new tool that could potentially impact the epidemic among Hispanics and other “late testing” populations. In order to develop appropriate programming at a local level, a community readiness assessment was conducted to understand community member perceptions of the Accessibility, Acceptability and Availability of the home test in order to develop appropriate community-based programming.

Methods: A 2-page survey (English and Spanish) was designed to assess Accessibility, Acceptability and Availability of the Home HIV Test. Convenience sampling was used to recruit respondents (n=76) to complete self-administered a self-administered survey (available in Spanish or English) at 3 locations: 1) street-based in a Latino neighborhood; 2) during a faith-based health intervention; and 3) before a community-level intervention for gay/bisexual Latinos. Respondents were volunteers and not provided compensation. Descriptive statistics, chi-square and ANOVA were conducted using SPSS.

Results: The sample reported high rates of HIV testing (65.8%) compared to NYS as a whole (43.2%). In terms of Acceptability of the home test, 45% of respondents reported being ‘comfortable’ or ‘very comfortable’ with taking the test. Further, 50% indicated being ‘likely’ or ‘very likely’ to use the test; those who reported being sexual active, having previous experience with home screening kits, and having been born outside the US and its territories reported statistically higher likelihood of using the test. In terms of Accessibility, respondents reported an average distance to ‘their pharmacy’ of 3.6 blocks. Accessibility also includes ‘accessing accurate results;’ only 18.4% of respondents correctly identified the appropriate time to use an HIV test (after the window period) and 50% reported they would use the test immediately after potential exposure. At a retail price of nearly \$40, the home test is not generally accessible to those in this sample – only 7.9% of respondents indicated they would pay within this range. In terms of Availability, 59.2% of respondents were aware of the test; however there was a sizable minority that utilizes small neighborhood pharmacies that may or may not carry the test.

Conclusions/Implications: Key implications for prevention programs include: 1) As knowledge of how to effectively use the test is low (particularly regarding the “window period”), consider incorporating health literacy on at home testing into education programming; 2) As the current price of the at home test is prohibitive for many, consider creative mechanisms to address the primary reasons respondents indicated for seeking out the home test (speed and privacy); and 3) As there are moderate levels of comfort with buying the test, particularly at a pharmacy, consider building on this adaptive strength and increasing collaborations with pharmacies for HIV prevention services.

Abstract 1662 - Using Social Networking Sites with Latino MSM to Promote HIV Testing, Prevention and Care

Author(s): *Frank Galvan, Ronald Brooks, Honghu Liu, Jesus Duran, Ying-Tung Chen*

Background: Many Latino men who have sex with men (MSM) delay accessing HIV testing and medical care and are in need of innovative interventions to facilitate earlier engagement with these services. Online social networking sites (SNS) provide a unique opportunity for identifying high-risk MSM. SNS have redefined how men who have sex with men interact socially and sexually. MSM who use SNS for sexual hook ups often engage in high-risk sexual behaviors, including having unprotected sex. This study sought to determine how to use SNS to identify high-risk Latino MSM who are unaware of their HIV status, engage them for HIV testing and provide them with linkages to HIV prevention services and medical care.

Methods: Focus groups were conducted with Latino MSM to identify their use of SNS (e.g., most frequently used SNS), barriers to HIV testing, prevention services and medical care (the latter was asked only in the focus groups for HIV-positive individuals), and the dollar amounts of incentives that would motivate Latino MSM to engage in HIV-related services. Participants were recruited through bilingual ads in print media and Facebook, outreach at nightclubs/bars, LGBT service organizations, AIDS clinics, support groups, fliers distributed at community organizations and referrals from friends. Eight focus groups were conducted: two for each language (Spanish and English) and HIV serostatus (positive and negative) combination. Qualitative focus group data were analyzed through content analysis. Quantitative data (incentive amounts) were assessed using all possible pair-wise comparisons among different amounts.

Results: Fifty-two individuals participated in the focus groups: 29 Spanish- and 23 English-speakers and 24 HIV-negative and 28 HIV-positive individuals. The participants reported using 40 different SNS. The reasons for their use included connecting for sex, engaging in sex work, wanting to party and play (i.e., sex and drugs), meeting new people, dating, feeling bored, feeling lonely, desiring to go out, and keeping in touch with friends. Barriers to HIV testing that were identified included fear of knowing the outcome, fear of one’s family’s learning their HIV status and attitudes reflective of machismo. Barriers to linkage to prevention services included drug use and not wanting to use condoms. Barriers to linkage to medical care included concerns of being discriminated for being undocumented, fear of stigma from others for being HIV-positive and social circumstances (e.g., living with others with whom one does not want to share knowledge of their HIV status). Regarding the preferred amounts to offer as incentives for different HIV-related services, the following were recommended. For HIV testing, \$15 is adequate,

but \$20 is preferred. For going to HIV prevention services, \$5 is adequate, but \$10 or \$15 is preferred. For attending an HIV medical appointment, \$10 is adequate, but \$15 is preferred.

Conclusions/Implications: SNS provide new opportunities for promoting HIV-related services to Latino MSM. Conducting outreach through these sites can potentially reach Latino MSM who engage in high-risk sexual behaviors. In addition, such outreach can include ways of addressing their barriers to HIV-related services and incorporate incentive amounts that are reasonable and consistent with market levels.

Abstract 2172 - Discrimination, Stress and Social Support: Association with Sexual Risk Behaviors and HIV Testing Rates among Male Mexican Migrants

Author(s): *Natalie Rhoads, Xiao Zhang, Gudelia Rangel, Mebourne Hovell, Ana Martinez-Donate*

Background: Circular Mexican migrants, who repeatedly cross the border for work, family and other reasons, are at increased risk for acquiring HIV. Previous studies have identified migration as a structural factor that increases HIV incidence and vulnerability, however there is limited knowledge as to what factors, or combination of factors, encountered during migration are associated with increased HIV risk. Circular migrants are especially vulnerable because they are likely to face multiple risk factors during the migration process that may make them more vulnerable to HIV, including discrimination due to document status, ethnicity, sexual orientation, or other reasons. The migration process may also cause additional stress and lack of social support. We examined self-reported discrimination, acculturative stress and social support as predictors of sexual risk behaviors and HIV testing rates among male Mexican migrants traveling through the border city of Tijuana, Mexico.

Methods: From August to November 2009 we conducted a cross-sectional, probability HIV risk survey of male, mostly Mexican migrants that were returning from the U.S. either voluntarily (N= 900) or via deportation (N= 639) in Tijuana, Mexico. An interviewer-administered, computer-assisted questionnaire was used to collect information on discrimination, acculturative stress, social support, HIV testing and HIV risk behaviors in last 12 months. We constructed a HIV risk scale (range 0-20) based on a series of risk behavior items (e.g. sex /unprotected anal and vaginal sex with casual partners and sex workers), with a higher score representing higher risk for HIV infection. We created scales of self-reported discrimination (range 0-11), acculturative stress (range 0-6) and social support (range 0-4) levels, with higher scores representing higher levels. Multivariable linear regression models were performed to examine the association of discrimination, stress and social support with HIV risk scale and HIV testing.

Results: The average HIV risk scale was 1.1 (SD=1.6) and the prevalence of last 12-month HIV testing was 18.0% among male Mexican migrants. The average levels of discrimination, acculturative stress and social support were 2.5 (SD=2.9), 1.5 (SD=1.9) and 3.0 (SD=1.5) respectively. We found discrimination and stress to be significantly associated with HIV risk behaviors when controlling for sociodemographic characteristics and migration-related factors ($\beta=0.51$, $p<0.01$; $\beta=0.07$, $p<0.01$, respectively). Social support was found to be not significantly associated with HIV risk behaviors. Discrimination was negatively associated with last 12-month HIV testing rates ($\beta=-0.01$, $p<0.05$). Stress and social support were not associated with HIV testing rates.

Conclusions/Implications: Experiencing discrimination could contribute to HIV risk behaviors and impede HIV testing among male Mexican migrants. Higher levels of stress also led to more risk behaviors. Our findings call for interventions to decrease discrimination and stress during the migration trajectory and encourage safe sexual behaviors and HIV testing among this population.

Abstract 2324 - Engaging Latino Faith Based Communities in HIV Prevention with a Unique Model

Author(s): *Daniel Leyva, Guillermo Chacon*

Issue: The CDC states that Faith Based Organizations (FBOs) have long played an important role in addressing social challenges and protecting people at risk. Latino FBOs are often overlooked by decision makers that target HIV, HCV and STIs prevention programs. They do not realize that Latino FBOs comprise distinct social networks of individuals and institutions with shared communications, activities and interests. Each congregation has a set of alliances that reaches far beyond the four walls of the FBO itself and into the extended Latino families.

Setting: Beginning in 1995, the Latino Commission on AIDS has worked with Latino faith based communities throughout New York City's 5 boroughs. For close to twenty years of working with Latino Faith based communities, this has been a successful way to disseminate health information, and particularly, to gradually de-stigmatize HIV & AIDS across Latino faith communities of diverse denominations, with emphasis on providing education and HIV prevention services to Spanish speaking communities.

Project: Our program is based on a Leadership model, which tailors an individual prevention strategy per Faith Community. The model call to each Faith Based Organizations to identify a coordinator to receive training on specific health topics, skills to deliver education, HIV and HCV prevention strategies and education, and stigma reductions tools and strategies through a participatory process to ensure ownership and empowerment. One main goal is to ensure each FBO to be equipped to deploy a comprehensive HIV and HCV education and awareness to their respective congregations and low income communities.

Results: Every year, the FBO program of the Latino Commission on AIDS, in collaboration with 27 partner FBOs provides an average of 197 health educational workshops for congregants and per fiscal year (June to July), reaching about 6,500 individuals across the five boroughs of New York City. Additionally the Commission collaborates with HIV testing partners throughout the City to provide more than 500 HIV test in FBO settings. An average of 45 faith leaders participate in monthly educational and capacity building activities each year, in order to increase their capacity to provide HIV prevention, health promotion and AIDS stigma reduction strategies as part of working toward the elimination of health disparities.

Lessons Learned: Recognizing the centrality of communities of faith in many individuals' lives, representatives from these institutions play an important role in delivering up to date information about health issues, with emphasis on HIV/AIDS and Hepatitis C to their constituents in a non-traditional health setting.

The importance of gaining trust and increasing awareness about health issues in general and HIV/AIDS prevention strategies in particular, to gain active participation from faith based communities.

The role of HIV capacity building in changing risk behaviors for chronic health conditions including HIV and Hepatitis.

Session B30 - HIV, Mental Health, and Substance Use

Room: A703 (Atlanta Marriott Marquis)

Abstract 5038 - Assessing Efficacy of a Retention in Care Intervention among HIV Patients with Depression, Anxiety, Heavy Alcohol Consumption and Illicit Drug Use

Author(s): *Lytt Gardner, Gary Marks, Lokesh Shahani, Thomas Giordano, Tracey Wilson, Mari-Lynn Drainoni, Jeanne Keruly, Scott Batey, Lisa Metsch*

Background: We evaluated whether heavy alcohol use, illicit drug use or high levels of anxiety and depression symptoms were modifiers of the Retention through Enhanced Personal Contact ('REPC') intervention. Alcohol misuse, illicit drug use and symptoms of depression and anxiety are very common in HIV-infected patients. It is important to know if these co-morbidities are barriers to effective delivery of, or response to, a behavioral intervention directed at retaining HIV patients in care. The intervention had previously demonstrated overall efficacy in the parent study. In examining this "modifier" issue, one must determine whether sufficient elements of the intervention were actually delivered. In this analysis, we provide a detailed examination of effect modification that considers delivery and response to the retention intervention among subgroups differing on depression/anxiety, drug use and consumption of alcohol.

Methods: 1,838 patients from 6 U.S. HIV clinics were enrolled into a 12-month randomized trial in which 613 standard-of-care (SOC) patients received the clinics' established reminder system practices and 1,225 intervention patients received SOC practices plus an "enhanced contact" protocol from study staff (telephone calls, brief sessions at clinic). All participants completed an ACASI interview that measured depression and anxiety symptoms from the Brief Symptom Inventory, alcohol use from the AUDIT-C instrument, and drug use from the WHO (ASSIST) questions. The 12-month binary outcome was completing an HIV care visit in three consecutive 4-month intervals. The outcome was compared between intervention and standard-of-care patients within subgroups on the modifier variables using log-binomial regression models. The intervention effect measure was a risk ratio: outcome percentage in intervention-arm patients divided by outcome percentage in SOC-arm patients. Percentage of successful phone contacts was the measure of intervention delivery.

Results: In the parent study, the intervention-arm participants were superior to the SOC participants on the outcome (55.7% vs. 45.7%, risk ratio =1.22 (1.09, 1.36). However, 654 persons with high levels of anxiety or depression symptoms (scoring 34+ on the BSI inventory), those reporting illicit drug use (yes to any use in past 30 days of drugs on the ASSIST screener), or heavy alcohol consumption (scoring 5 or more on the AUDIT-C screener) had no response to the intervention: risk ratio=1.01 (0.85, 1.20); 1184 patients without these "higher-risk" characteristics had significant intervention effects: risk ratio=1.35 (1.19, 1.52). These risk ratios were significantly different from each other (p=0.0095). We examined

delivery of the intervention to further illuminate these findings. We found the higher-risk patients were less likely to have successfully received the telephone contact component of the intervention (40.6%) than lower-risk patients (50.7%, $p < 0.0001$). Among intervention arm patients in the upper third of successful telephone contacts, the response to the intervention was very similar between the higher-risk (62%) and lower-risk (69%) patients (not significant).

Conclusions/Implications: Our findings suggest that clinic-based retention-in-care interventions are able to have significant effects on higher-risk HIV patients with co-morbidities, but the design of those interventions must assure successful delivery of intervention components in order to be effective.

Abstract 5063 - Improving HIV Treatment Outcomes: Integration of Mental Health Treatment into HIV Medical Care

Author(s): JoLynn Wheatley, Briann Wolfe

Issue: Improving health care means more than meeting physical needs and providing medical care. For people living with HIV/AIDS, who have higher rates of depression and substance abuse than the general public, treating mental health disorders is especially critical. It has been estimated that the prevalence of HIV among individuals with a serious mental illness ranges from 1% to 24% (De Hert et al., 2011), much higher than the rates found among HIV-uninfected persons. The first step to treatment is recognition.

Setting: It is important for practitioners treating HIV infected individuals to be aware of the high likelihood of co-morbid mental health conditions and have a basic understanding of the diagnosis and treatment. The Family AIDS Clinic and Education Services (FACES) at Nationwide Children's Hospital (NCH) has integrated mental health services into HIV medical care for dual diagnosed patients.

Project: Screening HIV+ patients for mental illness or substance use is very important. Current screening tools being used in the FACES Clinic at NCH are PHQ-9 (depression), GAD-7 (anxiety), CAGE (alcohol/substance use), and DAST-20 (drug use). Social Workers in the FACES clinic screen patients over the age of 12 at least annually and anyone screening positive is referred for mental health/AOD services. FACES received a Behavioral Health Grant through the Columbus Health Department in March 2014. FACES has two mental health clinicians and a contracted Psychiatrist to provide short and long term outpatient counseling and outpatient psychiatric assessments and treatment. Cognitive-behavioral therapy and pharmacological interventions can improve mental health among persons living with HIV by improving coping skills and stress management. Achieving better mental health may in turn lead to a reduction in sexual risk behaviors and improvements in HIV treatment adherence. In this way, "mental health treatment provides added, and potentially essential value to secondary HIV prevention" (Sikkema et al., 2010).

Results: FACES social workers completed 142 screenings in 2014. Throughout 2014, 60 patients were provided counseling by FACES mental health counselors which included 264 encounters. In 2014, 20 patients were evaluated by the FACES contracted Psychiatrist which included 56 encounters. Current viral load suppression rate based on FACES definition (< 40 copies/mL) is 76%. With HRSA and the National definition of viral load suppression (< 200 copies/mL), FACES is at 80%.

Lessons Learned: The FACES clinic has integrated mental health services into the HIV medical care which is improving the HIV treatment outcomes for dual diagnosed patients (results are still being evaluated). Integrating behavioral health care in HIV primary care maximizes opportunities to lower the community's viral load. Mental health is just as important as physical health. We need to treat the whole person, not simply part of the person or their individual illnesses.

Abstract 5073 - Prevalence of HIV Viral Load Suppression among Psychiatric Inpatients with Comorbid Substance Use Disorders

Author(s): Donna Coviello, Michael Blank, Dave Metzger, Marlene Eisenberg, Regina Szucs-Reed, Natasha Kiryankova-Dalseth, Rebeka Lovato, Katilin Apostol, David Kelly,

Background: A consistently suppressed viral load enables HIV+ patients to live longer and healthier lives and reduces the probability of transmitting the virus. Overall, in the United States the CDC reports that 30% of HIV-infected persons in medical care have a suppressed viral load. Since the prevalence of HIV is four times higher among those with psychiatric disorders than the general population, it is likely that this group would also have greater difficulty achieving viral suppression.

Methods: Screening data from the PATH for Triples Study were examined to assess HIV load suppression (< 200 copies/mL) among 254 psychiatric inpatients with comorbid substance use disorders in Philadelphia. Viral load results from the past 12 months were obtained from medical records for 63 HIV+ patients.

Results: The sample was predominately African American (76%), male (56%) and the average age was 43 years. Psychiatric disorders included depression (64%), schizophrenia (21%), and bipolar disorder (13%) with patients reporting use of alcohol (73%), cocaine (64%), cannabis (29%) and opiates (16%) in the 30 days prior to admission. Among this high risk sample of HIV+ patients, about one half (52%) achieved viral suppression, significantly higher than the general population reported by the CDC (2014). While there were no differences in demographics or psychiatric diagnosis when controlling for other covariates, recent opiate users were six times more likely to have a detectable viral load compared to non-opiate users (OR=6.0, CI=1.1-31.7, p=.035).

Conclusions/Implications: The higher rate of viral suppression among psychiatric inpatients compared to the general HIV population is encouraging from a public health perspective; however, our prevalence rate is not directly comparable to CDC estimates.

Abstract 5135 - Maximizing Health, Minimizing Harm: Drug User Health as High Impact Prevention

Author(s): Chris Taylor

Issue: Since the earliest days of the HIV epidemic, people who inject drugs (PWID) have been disproportionately impacted. This population has also been disproportionately impacted by hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV). The National Alliance of State & Territorial AIDS Directors (NASTAD) and the health department members we represent have long been concerned about the role of substance use in the

transmission of HIV and hepatitis, health outcomes for people living with HIV and hepatitis with substance use disorders, and the structural and policy barriers to effectively address the prevention, care and treatment needs of persons who inject drugs. To address the prevention, care and treatment and policy needs related to drug user health, NASTAD has advanced the issues through technical assistance, policy change and coalition engagement. To best meet the needs of people who inject drugs, NASTAD has partnered with federal, state and local governments and for- and not-for-profit community partners to continue to raise awareness of and action to best meet the health needs of this population.

Setting: While there has been tremendous progress in reducing HIV transmission among people who inject drugs, transmission continues to occur. There remains an epidemic of HCV transmission and overdose among this population with an increase in new HCV infections among young people who inject drugs. Health departments play an essential role in assuring an adequate response to public health – this includes the prevention, care and treatment needs of people with substance use disorders. Historically, HIV and hepatitis programs have focused primarily on the infectious disease needs of this population, though increasingly there is a movement to collaborate with other health and social justice organizations to address the holistic health needs of people with substance use disorders. Just as the health needs of this population are complex and multi-layered, our response to these needs will include multiple stakeholders and approaches. Health department infectious disease programs have unique perspectives and skills to bring to this response.

Project: NASTAD provides technical assistance on providing comprehensive services for people with substance use disorders. This presentation will include an overview of factors to be included in a comprehensive program.

Results: To eliminate HIV and viral hepatitis among people with substance use disorders, comprehensive programs must be established that address substance use prevention and treatment, HIV and viral hepatitis prevention, care and treatment, mental health services, syringe services programs, ongoing support and access to insurance coverage.

Lessons Learned: As more jurisdictions prepare to prevent and/or respond to HIV and HCV outbreaks among people who inject drugs, they must be equipped with the tools and technical assistance to best meet the needs of their jurisdiction and populations at risk.

Track C

Session C10 - Meeting the HIV Prevention Needs of Teen YMSM: Baseline Data, Promising Approaches, and Lessons Learned from a School-Centered Approach

Room: A601 (Atlanta Marriott Marquis)

Abstract 1303 - An Early Start: High Schools as a key venue for HIV Prevention among Young Men who Have Sex with Men

Author(s): *Catherine Rasberry, Elana Morris, Catherine Lesesne, Andrew Hebert, Elizabeth Kroupa*

Background: Recent increases in diagnosed cases of HIV have been driven largely by young men who have sex with men (YMSM), particularly those ages 13-24. Although many programs focus on reaching youth in the upper end of this age range (ages 18-24), fewer have been designed specifically for younger YMSM. School-based HIV prevention programs have been one approach used to reach these youth.

Methods: As baseline evaluation for a school-centered HIV prevention program focused on YMSM, a 46-item paper-and-pencil questionnaire assessing sexual risk and protective behaviors was administered to 11,681 students in 7 high schools participating in the program. Data were analyzed to identify YMSM based on criteria of attraction, identity, and/or behavior. Chi-square tests examined differences in sexual risk and protective behaviors between males who were classified as YMSM and those who were not (“other males”) and between the subgroup of YMSM who do not identify as gay or bisexual and YMSM who do.

Results: Frequency distributions revealed 301 males met the study’s definition of YMSM based on attraction to other males or both males and females (n=245, 81.4% of YMSM), identifying as gay or bisexual (n=204, 67.8% of YMSM), and/or having had sex with a male partner or both male and female partners (n=130, 43.2% of YMSM). YMSM were significantly more likely than males who were not classified as YMSM (“other males”) to have ever had sex (58.6% of YMSM, 47.3% of other males, $X^2=14.038$, $p<.001$). Among males who reported having had sex, YMSM were significantly less likely than other males to have used a condom at last sex (51.8% of YMSM, 72.4% of other males, $X^2=32.097$, $p<.001$), but YMSM were significantly more likely than other males to have been tested for HIV (31.4% of YMSM, 21.3% of other males, $X^2=9.351$, $p=.004$) and tested for STDs (28.2% of YMSM, 16.6% of other males, $X^2=15.136$, $p<.001$).

YMSM who did not identify as gay or bisexual (n=201) were significantly more likely than other YMSM (n=89) to have ever had sex (74.2% of YMSM who did not identify as gay or bisexual, 51.7% of other YMSM, $X^2=12.778$, $p<.001$). Among YMSM who had had sex (n=170), there was not a significant difference between YMSM who did not identify as gay or bisexual and other YMSM for having used a condom the last time they had sex (45.3% and 55.9%, respectively), or having been tested for HIV (27.3% and 34.0%, respectively) or STDs (27.3% and 28.8%, respectively).

Conclusions/Implications: Elevated risk among YMSM compared to other males in this study confirm that high school age YMSM may need focused HIV prevention efforts. Furthermore, findings illustrate YMSM of high school age are at varying stages of identity formation, and data highlight the need to reach YMSM who may not identify as gay or bisexual. Schools offer access to these youth, who may not engage with community resources focused on MSM.

Abstract 1891 - A School-Centered Structural and Behavioral HIV Prevention Intervention Project for Teen Black and Latino YMSM

Author(s): Sharon Wong, Yesenia Wilkins

Issue: While the HIV epidemic has been relatively stable in the US, men who have sex with men (MSM) accounted for 61% of new HIV infections in 2011. Among MSM, the increase in HIV diagnoses is driven

by young MSM (YMSM), especially 13–24 year olds. Black and Latino men who have sex with men (MSM) are disproportionately affected by HIV and combined account for 78% of the HIV infections among 13-29 year old MSM. Although the number of cases of HIV among teens is small, sexual risk behaviors often begin in adolescence. There is a dearth of HIV prevention programming specifically targeting black and Latino teen YMSM.

Setting: Schools are critical in promoting the wellbeing and safety of teens and helping them establish lifelong healthy behaviors. The Centers for Disease Control and Prevention's (CDC) Division of Adolescent and School Health works with school districts because research shows academic achievement is strongly linked with health. More than 22 million teens are enrolled in US schools, making school systems a key environment for reaching large numbers of youth with health-enhancing education and services.

Project: This project uses a school-centered approach that includes working directly with schools as well as establishing and enhancing collaboration between schools and community organizations with expertise in serving YMSM. This project goal is to reduce HIV/STD infections among black and Latino YMSM ages 13-19 through school- and community-based partnerships by 1) increasing the number of teen YMSM who are tested and treated for HIV/STDs; 2) decreasing sexual risk behaviors among teen YMSM; and 3) reducing rates of absenteeism and school dropout among teen YMSM.

Results: CDC funds school districts in Fort Lauderdale, FL, Los Angeles, CA, and San Francisco, CA to implement this project, with capacity building support from the national non-governmental organization Advocates for Youth. These 3 school districts focus programmatic activities in 21 schools that enroll over 36,000 high school students. Activities include providing HIV/STD testing and treatment in schools and school-based health centers (SBHC); creating organizational partnerships, particularly to support testing and treatment; establishing and marketing systems for referring students to testing and treatment; assessing and providing training on policies related to testing, treatment, and prevention interventions; creating safe and healthy school and SBHC environments inclusive of black and Latino teen YMSM; and implementing targeted evidence-based sexual risk reduction interventions for black and Latino teen YMSM.

Lessons Learned: Organizational partnerships between schools, clinical providers, and other community organizations are essential to the infrastructure of this project. Within schools, administrators, nurses, social workers, health educators, and guidance counselors are important staff to engage. Funded school districts used these partnerships to create referral guides with lists of local sexual health service providers, highlighting those that serve black and Latino teen YMSM; to standardize school referral procedures; and to implement young men's health groups in schools.

Abstract 1911 - Culturally Competent School-Centered HIV Prevention Interventions for Teen Black and Latino YMSM: Examples from Three Urban School Districts

Author(s): *Yescenia Wilkins, Donovan Thomas, Timothy Kordic, Christopher Pepper, Sharon Wong*

Issue: Increasing attention is given to the HIV prevention needs of black and Latino young men who have sex with men (YMSM). However, these efforts have largely focused on young adults rather than on adolescents. School settings provide an important opportunity to reach a broad range of teen YMSM

(13-19 years old) with both HIV primary prevention education efforts and clinical services. Trusted school staff can be a particularly essential starting point for YMSM who have initial discomfort or accessibility issues in choosing an appropriate sexual health services provider.

Setting: Most schools have some health service systems in the form of staff (e.g., school nurses, guidance counselors, social workers) and, more exclusively, structures (e.g., school-based health centers, wellness centers). These staff and structures are well-positioned to provide direct care or to refer teens to sexual health services such as HIV/STD testing and treatment by youth-friendly local organizations. Broward County Public Schools (BCPS), Los Angeles Unified School District (LAUSD), and San Francisco Unified School District (SFUSD) are implementing promising school-centered approaches to increase access to HIV/STD testing and treatment for black and Latino teen YMSM students.

Project: BCPS developed an LGBTQ Critical Support Guide for school staff to increase safe and supportive environments for LGBTQ students and a Teen Health Resource Guide for students with lists of local sexual health service providers, highlighting those that serve black and Latino teen YMSM. LAUSD forged strong school and community partnerships to standardize referral procedures that allow school staff to refer students to school-based health centers for sexual health services. LAUSD is working to ensure school-based health centers are welcoming and culturally competent for black and Latino YMSM. SFUSD collaborated with local youth-serving organizations to develop and implement young men's health groups in schools. These groups are open to male students and explore topics such as healthy relationships, masculinity, sexuality, LGBTQ issues, and negotiating HIV/STD testing and treatment.

Results: BCPS distributed the LGBTQ Critical Support Guide and will distribute the Teen Health Resource Guide in 7 pilot high schools, reaching 16,000 students. For the 2015-2016 school year, LAUSD will implement standardized sexual health services referral procedures in 7 pilot high schools and their associated school-based health centers, serving 14,000 students. In SFUSD, more than 90 male students across 7 pilot high schools participated in young men's health groups in the 2014-15 school year. These groups will be expanded in the 2015-16 school year, and the district will also begin offering coming out groups.

Lessons Learned: School-centered programs offer unique opportunities and challenges to reduce HIV and STD among teen black and Latino YMSM. All activities must ensure confidentiality and avoid stigmatizing or inadvertently outing YMSM in schools. Current evaluation efforts are assessing how effectively these school districts can increase the number of teen YMSM tested for HIV/STD, refer YMSM students for HIV/STD testing, and improve the school climate for YMSM.

Abstract 2389 - Developing Safe and Supportive Environments in the Nation's Schools

Author(s): *William Potts-Datema, Elizabeth Haller, Carmen Ashley*

Issue: Bullying and sexual harassment are highly prevalent in schools. About 20% of high school students report being bullied on school property in the previous year, and 15% report being bullied electronically. Perpetrators and victims of bullying may be more likely to have casual sex, sex under the influence of drugs/alcohol, and sex with four or more partners compared to those students not involved in bullying.

Bullying perpetration is also associated with sexual violence perpetration over time. Eight in 10 students (81%) experience some form of sexual harassment during their school lives. However, bullying and sexual harassment prevention, such as anti-bullying policies and staff training related to sexual harassment, are associated with improvements in school safety.

Setting: Schools are critical in promoting the well-being and safety of teens and helping them establish lifelong healthy behaviors. Promoting and providing a learning environment in which all students and staff feel safe and supported is an essential function of schools. Two aspects of the school environment—climate and safety—are particularly important. Research shows that a positive school climate and school safety are associated with improved education and health outcomes for students, including students at disproportionate risk for HIV and other STD. School connectedness has been identified as a protective factor for adolescent sexual and reproductive health. For example, adolescents who feel connected to their school are less likely to initiate sexual activity or initiate sexual activity at an early age.

Project: The Centers for Disease Control and Prevention Division of Adolescent and School Health (CDC-DASH) works with 19 state education agencies and 17 large city education agencies to implement exemplary sexual health education, increase access to key sexual health services, establish safe and supportive school environments for students and staff, educate decision makers on policy, and help schools implement policies. These agencies help districts and schools establish school environments characterized by supportive and caring relationships between adults and students and by the absence of discrimination, intimidation, taunting, harassment, and bullying. This approach involves implementing clear policies, procedures, and program activities designed to increase school connectedness and parent engagement and to prevent bullying and sexual harassment.

Results: Education agencies funded by CDC-DASH have made major strides toward creating safe and supportive school environments. State departments of education in Michigan, North Carolina, Rhode Island, and others have implemented professional development for school faculty and staff that build their skills in creating safe and supportive environments. Local education agencies including the New York City Department of Education and San Diego Unified School District have expanded policy initiatives to cover youth at disproportionate risk for HIV and STD, including transgender youth. Education agencies including the Los Angeles Unified School District and San Francisco Unified School District have multifaceted programs that enable safe and supportive environments.

Lessons Learned: Education agencies can be effective change agents in creating safe and supportive environments in schools. They can successfully employ a variety of methods to establish and implement clear policies, procedures, and program activities that develop environments within which young people can remain healthy and thrive academically.

Session C19 - Building Effective Linkage to Care Programs

Room: A704 (Atlanta Marriott Marquis)

Abstract 1149 - I Can't Breathe: The Intersection of Barriers to Linkage to Care in the Deep South

Author(s): *Jacquelyn Bickham, Antoine Brantley, Samuel Burgess, Lara Jackson, DeAnn Gruber*

Issue: According to CDC, improving the health of persons with HIV and reducing the number of new HIV infections will depend on increasing access to HIV medical care and eliminating disparities in the quality of care received. In the Deep South, structural barriers such as poverty, racism, heterosexism, transphobia, and limited access to quality health care intersect with individual-level challenges, such as mental health issues, illiteracy, and substance abuse and thwart successful engagement in care, particularly among racial and ethnic minorities. In Louisiana, Blacks make up 32% of the population, but account for 70% of new HIV diagnoses, 69% of PLWHA not engaged in HIV medical care, and 72% of PLWHA who were not virally suppressed (2012).

Setting: LA Links is a linkage/re-engagement to care and patient navigation intervention that is implemented in three regions of the state (New Orleans, Baton Rouge, and Shreveport) which have the highest HIV prevalence and experience high unmet need for HIV care.

Project: The Louisiana Office of Public Health STD/HIV Program employs five Linkage to Care Coordinators (LCCs) who utilize surveillance data to identify PLWHA who are (1) newly diagnosed, (2) previously diagnosed, (3) experiencing virologic failure. LCCs are a distinct member of the client's care team, separate from HIV medical and /or non-medical case managers. The LCC works on identifying and addressing barriers that prevent the client from engaging in HIV medical care and facilitates engagement. The LCC's role ends once the client has achieved early retention, indicated by the client's attendance at three HIV medical visits with a prescribing provider. The intervention timeline is adjusted to each client's needs and medical appointment frequency. LCCs accompany their clients to medical appointments to provide support, advocacy, and assistance in navigating daunting and complex systems.

Results: During the first year of implementation (September 2013 – September 2014), 300 persons were enrolled. 90% were Black, 31% were MSM, and 55% were male. 84% (n=252) of total enrollees and 86% (n = 230) of Black enrollees were linked to care. 49% (n=146) of all enrollees and 48% (n=130) of Black enrollees achieved viral suppression by the end of Year 1. By comparison, only 54% of Blacks living in the study region were in care before the implementation of LA Links, and only 38% were virally suppressed. There were no significant racial/ethnic disparities in the outcomes of LA Links.

Lessons Learned: In Louisiana, intersections of structural, societal, and individual barriers to HIV care are too overwhelming for many PLWHA to overcome on their own. High-acuity individuals who are not engaged within the current system of care can benefit from an intensive, individualized intervention that works from a framework of intersectionality, provides vital emotional and social support, and addresses barriers holistically. Health Department Linkage to Care Coordinators are able to provide tailored and flexible assistance and advocacy in navigating the fragmented web of social and medical services. Eliminating racial/ethnic disparities will require in-depth examinations of the causes of health disparities while implementing effective and nontraditional strategies.

Abstract 1259 - Linkage to Care, Linkage to Life: Programmatic Process and Results, 2013-2014

Author(s): *Derrick Greenwade, Katie Rybka, Mary Roberts, Cory D'Ambrosio, Linda Laroche*

Issue: Columbus, Ohio (Franklin County) has the highest rate of HIV infection in the state of Ohio and over 250 new diagnoses are made each year. Suppressing community viral load is imperative to reducing the number of new infections and decreasing the overall burden of HIV infection in the community. The number of new HIV infections can be reduced by linking all newly diagnosed individuals, as well as previously diagnosed individuals who may have fallen out of care, to the necessary medical care for treatment.

Setting: Columbus Public Health (CPH) is located in an urban community and employs a carefully selected team of Linkage to Care (L2C) professionals who, together, carry over 75 years of experience working within the HIV community. Services are provided all Persons Living with HIV/AIDS (PLWHA) regardless of age, immigration status, income, sexual orientation, race, and ethnicity to HIV-positive individuals within Franklin County and seven surrounding counties. The main goal of the L2C program is to assure access to medical care for all PLWHA. The Ryan White program, however, specifically targets disproportionately impacted populations, including young African American men who have sex with men (MSM).

Project: Using a strengths-based model approach – ARTAS (Anti-Retroviral Treatment and Access to Services) – clients create goals for themselves and establish effective working relationships with their L2C coordinator. ARTAS consists of up to five client sessions conducted over a 90 day period or until the client is linked to medical care – whichever comes first. CPH defines “linked” as two medical appointments with an HIV medical provider. ARTAS views the community as a resource for the client and following the final session, the client may be linked to a long-term medical case manager and/or other service organization to address any barriers that may impact the client’s ability to remain in care.

Results: In 2013, 217 HIV-positive individuals were enrolled into the L2C program at CPH and 194 (89.4%) were successfully linked to care. In 2014, 154 of the 167 (92.2%) individuals that were enrolled were successfully linked to care. Between 2013 and 2014, the number of new diagnoses that were linked to care increased from 89.1% to 91.8%. Of the 348 HIV-positive individuals that the L2C program linked to care in 2013 and 2014, 27% were young African American MSM.

Lessons Learned: The success of the L2C program at CPH can be credited to a diverse staff of L2C coordinators that are willing to work flexible hours and who are committed to client centered care. In addition, the use of social media and local advertising to encourage HIV/STI testing and to market the L2C program have helped reduce the number HIV-positive individuals who lack access to HIV medical care. The ability of state and local health departments to work alongside community-based organizations and to communicate effectively with community stakeholders, including the state correction system, are essential in linking HIV-positive individuals to care and to improving the lives of all PLWHA.

Abstract 2265 - Improvements in Retention in Care and Viral Suppression: Results from the First Year of the Medical Care Coordination Program in Los Angeles County

Author(s): *Wendy Garland, Sonali Kulkarni, Angela Boger*

Issue: Of the 45,474 people diagnosed with HIV in Los Angeles County (LAC) in 2012, 58% had seen had a doctor for their HIV at least twice in the past year and 56% had suppressed viral load less than 200 copies/mL. These data prompted the LAC Department of Public Health (DPH) to launch innovative prevention and treatment strategies to improve engagement in the HIV care continuum and reduce HIV transmission through sustained viral suppression.

Setting: To improve engagement in the HIV care continuum, the LAC Commission on HIV allocated over \$9 million in Ryan White program (RWP) funding to 35 HIV medical homes in 2012 to implement the Medical Care Coordination (MCC) program, an integrated service model that addresses patients' unmet medical and psychosocial needs (i.e., multiple comorbidities, mental health, substance abuse, housing) to support engagement in care and adherence to antiretroviral therapy.

Project: The MCC program requires that: 1) HIV medical homes screen their patient population every 6m to identify those at risk for poor health outcomes; 2) enroll identified patients in the MCC program; 3) assess medical and psychosocial needs and determine patient acuity; 4) develop and implement a care plan; 5) delivery targeted, brief interventions based on identified need; 6) re-assess and deliver services until can manage own care. MCC services are delivered by multidisciplinary teams that are co-located at the HIV medical home and consist of a nurse, a social worker and a case worker. Baseline assessment, laboratory and MCC service data were collected. Medical visits were estimated using HIV laboratory test dates. A quasi-experimental pre-test post-test design was used to evaluate differences in 12m outcomes. The main outcomes were VL<200 copies/mL and retention in care(≥ 2 HIV test dates >90 days apart in past 12m). Differences in the main outcomes at 12m were compared using McNemar's test for paired data.

Results: Between 1/2013-12/2013, 1,204 patients were enrolled MCC at 25 HIV clinics (49% Latino, 26% Black; 85% male; 76% living at or below federal poverty level; 51% ≥ 40 years; 23% diagnosed with an STD in the past 6m; 10% incarcerated in past 6m; and 73% on ART). At 12m, patients had received 17.3 median hours of MCC services (range=0-147.5). From 12m pre-MCC to 12m post-MCC, the proportion of patients with viral suppression increased from 30% to 60% ($p<0.0001$) and those retained in care increased from 52% to 84% ($p<0.0001$).

Lessons Learned: Promising results from the first year of MCC suggest that it has the potential to improve retention in HIV care and viral suppression among persons living with HIV and to positively impact engagement in these key HIV care continuum components. Patients with higher acuity levels receive more MCC intervention hours suggesting that the patient-centered, targeted approach of the MCC model is feasible and can be successfully implemented in clinical HIV settings.

Abstract 2285 - What Effect Does HIV Case Management Have on Retention and Viral Suppression? A Review of National Ryan White HIV/AIDS Program Data

Author(s): *Marlene Matosky, Emily Chew, Vimal Rao, Rupali Doshi, Pam Klein*

Background: The Ryan White HIV/AIDS Program provides services to over 520,000 people living with HIV in the United States annually. The National HIV/AIDS Strategy and the HIV Care Continuum Initiative highlight the importance of retention in medical care and viral suppression for people living with HIV.

CDC estimates 61.3% of all HIV transmission in the United States occurred due to individuals who were not retained in care. In a previously published analysis of Ryan White HIV/AIDS Program data, a link between retention in medical care and viral suppression was established. Case Management (medical and non-medical) is the provision of a range of client-centered activities focused on improving health outcomes along the HIV Care Continuum that link clients with health care services. However, the role of HIV case management in supporting client retention and viral suppression has not been fully explored.

Methods: Grantees and providers funded by the Ryan White HIV/AIDS Program annually report demographic, core medical and support service utilization, and clinical data. Clients receiving medical care (n=313,921) in 2013 were grouped into receipt of HIV case management (n=216,161) and no case management (n=97,760). Demographics, retention, and viral suppression were calculated for each group. Viral suppression was calculated two ways: 1) viral load test <200 copies/mL at last test during year and 2) first viral load test during year >200 copies/mL and last test during year <200 copies/mL. Comparisons for retention and viral suppression were stratified by demographics as well as the number of HIV case management visits.

Results: Eighty-three percent of clients receiving HIV case management were retained in medical care compared to 76% of clients not receiving HIV case management ($p<0.0001$). Greater retention in medical care was observed for those receiving HIV case management when stratifying by various demographics including housing status, gender, age, race/ethnicity, risk, poverty level, and insurance status with some differences being 10% or greater (all $p<0.015$). A relationship between the number of HIV case management visits and retention was identified. Overall, very little difference in viral suppression (at last test during year) was seen between clients receiving HIV case management (78%) and those who did not (80%). However, HIV viral suppression was higher (39%) among clients whose first viral load test count in the year was not suppressed and who received HIV case management compared with the clients whose first viral load test in the year was not suppressed and who did not receive HIV case management (34%) [$p<0.0001$].

Conclusions/Implications: HIV case management plays a role in facilitating retention in medical care. Vulnerable populations appear more likely to be retained in medical care when they also receive HIV case management. HIV case management plays a role in viral suppression; however, the extent of the relationship is not entirely clear and warrants further analysis. HIV case management may indirectly contribute to viral suppression. Additionally, HIV case management, through the impact on retention, may also have result in a reduction of HIV transmissions.

Abstract 2368 - Linkage and Re-engagement Collaborations: Volusia County's Linkage to Care Program

Author(s): *Patrick Forand, Marvin Hall*

Issue: In recent years Linkage to Care (LTC) has become a critical step in ensuring newly diagnosed individuals receive care and treatment as soon as possible. The sooner a newly diagnosed HIV-positive person can be linked to and retained in HIV/AIDS medical care, the sooner medications can be prescribed and viral suppression can be achieved.

Setting: This program demonstrates the importance of early LTC and identification of individuals lost to care for re-engagement purposes. The program represents a collaborative effort between the Sexually Transmitted Disease Program, Medical Case Management, and HIV/AIDS Counseling and Testing agencies.

Project: Florida Statute requires that all HIV/AIDS test results be reported and the majority of test results are reported electronically into a statewide surveillance database. At the county level, the surveillance coordinator notifies the LTC coordinator of a new HIV positive test result and the LTC coordinator begins the process of notifying the individual and providing LTC information. Within this program, the LTC coordinator is a trained Disease Intervention Specialist (DIS) and a member of the HIV team, providing the LTC coordinator with the best tools to encourage individuals to initiate HIV care. At each LTC appointment, the LTC coordinator provides a packet of information to the individual that includes: educational information, referrals for assistance within the community and a network of individuals they can speak with about their new diagnosis. The LTC Coordinator works closely with HIV/AIDS medical case managers to provide appointments for all LTC clients at the time of the visit. Medical case managers and the LTC coordinator in tandem to identify clients that have been lost to care.

Results: In the first year (April 2014 – March 2015) of program implementation, 42 individuals were linked to care. Of those, 31 were newly diagnosed, nine were previous positives that were lost to care and two cases were referred from the jail/prison linkage program. Medical case managers worked with the LTC Coordinator to not only locate these individuals but also track each individual to confirm the client accessed care. This process is more than making the referral but tracking the individual with medical case management to make sure the individual attended the appointment with the medical case manager and made an appointment with a local physician.

Lessons Learned: This type of initiative cannot be completed by one person and one program alone. It takes an entire system of care and effective partnerships with community-based agencies to link an individual to treatment, from the moment of the positive test result, all the way through to starting medications. Ensuring LTC coordinators have diverse skill sets which include DIS training and HIV/AIDS education is key to producing successful linkages.

Session C31 - Capacity Building: Couples Interventions

Room: A707 (Atlanta Marriott Marquis)

Abstract 1397 - Two is Greater than One: Expanding HIV Testing Together for Couples in the U.S.

Author(s): *Kristina Grabbe*

Issue: Although 86% of people living with HIV in the United States know they're infected, still more than 186,000 individuals do not know they have HIV. Additionally, persons with undiagnosed HIV infection account for one-third of new HIV infections in the U.S. In order to reduce HIV transmission, novel efforts are needed to diagnose these persons, link them with HIV care and treatment services, and retain them in care. Couples HIV testing and counseling (CHTC), or "Testing Together" is a new approach to HIV testing that has the potential to reach undiagnosed, high-risk populations, including partners of people living with HIV.

By testing together for HIV, two or more persons who are in—or are planning to be in—a sexual relationship learn their HIV status together. HIV testing providers help facilitate future-focused dialogue between couples, aimed at helping them develop agreements that will help prevent HIV transmission and support them to access follow-up services such as care and treatment, PrEP, or behavioral interventions, based on their results.

Setting: Since 2012, CDC has worked with health departments, community-based organizations, and clinics throughout the country to expand CHTC services. Conducting an average of 30 trainings per year has led to roll-out in most major cities, and new programs continue to be supported with implementation through training and technical assistance. This presentation will highlight CDC’s training and technical assistance efforts nationwide, and will draw upon implementation efforts in Chicago, New York, Florida, and San Francisco.

Project: The Division of HIV/AIDS Prevention, Capacity Building Branch at CDC funds 11 capacity-building assistance (CBA) agencies to conduct training and technical assistance on CHTC. Trainings equip providers with the skills to begin implementing HIV testing together for couples at their agency, following the eight-step CHTC protocol. Technical assistance is provided to various agencies for implementation support, including data collection, monitoring, quality assurance, targeting and promotion, policy review, and the development of standard operating procedures.

Results: Between April 1, 2014 and March 31, 2015, these agencies will have conducted 30 CHTC trainings, reaching close to 600 HIV testing providers and program managers. Technical assistance has been provided upon request and proactively with various health departments, including Florida State Department of Health, New York City Department of Health and Mental Hygiene, and Chicago Department of Public Health. In the next funding year it is anticipated that 36 trainings will be held, and at least 11 technical assistance visits conducted.

Lessons Learned: CHTC is an effective HIV prevention tool, and is easily integrated into existing HIV testing programs with adequate training and technical assistance. By offering HIV testing services to couples, not just individuals, this innovative approach can reach persons who are not otherwise testing. CHTC can improve HIV prevention, care, and treatment outcomes by identifying persons who are undiagnosed and discordant couples and linking them with follow-up services. As the first step along the continuum of care, HIV diagnosis remains important as ever, and novel approaches such as CHTC provide opportunities for contributing to reduced HIV transmission in the U.S.

Abstract 1421 - SMART (Sharing Medical Adherence Responsibilities Together) Couples: A New e-learning Module Supported by CDC to Improve HIV Treatment Adherence

Author(s): *Kathleen Green, Rhondette Jones*

Issue: Despite improvements in the potency and tolerability of antiretroviral treatment (ART), more than 800,000 of the estimated 1.2 million people living with HIV in the United States do not have a suppressed viral load. HIV medication adherence is a key component of both treatment and prevention. Just as ART improves the health and prolongs the lives of persons with HIV, studies show that HIV

treatment can also reduce the likelihood of transmission from an HIV-positive person to their partner by 96%. SMART Couples is an evidence-based intervention for HIV-discordant couples that was proven efficacious in improving adherence to HIV treatment in the HIV-positive partner with poor adherence.

Setting: The CDC is offering an e-learning training on SMART Couples, which can be accessed at <https://effectiveinterventions.cdc.gov>. Implementation of SMART Couples can be delivered by a variety of HIV care providers including nurses, licensed clinical social workers, HIV case managers, or health educators, allowing providers to optimize resources and shift activities to other front-line HIV care professionals. SMART Couples may also be helpful for improving adherence to Pre-exposure prophylaxis or PrEP.

Project: The CDC's Division of HIV/AIDS Prevention Capacity Building Branch selected SMART Couples for translation into an interactive e-learning training to support providers as they counsel and encourage patients to attain maximum adherence to their HIV regimen. The Capacity Building Branch at CDC funds capacity-building assistance (CBA) agencies to provide technical assistance on SMART Couples. Technical assistance is available to various organizations to support intervention implementation, including the selection of staff and alignment of resources.

Results: As of March 20, 2015 a total of 32 learners have completed the e-learning module for SMART Couples. Technical assistance is provided upon request.

Lessons Learned: By offering SMART Couples to HIV-discordant couples multiple outcomes around risk reduction and improvements in ART and PrEP adherence may be achieved. The intervention may also link couples to ancillary services.

Abstract 1467 - A Multi-outcome Behavioral Intervention for HIV-Discordant Couples

Author(s): *JoAna Stallworth, Timothy Hunt, Sandra Serrano-Alicea, Jorge Alvarez, Jaime Altamirano, Charles Collins*

Issue: CONNECT is an evidence-based intervention for couples that was proven efficacious for both HIV-negative couples and HIV-discordant couples and was recognized as efficacious by CDC DHAP PRB's Research Synthesis Project (El-Bassel, et al, 2003 and El-Bassel et al, 2005). However to support the goals of the National HIV AIDS Strategy and DHAP's High Impact Prevention initiative, the CONNECT intervention has been adapted to include a couples-based approach to ART adherence (Remien, et al 2005). Thus the new adapted version of CONNECT will: (1) support HIV risk reduction to ensure the HIV-negative partner does not become infected (Wu, El-Bassel, et al. 2010; Wu, El-Bassel, et al. 2011; Mitchell, 2013), (2) encourage use of PrEP for the HIV-negative partner, and (3) encourage ART adherence for the HIV-positive partner (Remien, et al, 2005).

Setting: The CDC has disseminated the original risk-reduction version of CONNECT with health departments and community-based organizations throughout the country. The new adapted version should now be more appropriate for clinical medicine settings since it uses a couples –based model for medication adherence for both PrEP and ART.

Project: The Division of HIV/AIDS Prevention, Capacity Building Branch at CDC funds capacity-building assistance (CBA) agencies to conduct training and technical assistance on CONNECT. Trainings equip providers with the skills to begin implementing at their agency. Technical assistance is provided to various agencies for implementation support, including couples recruitment. The intervention has been disseminated to CBOs and health departments, but the new goals are to increase the number of CBOs and HD that decided to implement the intervention and to expand the type of agency that will implement to clinical medicine settings.

Results: As of March 20, 2015 a total of 19 CBOs and 7 health departments have been trained on CONNECT. Technical assistance has been provided upon request and proactively with various health departments.

Lessons Learned: By offering CONNECT to HIV-discordant couples multiple outcomes around risk reduction, ART, and PrEP may be achieved. The intervention may also link couples with follow-up services.

Session C38 - Implementing PrEP in a Variety of Settings

Room: A706 (Atlanta Marriott Marquis)

Abstract 1344 - Public Health Detailing on Pre- and Post-Exposure Prophylaxis (PrEP and PEP) in New York City, 2014-2015

Author(s): *Zoe Edelstein, Amanda Reid, Demetre Daskalakis, Julie Myers*

Background: Pre- and post-exposure prophylaxis (PrEP and PEP) are scientifically-proven HIV prevention interventions. However, major barriers to providers prescribing PrEP and PEP still exist, including limited and sometimes incorrect knowledge, and unwillingness to screen for sexual behavior. Building on a history of successful public health detailing (PHD) campaigns, the New York City Department of Health and Mental Hygiene (DOHMH) sought to address provider barriers with a PrEP and PEP PHD campaign. The campaign's key messages were: 1) take a sexual history as a routine part of care, 2) appropriately screen and treat sexual transmitted infections, 3) discuss PrEP and PEP with eligible patients, and 4) prescribe PrEP and PEP to patients who would benefit.

Methods: Between October, 2014 and January, 2015, 5 trained DOHMH representatives visited clinical facilities citywide. Facilities were chosen based primarily on specialty in primary care or infectious disease (ID) and having newly diagnosed at least one person as HIV positive in 2012, as identified by HIV Surveillance data. Preference was given to facilities identified as having diagnosed at least one man who had sex with men (MSM) of color or being located in a neighborhood identified by DOHMH as high-need. Representatives performed initial and follow-up visits consisting of short presentations using the PrEP and PEP Action Kit. The Kit contained patient and provider resources for each of the key messages. Representatives aimed to speak individually to all members of the clinical care team, focusing on potential prescribers [MDs, nurse practitioners (NPs), and physician assistants (PAs)]. The evaluation consisted of questions asked of potential prescribers in the same manner at initial and follow-up visits. Questions measured the following clinical practices: taking a sexual history from all patients, history of PEP prescribing for non-occupational exposures, and history of PrEP discussion and prescribing.

Responses at initial and follow-up visits were compared only among providers queried at both. Proportions were calculated and statistical comparisons were adjusted for clustering by facility.

Results: A total of 904 providers were visited at 353 facilities. Among the 691 (76%) providers who had an initial and follow-up visit, 324 (47%), 251 (36%), and 116 (17%) identified as primary care MDs, ID MDs, and NPs/PAs, respectively. Between initial and follow-up visit, report of taking a sexual history from all patients increased from 65% to 76% ($p<0.01$). Although there was no significant increase in PEP prescribing (33% to 35%, $p>0.20$), report of PrEP discussion increased from 25% to 35% ($p<0.01$), and report of PrEP prescription increased from 19% to 26% ($p<0.01$). For PrEP prescription, significant increases were still seen when the analysis was limited to primary care MDs (12% to 18%, $p=0.02$) and ID MDs (27% to 38%, $p<0.01$), but not when limited to NPs/PAs (20% to 22%, $p>0.20$).

Conclusions/Implications: In New York City, PHD was successfully conducted about PrEP/PEP prescribing and associated best practices. Modest improvements were seen in self-reported rates of prescribing. PrEP and PEP PHD is likely adaptable to other settings.

Abstract 1736 - Programmatic Experience Offering Pre-Exposure Prophylaxis (PrEP) as Part of Routine Sexual Health Services at a Municipal Sexually Transmitted Disease Clinic

Author(s): *Stephanie Cohen, Robert Wilder Blue, Robert Kohn, Amanda Jernstrom, Sally Grant, Jonathan Fuchs, Oliver Bacon, Susan Philip*

Issue: Pre-Exposure Prophylaxis (PrEP) is a highly efficacious HIV prevention tool. For PrEP to reduce HIV incidence at a population level, uptake must be high among populations at elevated risk, such as those who attend sexually transmitted disease (STD) clinics. We studied the feasibility of integrating PrEP into routine sexual health services at a busy municipal STD clinic.

Setting: San Francisco City Clinic (SFCC) serves approximately 11,000 clients each year, including over 4300 HIV-negative men who have sex with men (MSM). From 9/12 through 9/14, SFCC participated in the US PrEP demonstration project and enrolled and followed 300 individuals on PrEP. Demand for PrEP was high and some participants interested in continuing PrEP after completing the study had difficulty accessing it. In response, and in order to be able to continue to offer PrEP to those at elevated risk, SFCC initiated its PrEP navigation program.

Project: The SFCC PrEP navigation program is staffed by a program coordinator, a counselor and a half-time nurse practitioner. Program staff provide PrEP education and counseling to SFCC clients who have questions about PrEP, or whom clinic staff identify as being potential PrEP candidates during a routine visit. Insured clients are provided counseling, education and health systems navigation to help them access PrEP at their medical home. Uninsured clients and those who can't access PrEP at their medical home due to underinsurance, provider barriers or confidentiality concerns, start PrEP and are followed in the clinic, and are encouraged to seek insurance if eligible and link to a primary care provider skilled in PrEP delivery.

Results: Between 5/14 and 3/15, over 450 clients were provided PrEP counseling, education and navigation, and 111 initiated PrEP at the clinic. The mean age of those initiating PrEP was 32 (SD 9) and

25% were age 26; 43% were white, 8% black, 29% latino, 15% asian and 4% other. Most (96%) were MSM. Over one-third (36%) had previously received nPEP at the clinic and 40.5% had a history of a syphilis, rectal gonorrhea or chlamydia in the prior year. Of those initiating PrEP, 57% were uninsured and enrolled in a medication assistance program (MAP) and 43% had insurance (65% Medi-Cal, 35% other). Of those who were uninsured at the time of PrEP initiation, 38% have enrolled in health insurance.

Lessons Learned: PrEP delivery in a municipal STD clinic setting is feasible and requires dedicated staff to provide counseling, assist with enrollment in MAPs and other benefits, and manage a panel of individuals on PrEP. Having staff available for immediate consultation and ongoing case management, including referrals for housing, employment, mental health and substance use treatment, may have facilitated PrEP uptake and retention. Consensus guidelines on how best to transition a client from nPEP to PrEP are needed. By offering PrEP in our STD clinic, we were able to reach a diverse population at substantially elevated HIV risk, and increase access to care by helping clients enroll in health insurance.

Abstract 1742 - Utilizing STD Partner Services to Target High-Risk Men Who Have Sex with Men for Pre-Exposure Prophylaxis Referral: Programmatic Experience in King County, Washington

Author(s): *Galant Chan, David Katz, Matthew Golden, Julie Dombrowski*

Issue: Pre-exposure prophylaxis (PrEP) has been shown to be highly effective in the prevention of HIV acquisition among men who have sex with men (MSM). However, despite the increasing public awareness surrounding PrEP among MSM and their providers, the true scalability and cost-effectiveness of this intervention will depend at least partly on the ability to target PrEP to the highest risk individuals within this population. The question of how to best address this challenge at a programmatic level remains unanswered.

Setting: MSM who are diagnosed with bacterial STIs, particularly those with early syphilis or rectal gonorrhea, are at significantly higher risk for future HIV acquisition. Public Health – Seattle & King County (PHSKC) offers partner services via Disease Intervention Specialists (DIS) to all MSM diagnosed with bacterial STIs, thus providing a potential opportunity to target PrEP to this high-risk population.

Project: In October 2013, DIS began to routinely assess for PrEP use and offer PrEP referral during partner services interviews with HIV-negative MSM diagnosed with early syphilis. Starting in July 2014, this assessment of PrEP use was expanded to include MSM diagnosed with rectal gonorrhea. Individuals who reported not already being on PrEP were then counseled on basic information regarding PrEP and offered a referral to local PrEP providers. After the PHSKC PrEP clinic became operational in October 2014, interested individuals were offered an appointment to initiate PrEP at the clinic.

Results: From October 2013 through March 2015, 179 HIV-negative MSM were diagnosed with early syphilis in King County and participated in a partner services interview. Of these, 14 (7.8%) reported that they were already on PrEP. DIS were subsequently able to offer a referral for PrEP to 93 (56.4%) of those who did not report already being on PrEP. Of those who were offered a PrEP referral, 26 individuals (28.0%) accepted immediate referral for PrEP initiation. The experience was similar among cases of rectal gonorrhea. From July 2014 through March 2015, 165 HIV-negative MSM diagnosed with

rectal gonorrhea in King County participated in a partner services interview. Twenty-nine (17.6%) reported already being on PrEP. Of those not already on PrEP, an additional 59 (43.4%) were offered a referral for PrEP, of whom 29 (49.2%) accepted an immediate referral for PrEP initiation.

Lessons Learned: Integrating PrEP referral into STD partner services is a feasible method to target high-risk MSM, although PrEP uptake among this group remains suboptimal. Further evaluation is necessary to determine the rates of successful initiation and retention on PrEP and to develop methods to optimize the overall uptake of PrEP among this group.

Abstract 1940 - Implementation of PrEP Services in an STD Clinic – Where to Start?

Author(s): *Patricia Coury-Doniger, Susan DiLaura, Vanessa Johnson, Roberta McCaffery, Maureen Scahill, Ann Schwartz*

Issue: HIV PrEP was approved by the FDA in July 2012 as an effective biomedical HIV prevention intervention. Subsequently, the CDC issued guidance recommending PrEP for high risk MSM, IDU, and high-risk heterosexuals (collectively referred to as PrEP candidates). Reaching large numbers of persons in these three groups is a challenge. Compared to other clinical and community-based settings, public health STD clinics and corresponding partner services programs in the community have great potential to reach a large number of potential PrEP candidates, however resources are often limited.

Setting: The public health STD Clinic in Rochester, New York provides integrated STD/HIV prevention services with over 12,000 walk-in visits per year. When rapid HIV testing became available, benefits of using this technology in an STD clinic were apparent, however due to high patient volume and lack of additional staffing, a selective implementation strategy was needed. An analysis of STD clinic and surveillance data in the previous five years was conducted to identify risk characteristics of STD clinic patients who became HIV infected. The results were used to develop Rapid HIV Testing Criteria which were implemented in 2005. Utilization of the Criteria results in the administration of rapid HIV testing in 33% of patient visits and the identification of 95% of all newly diagnosed cases of HIV.

Project: HIV PrEP services were implemented in November 2014 by integrating PrEP counseling into the behavioral counseling intervention used for routinely provided HIV pre- and post-test counseling. Due to lack of additional resources, PrEP counseling was offered only on a part-time basis and only to MSM patients meeting more than one Rapid HIV Testing Criteria. PrEP Counseling services included an assessment of the patient's sexual partner(s), risk behaviors of patient/partner(s), individual circumstances of risk behaviors, and knowledge, attitudes/beliefs regarding HIV PrEP. Each patient's readiness to be referred for PrEP treatment was assessed, followed by a stage-matched behavioral counseling strategy to increase readiness. Information about the benefits of PrEP based on the patient's individual circumstances was discussed and perceived barriers to accepting a referral for PrEP treatment addressed. Directed referrals were made if patients indicated readiness. Others received an HIV PrEP packet including FAQs and a directory of local prescribing providers and were invited to return in 3 months.

Results: From November 2014 through April 2015, a total of 215 MSM patients were seen including 72 (33%) AA/Black MSM. 85 MSM (40%) received PrEP counseling services; 50% White, 32% AA/Black, and

18% Hispanic/Other. Reported ages were 35% 18 – 22 years; 35% 25 – 25 years; and 29% over 35 years. Based on a single counseling session, 33% accepted a referral for PrEP clinical services; 41% white and 59% AA/Black.

Lessons Learned: Large numbers of PrEP candidates are already being served in public health STD clinics and partner services programs offering a window of opportunity to recruit and link those hard-to-reach patients to HIV PrEP treatment. Implementing PrEP counseling services even on a limited basis to MSM at high risk is a starting point if resources are limited.

Session C39 - Emergency Departments: Screening and nPEP

Room: A602 (Atlanta Marriott Marquis)

Abstract 5006 - An Examination of HIV Screening in the Emergency Department

Author(s): *Michael Cirone, Beatrice Probst, Jerry Goldstein, Mark Cichon, Talar Markossian*

Background: In 2006 the CDC recommended that HIV testing be offered in all healthcare settings in an effort to increase the number of HIV-infected persons who are aware of their serostatus¹. Emergency Departments (ED) are explicitly emphasized in the initiative as EDs often serve as a site for routine healthcare visits. In March 2013, the US Preventive Services Task Force released a drafted statement changing their assigned recommendation grade for routine HIV screening from a “C” to an “A”². During a pilot study to determine the feasibility of implementing a 3rd generation point-of-care (POC), opt-in, rapid HIV testing program in our urban, 54,000 volume, level 1 trauma center during the summers of 2011 and 2012, 93% of 456 patients consented to HIV testing³. Following the pilot study, the ED participated with the Illinois Department of Public Health in a CDC Care and Prevention in the United States (CAPUS) grant to expand HIV testing in the Department using the 4th generation Abbott Architect HIV antibody assay. Initially, only patients receiving other ED blood draws were approached but after 11 months, protocol changes allowed testing on all eligible patients. Additionally, point of care HIV testing was implemented in three affiliated Immediate Care (IMC) sites.

Methods: A retrospective query was performed to determine the number of patients tested and the number of reactive results during 12 months of ED HIV testing. The number of ED visits by patients who met age criteria for testing was then obtained to establish a testing rate. Patients’ ages, sex, race, zip codes, and prior HIV testing history were also obtained. The same data points were then obtained from participating IMCs.

Results: During the testing period, 1968 patients were tested for HIV in the ED. Six ED patients (.3% of those tested) were identified as HIV positive. 14% of all eligible ED patients were tested. One of the additional 802 patients tested in the IMC setting tested positive for HIV. The mean age of HIV positive patients was 35 with a range of 18 to 47. Five of these patients were male.

Conclusions/Implications: After 12 months of testing in the ED, and subsequent implementation of similar programs in IMC settings, 2770 patients were tested for HIV without the need for additional support staff. Six seropositive patients were linked to care at the hospital’s Infectious Disease clinic.

References:

1. Rothman, et al. Infectious Disease/CDC Update 49(5): 2007
2. Bayer R, Oppenheimer G. New England Journal of Medicine 368; 10. 2013
3. Cirone M, Probst B. Annals of Emergency Medicine, Volume 62, Issue4, S64

Abstract 5024 - Cost-Effectiveness of an Automated Opt-Out HIV Screening Program Using Blood-in-Lab for Adult Patients in an Urban Emergency Department

Author(s): *Steven Aronin, Ann Keehn, Andee Krasner, Dulce Dones-Mendez*

Background: The CDC recommends routine HIV testing in patients aged 13-64, the use of an opt-out approach, integration of consent into the general consent for care, and limited prevention counseling where HIV prevalence is estimated to be > 0.1%. However, both “universal” and “targeted” opt-out testing in Emergency Departments (EDs) can be difficult to implement. Cost-effectiveness may be difficult to achieve within EDs because of inadvertent testing of patients with known HIV, repeated testing of frequent users of the ED and by congruent testing programs, and lack of consistent access to HIV care. However, more patients are newly diagnosed with HIV in the ED than in any other clinical setting and many patients with late-stage HIV visit the ED in the preceding years to their diagnosis. Despite studies demonstrating cost-effectiveness of “targeted” opt-out screening in EDs, most EDs rely on physician-directed diagnostic testing and have not scaled up routine testing programs.

Methods: A detailed work flow diagram was developed for an opt-out HIV testing program in the ED for eligible blood draw patients aged 18-64, HIV status unknown. The work flow included: intake, HIV test ordered in ED, running HIV test in the lab, sending the confirmatory test to reference laboratory, informing the ER and ID specialist of results, and communicating the results to the client.

Costs: Gross add-on costs were calculated for staff time, changes to EHR, and for HIV tests. Revenue for HIV testing was estimated based on relevant CPT codes, payor mix and hospital cost-to-charge ratio. Net costs were calculated subtracting revenue from gross costs.

Effectiveness: A cohort of 53 people newly diagnosed with HIV that had their first visit to the Waterbury Hospital HIV Clinic (WHIC) between January 1, 2011 and December 31, 2013 was abstracted from WHIC’s patient roster. The city-wide ED utilization and hospital admission rates one year prior to- and one year post- first visit to the WHIC will be compared. Costs or savings to the hospital system will be calculated based on the comparison of ED and hospital utilization rates.

Results: The gross costs for implementing the HIV opt-out testing program are estimated to be \$103,780 per year plus a one-time cost of \$5,300 for modifications to the EHR. Annual costs included internal laboratory supplies and payments to an outside referral laboratory. Staff time for training and implementation was not included because it will be subsumed in normal operations.

Annual operating costs were offset by net patient service revenue collections from laboratory charges added to the ED visit and for confirmatory tests. Collections were estimated to be \$174,450 based upon

hospital's fee schedule, payor mix, and reimbursement rates. One caveat is that third-party payors may deny the test since it is a screening vs a diagnostic test.

Cost-effectiveness results available September, 2015.

Conclusions/Implications: With the implementation of the ACA and renewed focus on overall costs to hospital systems, automated opt-out HIV screening programs may prove to be cost-effective for EDs to adopt.

Abstract 5071 - Administering nPEP for Sexual Assault Survivors Presenting in an Emergency

Department: Protocol Evaluation

Author(s): *Bethany Foster, William Berk*

Issue: The CDC recommends non-occupational post-exposure prophylaxis (nPEP) for sexual assault survivors who were evaluated for possible HIV exposure within 72 hours of the event. Those offered nPEP must complete a 28-day, antiretroviral drug therapy. In Southeast Michigan, there are a limited number of medical facilities administering nPEP to sexual assault survivors.

Setting: Detroit Receiving Hospital Emergency Department (DRH ED) averages over 80,000 visits per year. A Michigan Department of Health and Human Services (MDHHS) funded program is located within the ED and offers free rapid HIV testing. The program's goals are to provide screening, confirmatory testing, counseling, and ensure linkage to care for HIV positive individuals and sexual assault survivors.

Project: The program performs over 10,000 rapid HIV tests a year. In 2013, this program expanded its services to include nPEP referrals for sexual assault survivors. When a sexual assault survivor presents to the ED for nPEP, the physician 1) determines risk of HIV transmission, 2) provides nPEP education, 3) requests a rapid HIV test, and 4) orders screening tests (serum hCG, serum creatinine, and AST) to assess for safety of nPEP. Patients with normal lab results receive their initial nPEP dose in the ED. Patients with insurance are given full prescriptions for the nPEP medications and are provided a referral to an ID clinic. Patients without insurance are given a starter pack of medication and referred to an ID clinic that could provide financial assistance for the medications. Patients between the ages of 13 and 24 years old are referred to the adolescent clinic, and patients over the age of 25 years old are given a referral for the adult clinic.

Results: Between March 2013 and June 2015, 84 patients from the DRH ED were referred to an ID clinic for nPEP follow-up. Of those, 67 (79.76%) received their initial dose of nPEP in the ED, and 37 (44.05%) patients went to their scheduled appointment. 27 patients without insurance were given an nPEP referral and 13 (48.15%) went to their appointment. Of those with insurance given full prescriptions for the medications, 54.35% (25 of 46) were not linked. In 2015, the Program Coordinator began making appointment reminder calls. Since then, there has been a 60.00% (9 of 15) successful linkage rate for those who received a call prior to their scheduled appointment compared to 40.58% (28 of 69) for those who did not receive a call.

Lessons Learned: With the release of the MDHHS nPEP guidelines and the completion of the program evaluation, we determined several areas for improvement: 1) increasing the number of doses (5 days) provided in the starter pack, 2) writing every patient full prescriptions for the nPEP medications, and 3) calling patients prior to their appointments. Educating the patient about nPEP and the importance of following up with an ID clinic must also occur to help increase those linked to care.

Track D

Session D05 - Creating Creative HIV Testing: Collaborations and Partnerships

Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1463 - Building An Effective Collaboration To Address HIV Testing Challenges In New York City

Author(s): *Melissa Thomas Proctor, Stacey Bourgeois, Angelica Ramirez, James Tesoriero, Ben Tsoi*

Issue: CDC-funded New York City (NYC) HIV prevention programs had reported challenges in meeting their funding opportunity announcement HIV testing performance standards and objectives. Most NYC CBOs are funded for HIV testing under multiple local, state, and federal funding sources, including NYSDOH, NYCDOHMH, Health resources and Services Administration (HRSA), and Substance Abuse and Mental Health Administration (SAMHSA). However, no single agency was responsible for assessing the extent of HIV testing in NYC.

Setting: This collaboration was initiated in NYC and targets CDC's direct HIV prevention investment of approximately \$43M annually.

Project: The NYC HIV Testing Collaboration was developed to address the HIV testing challenges in NYC with key multiple local, state, and federal funders. Key activities included: 1) CDC conducting qualitative/quantitative reviews of data reported by NYC CBOs, NYSDOH, and NYCDOHMH to identify contributing factors; 2) assessing HIV testing oversaturation, including developing and populating a master HIV testing matrix of key funders and funded agencies; 3) eliciting support and participation of all key funders, including NYSDOH and NYCDOHMH, as well as the HHS Region II Office in NYC to facilitate HRSA and SAMHSA participation; 4) convening meetings with key funding agencies to develop recommendations to address testing oversaturation; and 5) sharing collaboration information with other areas of the country.

Results: Contributing factors identified included: a) CBOs are often offering testing to the same target population in the same areas, venues, or at the same events as other CBOs; b) CBOs have extended their catchment area in order to meet their targeted funding objectives or performance standards c); CBOs have multiple funded HIV testing program and are often competing within their own agency; and d) HIV testing in NYC is highly incentivized. A master HIV testing matrix of the NYC testing programs was developed and populated with information provided by key funders of their funded programs, which indicated that 72 different agencies with 126 individual HIV testing programs were being funded for HIV testing in NYC. The first collaboration meeting was hosted and coordinated by the HHS Office in NYC. Its primary goal was to develop recommendations to inform future HIV testing activities and funding decisions in a more deliberate and coordinated manner across all funding streams, in order to minimize

any HIV testing oversaturation or other related challenges in NYC; maximize the impact of funding efforts and positive outcomes for each agency; allow for data sharing of funding agencies; and foster ongoing collaboration. A summary report was developed and used to drive future activities.

Lessons Learned: Positive project benefits included heightened awareness of NYC HIV testing challenges; a better understanding of funders' similarities, differences, challenges and successes; and other collaboration opportunities, e.g., joint site visits and use of advance testing technologies.

Abstract 1864 - Partnering To Create Sustainable Solutions To Expand HIV Testing In Clinical Settings. A Case Study From Alameda County, Ca

Author(s): *Shailey Klinedinst, Samantha Feld, Sarah Salomon, Lorenzo Hinojosa*

Issue: Early identification of HIV empowers individuals to take action that benefits both their own health and the public health. Alameda County is a large metropolitan county in Northern California that is diverse in race and social economic status, and has struggled to integrate routine HIV screening into health care settings and reduce the rates of late diagnosis.

Setting: Beginning in 2011, the County health department embarked on a unique partnership with funding from CDC and California Office of AIDS with the goal to pool resources and expertise to build sustainable systems to expand and routinize HIV testing throughout various health care settings. Participating agencies included: Corizon Health, the correctional healthcare provider at the County Jail; HEPPAC, an organization which targets injection drug users; Methadone Maintenance Treatment Programs; La Clínica, a community health center serving Latinos and school health centers; LifeLong Medical, a community health center located in the largest burden area of the County; and Planned Parenthood Mar Monte (PPMM), which provides reproductive health services for men and women. In addition, Cardea Services supported this initiative bringing expertise in training, capacity building and data management for the program.

Project: Our unique partnership for this project enabled us to overcome challenges associated with creating organizational change, building leadership, and getting buy-in to routinize testing, particularly in settings experiencing resistance and competing priorities. In the presentation we will describe approaches for provider trainings and protocol development, and tools and strategies, such as creating provider report cards and panel management to identify clients needing testing. Billing and reimbursement protocols, and the process of using data for program monitoring and improving collaborations for effective linkage to care strategies will also be discussed along with program data.

Results: HIV testing was implemented at 20 different sites and over 41,000 tests were conducted between 2011 and 2014, with majority of the testing conducted with people of color at sites that were not previously testing. 83 HIV positive clients were identified who were either newly diagnosed or out of care, half from the County Jail, where no testing was being done prior to project launch. Clinic staff including doctors, nurses, or medical assistants conducted the tests and the test technology varied from rapid tests to conventional testing. All the sites embraced testing and surpassed their testing goals!

Lessons Learned: • Involve all levels of the staff including administrators, clinic medical directors, testers, linkage to care staff and even front desk staff and identify a champion.

- Provide education on CDC screening guidelines & HIV 101. Many providers had biases about who really needs to be tested for HIV and some chose not to test certain patients, for example their older patients or heterosexual clients.
- Routine dissemination and discussion of results/data to all involved parties throughout the project facilitated quality improvement
- Provider report cards help encourage testing
- Develop clinic specific case studies of missed opportunities and successful linkage to care to build a case for testing.

Abstract 2048 - IMPACT: Integrating HIV & HCV Testing into a Municipal Court and Syringe Access Program

Author(s): *Lydia Anne Burgess, Joseph Olsen*

Issue: New Orleans has consistently ranked in the top 5 for both estimated AIDS and HIV case rates among large metropolitan areas, according to the CDC. Additionally, a 2011 report by the Louisiana Office of Public Health estimated 60,000 Louisianans have Hepatitis C Virus-Past or Present Infections (HCV-PPI). Finding a location frequented by at-risk individuals who may not have access to these health screenings led to the courthouse and syringe access program. According to a 2013 Department of Justice report, Louisiana has the highest incarceration rate in the nation, with Orleans Parish being highest in the state. Orleans Parish Municipal Court (OPMC) oversees cases for more than 20,000 arrests made in Orleans Parish; a disproportionate number of whom are either low-income, African American, substance abusers, sex workers, homeless or otherwise high-risk for HIV and/or HCV. New Orleans Syringe Access Program (NOSAP) is the only legal syringe access service in the region and disposed of 286,000 syringes in 2014.

Setting: The purpose of Project IMPACT (PI) is to serve individuals who are at risk, but who do not routinely test in a clinic environment. Housed inside OPMC, the program is an HIV and HCV testing program that recruits individuals summoned for the OPMC morning and afternoon court sessions and individuals participating in NOSAP for voluntary testing, counseling, and referrals.

Project: The program uses an opt-in recruiting strategy, asking everyone passing through the court building and NOSAP during testing hours if they want to be tested for HIV, and testing those who volunteer. In addition, if the person has risk factors for HCV, an HCV test is offered. For those testing reactive for HIV, a second test is used with the Rapid/Rapid testing model, an HIV patient navigator is notified, and linkage to care is arranged. For those testing positive for HCV antibodies, an HCV patient navigator is notified, RNA testing and linkage to care is arranged with a local Federally Qualified Health Clinic that offers HCV treatment.

Results: Since its inception in February 2013, PI has conducted 3,881 HIV and 335 HCV tests with an HIV positivity rate of 0.8% and HCV-PPI rate of 36% overall. At NOSAP, the HIV positivity rate is 1% and HCV-PPI rate is 50%. Of all of those tested, 20% had no previous testing history for HIV, and only 2% had

taken an HCV test. HIV linkage increased from 25% 2013 to 70% in 2014 due to the implementation of the Rapid/Rapid testing model.

Lessons Learned: From finding space to creating working systems with the court staff to allow clients to test without losing their place on the docket, to creating partnerships both within and outside the agency to link clients tested at one site to services at another, operating inside a courthouse requires a high level of logistical finesse. PI staff has also used the knowledge gained from integrated HIV/HCV testing at OPMC to bring those same services, including linkage to care, to a syringe access program.

Abstract 2508 - Establishing the Chicagoland HIV Testing Collaborative (CHTC) and their “Step Up. Get Tested” Campaign: the Power of Partnerships

Author(s): *Peter McLoyd, Anthony Galloway, Anne Carmak*

Issue: Creation of a Collaborative that would help Chicagoland ASO agencies and other community partners launch a unified presence in an effort to promote HIV testing was proposed as an “experiment” in 2011. It was unknown if such a Collaborative could work in Chicago and receive the necessary support from agencies working together and in partnership with public sector, corporate, foundation and institutional support.

Setting: In 2012, the Chicagoland HIV Testing Collaborative (CHTC) was established by staff from the Ruth M. Rothstein CORE Center, HHS Region V Regional Resource Network, the CORE Foundation and 23 community-based agencies and organizations located throughout Cook County in recognition of National HIV Testing Day. The impetus for creating this Collaborative was the recognition that if local AIDS service organizations (ASOs) collaborated and leveraged resources and talents, then the importance of getting testing, knowing one’s status, dispelling stigma related to HIV infection, getting linked to care if HIV positive and promoting routine testing would be more powerful and have greater impact.

Project: CHTC’s collaborative partners have all provided testing at their agency sites and in the community for years, and the Collaborative offers agencies the opportunity to work together to achieve common goals while highlighting the strength of the Chicagoland HIV/AIDS community to come together to provide testing services to men and women from communities of color that have disproportionately high HIV/AIDS infection rates.

At its inception, CHTC created the framework of its testing campaign, Step Up. Get Tested. by establishing relationships with funders/supporters, supporting testing events hosted by collaborative agencies throughout the month of June, and a culmination event held on National HIV Testing Day.

Results: In its inaugural year, CHTC provided 5,639 tests (identifying 28 HIV+ individuals). In 2013, 5,160 tests were provided (42 HIV+ individuals identified). In 2014 CHTC was very successful in continuing to establish partnerships with not only public sector partners such as CDPH and IDPH but also with corporate, foundation and institutional partners (now >30 collaborative agencies) and 5,692 tests were provided (62 HIV+ individuals identified).

Lessons Learned: The first three years of the Collaborative's history have been marked by successes and steady growth in programming and services offered, . In its fourth year 2015, the Collaborative will continue to offer programming and services to at-risk populations, supporters and providers, but is also focusing on initiatives that will strengthen its community mobilization efforts by engaging the community more directly using social media and digital storytelling.

As the Collaborative enters its fourth year of operations in 2015, it is clear that this "experiment" in combining efforts has helped the Chicagoland HIV/AIDS community establish a successful framework to promote testing with greater visibility and achieve outcomes that would not have been possible for a single agency to reach.

Session D08 - Hooking Up Online: What Attracts MSM

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1232 - GRINDR Meets Public Health: Rhode Island's Use of Internet-based Media Tools to Promote HIV/Syphilis Testing & Prevention among MSM

Author(s): *Thomas Bertrand, Angela Lemire, Philip Chan, Jaime Comella, Jacob van den Berg, Don Operario, Sally Johnson*

Issue: Infectious syphilis among men who have sex with men (MSM) in Rhode Island (RI) increased dramatically from 52 cases in 2013 to 80 cases in 2014. Many of these cases (33%) were also HIV-positive. Concurrently, from 2013 to 2014, the number of newly diagnosed HIV cases among MSM increased from 40 to 56. More than 90% of the HIV and syphilis cases among MSM indicated they had met their sexual partners through social networking websites and/or geo-targeted smart-phone applications, often referred to as "dating apps" or "hookup sites." This highlighted an urgent need to educate and test MSM in Rhode Island for HIV and syphilis.

Setting: This statewide project was led by the Rhode Island Department of Health with the goal of reaching MSM with HIV/syphilis prevention and testing information via social marketing and online technology.

Project: This project was developed and implemented by staff from the RIDOH Office of HIV/STD/TB/Hepatitis. Technical and creative assistance was received from the National Coalition of STD Directors, the Colorado Department of Public Health, Brown University Gay Men's Health Community Advisory Board, and The Miriam Hospital (TMH) STD Clinic.

The first step was to develop a custom webpage on the RIDOH website entitled "Sexual Health Information for Gay Men." This page included HIV/syphilis prevention messages, as well as links to both local STD/HIV testing services and a website, <http://www.Men2Menri.org>, to help men find gay-friendly doctors in Rhode Island. Digital eye-catching advertisements were used to compete for the attention of viewers on hook-up sites, with the goal of having them "click-through" to the "Sexual Health Information for Gay Men" webpage. A three-month paid advertising campaign was launched starting in December 2014 on eight hook-up sites. The campaign included a combination of pop-up ads and e-mails to site members.

Results: For a period of two months following the kick-off of the campaign, “Sexual Health Information for Gay Men” became one of the top ten most visited webpages on the RIDOH website, with an average of 206 page views per day. About 92% of the traffic to the website was from mobile phones. Spikes in online visits occurred when various messages were launched across hookup sites. During the campaign, a 125% increase in visits to <http://www.Men2MenRI.org> was observed. When compared to the average of the prior three months, in January 2015 there was a substantial increase in number of STD Clinic patients (from 13 to 23) that referenced the RIDOH as their referral source. Based on estimates of the population size of MSM in Rhode Island and the number of unique visitors to the RIDOH website, it is approximated that one in four of adult gay/bisexual men living in Rhode Island viewed a campaign ad and clicked-through to the RIDOH website.

Lessons Learned: This project demonstrated that an online public health campaign (via local popular “hook-up sites”) targeting MSM may effectively result in directing a significant proportion of the MSM community to a health department website and subsequently prompting them to access STD/HIV clinical services and additional web-based sexual health information.

Abstract 1926 - Men Who Have Sex With Men (MSM) and Community-Based Risk and Harm Reduction Strategies for Online Social Networking

Author(s): *Erik Santacruz*

Background: According to the Centers for Disease Control and Prevention (CDC), the HIV epidemic continues to disproportionately affect men who have sex with men (MSM). In particular, between 2008 and 2010, young men who have sex with men (YMSM) experienced a 22% increase in HIV infections. Research has proposed that online social networking may play a role in facilitating sexual risk behaviors amongst HIV at-risk populations, such as YMSM.

Methods: High frequency users were recruited from popular online social networking websites (e.g., Facebook, Grinder/Grindr, Twitter) to respond to a multimethod electronic questionnaire. Out of the 160 respondents, 119 responded to the open-ended question: “What recommendations do you have for YMSM who are about to start going online in search of friends, romance, or sex—given your knowledge of any risks or dangers involved in going online and your knowledge of any ways for reducing risks or dangers by engaging in self-protection?”

Results: Responses revealed four themes related to maintaining both physical and emotional safety: 1) communication, 2) behavior, 3) vigilance, and 4) trust. Communication: participants emphasized the necessity for YMSM to engage in two types of communication: open dialogue with their potential partner about their intentions, and about STD/HIV status, and testing history, both before and during any type of encounter; and that they must communicate with a trusted individual about their potential encounter with a stranger. Behavior: participants stated YMSM need to have several behavioral skills to increase personal safety, a) say “no” and walk away from a perceived risky situation, b) avoid encounters under influence of substances, c) use condoms, d) meet in public spaces for initial encounters when meeting someone first met online, e) avoid giving out too much personal information, f) carry your own condoms and lube g) test for HIV/STDs, h) attempt serosorting, and i) ensure safety

during sexual intercourse. Vigilance: participants noted the importance of being aware of a) thieves, b) picture collectors and exploiters, c) people who lie, and d) people who lie, in particular, about their HIV/STD status. Trust: participants highlighted the need to a) trust themselves, their instincts b) trust no person they just met online and c) assume the worst.

Conclusions/Implications: These recommendations are reflective of practical advice that reduces risk and harm for MSM provided by members from within the MSM community. Health educators, practitioners and researchers would benefit from forming partnerships and engaging in community-based participatory research with MSM individuals, as they are more likely to understand underlying issues that influence behavior that sometimes is only privy to those within this population. Indeed, as was implicitly echoed by the study participants, there is a need to incorporate topics related to online social networking into MSM health promotion curricula, as this is an important medium for MSM socialization and YMSM development. Furthermore, health promotion programs must not only continue to incorporate risk and harm reduction strategies that aim for absence of disease, but also include risk and harm reduction strategies that incorporate issues of physical and emotional safety when navigating online social spaces.

Abstract 2089 - Communicating HIV Risk to Diverse Audiences: Investigating Comprehension of the Numbers and Beyond

Author(s): *Jocelyn Taylor, Hannah Badal, Chassidy Hanley, Jen Uhrig, JoEllen Stryker*

Background: The current HIV prevention landscape, including new and complex HIV prevention strategies and the publication of new or updated estimates of HIV transmission and acquisition, creates novel challenges in the development and dissemination of messages on HIV risk and HIV risk reduction. Effective communications must originate from trusted information sources, address the complexity of combination prevention options, promote certainty about new strategies, and address key individual differences in motivation and receptivity. To help inform and enhance decision making about prevention strategies, research findings suggest employing innovative electronic tools to deliver personalized communication messages. Therefore, CDC is piloting an individually tailored HIV educational tool including comprehensive visual messaging through interactive and static graphical elements. The current study examines consumer comprehension of and receptivity to graphical representations of HIV risk estimates, assuming a serodiscordant relationship.

Methods: Interviews were conducted in Houston, TX and New York, NY (n=43) with gay, bisexual and other men who have sex with men (MSM), sexually active single heterosexuals, and individuals living with HIV. The one-hour interviews consisted of a 45-minute individual in-depth interview and 15-minute brief survey. Participants explored static and interactive versions of a graphic presenting per-act risks for HIV transmission of various sexual activities (insertive and receptive vaginal and anal sex, as well as many low risk behaviors, including oral sex), and allowing risks to be modified by factors that increase (i.e., STDs) or decrease (i.e., male condoms) risk. Static graphics were presented after participants read short messages about the sexual activities that contained per-act estimates. Measures included clarity, credibility, novelty, perceived relevance, comprehension, motivational appeal, self-efficacy and suggestions for improvement. Participants were recruited through a professional recruitment firm's proprietary database. Qualitative data were analyzed to identify themes and detect patterns and

relationships across interviews. Descriptive analyses on quantitative data were conducted data using SAS.

Results: Most participants responded favorably to the graphic and indicated they would recommend it to others. Although MSM were more knowledgeable about the breadth of HIV prevention options than their heterosexual counterparts, participants from both audience segments were unaware that per-act risk estimates varied for sexual activities. Exploring the interactive graphic led to increases in perceptions of understanding the benefits of prevention options and the relative risk of sexual behaviors. After reading the brief messages associated with the static graphics, most participants stated the per-act risk estimates were smaller than expected. This perception did not translate to diminished concern of personal risk of HIV transmission or acquisition. For example, many HIV-positive participants indicated any risk was too high to consider forgoing condoms with sexual activities. Further, due to the novelty of the data, many participants suggested that additional content accompany the interactive and static charts to aid with comprehension.

Conclusions/Implications: Interaction with graphical representations of risk helped promote increased understanding of personal risk, which could lead to more informed decisions about HIV prevention options. Comprehension challenges may be addressed by testing the interactive and static charts along with a complete HIV educational tool including comprehensive messages on HIV prevention options and sexual activities.

Abstract 2105 - Testing Updated HIV prevention Messages with MSM: The Audience Perspective

Author(s): *Jocelyn Taylor, Hannah Badal, JoEllen Stryker, Nickolas DeLuca*

Background: The ability to test messages with intended audiences helps to ensure they are clearly understood, culturally competent, relevant and acceptable to target populations, and provide helpful and actionable information. Further, message testing ensures messages are non-stigmatizing, and do not produce unintended consequences. In 2014, CDC substantially revised its prevention messaging for gay, bisexual, and other men who have sex with men (MSM) in preparation for the launch of the Start Talking. Stop HIV. campaign for gay and bisexual men. Messages were subsequently tested with MSM.

Methods: In 2014, CDC conducted two rounds of message testing with self-identified men who have sex with men (MSM) ages 18-64 (N=85) in 4 cities (Atlanta, GA; Los Angeles, CA; Chicago, IL; and Philadelphia, PA). Interviews were one hour, with a 45-minute in-depth interview and a 15-minute 24-item brief survey. Measures included message receptivity and reaction, perceived relevance, novelty, comprehension, knowledge, motivational appeal, and credibility. Topics included biomedical strategies (i.e. pre-exposure prophylaxis or PrEP, post-exposure prophylaxis or PEP, and antiretroviral therapy or ART); sexual activities, relative and cumulative risk, barrier methods, and STDs Participants were recruited by a professional recruitment firm through their proprietary database. Qualitative data were analyzed to identify consistent themes and detect unique insights, patterns and relationships across interviews. Basic descriptive analyses on quantitative data were conducted data using SAS.

Results: Research findings indicate that participants were knowledgeable about HIV prevention topics, but not always aware of the full range of HIV prevention options available. Most participants were

familiar with newer biomedical prevention strategies, yet were unable to distinguish between these strategies, and reported less knowledge about access and efficacy. Participants were not fatigued with condom messages, and were most receptive to messages on newer biomedical prevention strategies that included content on condom use. Although participants indicated most messages were credible, MSM who were not knowledgeable about the relative risk of different behaviors found the relative risk messages less credible. Participants rejected messages perceived as stigmatizing (e.g., reducing number of partners). Some MSM responded negatively to messages about biomedical prevention strategies and expressed stigmatizing beliefs about people who choose to use HIV prevention methods other than male condoms. Finally, participants reported anticipated or experienced barriers to PrEP, PEP and ART initiation and adherence.

Conclusions/Implications: Testing messages with priority audiences helps maximize comprehension of content on new and complex prevention strategies, while identifying potential unintended consequences of messages, such as perceived stigma. Message testing increases message receptivity by ensuring content is relevant to each audience segment within the target population. MSM are a heterogeneous audience, with differing motivations, beliefs, and levels of knowledge about HIV prevention. Therefore, messaging about HIV transmission risk should address this diversity by avoiding assumptions about audience knowledge, and producing a range of messages that allow men to extrapolate the prevention information they need to make informed decisions about HIV prevention.

Track E

Session E03 - Innovations and Adaptations In Response to the Affordable Care Act

Room: Baker (Hyatt Regency Atlanta)

Abstract 1485 - Maintaining the Availability of HIV Services in Texas through a Sustainability and Capacity Building Technical Assistance Program for Safety Net Providers

Author(s): *Tara Ray, Robin Atwood, Karol Kaye Harris, Jennifer Seth, Jesse Carter, Rosa Laura Valdez*

Issue: Ensuring continued availability and accessibility of HIV services in Texas by providing technical assistance (TA) to providers as they adapt to a changing health care funding environment.

Setting: While the Affordable Care Act (ACA) provides many HIV+ clients increased access to insurance, Texas elected not to expand Medicaid and many individuals living with HIV remain uninsured. At the same time, long-term public funding for HIV and STD services is uncertain. The Texas Department of State Health Services HIV/STD Program (DSHS) strives to ensure the continuation of public health services and support HIV providers as they adapt to a complex and changing health care funding environment.

Project: Sustainability and Capacity Building (SCB) is a project funded by DSHS to enhance the sustainability of safety-net services in Texas using a developmental evaluation approach. Surveys of DSHS-funded organization in 2013 and 2014, key informant interviews, literature and policy reviews, and ongoing feedback informed the development of TA. Data indicated that some organizations provided potentially reimbursable medical services that were not currently being billed for while others

offered non-medical services unlikely to be covered by third-party payers. The data led to the development of a model for sustainability that followed two tracks: financial/billing and strategic restructuring. Data collected in early 2014 began to explore the impact of ACA. Approximately 1 in 4 respondents indicated that they had expanded their services or the clientele they serve since January of 2013. Almost as many organizations reported that they had made no changes during that period. During 2013 and 2014, SCB offered webinars, conference calls, face-to-face trainings, and learning collaboratives, while maintaining contact with participating organizations through multiple mediums.

Results: The project resulted in the development of TA that was timely, relevant, and tailored to organizations responding to ACA implementation. The project TA, which varied in approach and intensity, reached diverse organizations, including community-based organizations (CBOs), hospital specialty clinics, community health centers, and local health departments. DSHS conducted face-to-face trainings for HIV CBO leaders to highlight the urgency for change, explore sustainability models, and plan for next steps. During the course of the project, organizations demonstrated an increased interest in bolstering their sustainability and began to adapt their organizational practices. Several organizations have taken steps toward expanding services, initiating partnerships, or exploring mergers.

Lessons Learned: Lessons learned emerged with implications for TA delivery and public health. Relationship-building is a key factor for TA delivery. Success was achieved by engaging in multiple strategies, establishing ongoing contact, and compiling resources. The TA needs of organizations are increasingly divergent and specific as the context evolves. From a public health perspective, while the capacity to bill among medical service providers can be enhanced, prevention-oriented HIV CBOs often lack the capacity and services necessary to bill, highlighting the need for continued grant funding.

Abstract 1571 - Low STD Testing Rate for Medicaid Patients who had a Diagnosed HIV Infection in 2009 in the United States

Author(s): *Guoyu Tao, William Pearson, Tom Gift*

Background: National guidelines for care of HIV patients include routine screening for curable sexually transmitted diseases (STD), including chlamydia, gonorrhea and syphilis, for all sexually active persons with HIV. Our objective was to determine whether patients with HIV received these preventive services as recommended.

Methods: We used the most recently available national Medicaid data, 2009-2010 MAX data, to identify Medicaid patients who had documented HIV diagnosis in 2009 as our study population. We used the earliest inpatient or outpatient visit date with any ICD-9 code for HIV infection (042, 079.53, or V08) as the index visit, and the study period of 13 months was defined as the month of the index visit plus 12 months after the index month for each patient. Procedure codes were used to identify chlamydia, gonorrhea, syphilis, and HIV viral load testing during the study period.

Results: Of 207,402 Medicaid patients with documented HIV diagnosis in 2009, 25.0% were non-Hispanic white, 51.0% non-Hispanic black, and 16.2% Hispanic or Latino; 42.7% were females; 4.1% were aged 15-20 years, 40.3% 21-44 years, and 49.9% 45-64 years; 10.4% had <10 visits, 42.5% 10-30 visits, 22.5% 31-55 visits during the 13-month study period. Of these patients, 18.2% were tested for

chlamydia, 16.8% for gonorrhea, 31.7% for syphilis, and 48.6% for HIV viral load during the study period. Chlamydia, gonorrhea, and syphilis testing varied by race/ethnicity (15.4%, 14.8%, and 29.6% non-Hispanic white, 19.6%, 17.7%, and 32.4% non-Hispanic black, and 18.8%, 17.4%, and 33.4% Hispanic or Latino), by age (42.2%, 39.6%, and 46.3% 15-20 years, 24.7%, 22.9%, and 37.4% 21-44 years, and 12.6%, 11.5% , and 28.5% 45-64 years), by sex (27.0%, 24.6%, and 34.7% female, and 11.7%, 10.9%, and 29.4% male), and by state residence (1.8% to 30.6%, 1.6% to 33.2%, and 3.2% to 59.1%), respectively. Chlamydia, gonorrhea, or syphilis testing rates also varied by the number of clinic visits during the study period (6.9%, 7.2%, and 13.9% <10 visits, 18.9%, 17.3%, and 31.0% 10-30 visits, 23.8%, 21.7%, and 37.9% 31-55 visits, and 16.6%, 15.3%, and 34.8% >55 visits, respectively). Chlamydia, gonorrhea, and syphilis testing rates were significantly ($p<0.05$) higher if they had an HIV viral load test performed during the study period (26.2% vs. 10.6%, 25.2% vs. 8.8%, and 50.6% vs. 13.9%), respectively.

Conclusions/Implications: Our results have demonstrated that most Medicaid patients with HIV do not receive recommended STD testing, regardless of their demographic characteristics. Low STD screening rates may create critical gaps for quality of healthcare for patients with HIV. Our analyses highlight that substantial barriers exist for complying with these guidelines. Clinical quality improvement interventions are needed, such as healthcare providers may order syphilis testing when an HIV viral load test is ordered, or providers order chlamydia and gonorrhea testing when women seek reproductive health services. Our finding also suggests that the states with low STD screening rates need to urgently evaluate their policies and clinical service coverage, identify barriers, and determine how to better promote STD screening practices for patients with HIV.

Abstract 2164 - Business Development - Creating Long Term Value for Public Health

Author(s): *Jonathan Stockton*

Issue: The landscape of public health is experiencing great change through the implementation of the Patient Protection and Affordable Care Act (ACA) and Medicaid expansion. The ACA brings considerable changes in health service, delivery and support, and evolving health information systems. With any great change there are challenges, but more so, opportunities. The new landscape affords health departments the opportunity to identify, cultivate and leverage the work of health delivery systems. Business Development (BD) is an innovative model that when applied to Public Health is dedicated to identifying, cultivating and supporting scopes of work that have the ability to influence infectious disease (ID) outcomes within this new landscape.

Setting: The Business Development Team resides in the Washington State Department of Health, Infectious Disease Prevention Section (IDPS).

Project: BD was created in response to several key factors from health care reform that has the potential to impact and influence the effectiveness of IDPS's portfolio of services. BD is responsible for expanding access to and utilization of HIV, STD and HCV prevention services with new non-traditional health partners as well as maintain relationships with our traditional public health peers. These new health delivery systems include medical providers, provider networks, health care payers and the systems within which they work. The BD team is comprised of staff with HIV, STD and adult viral hepatitis prevention experience as well as experience with health insurance payers and clinical services.

The team focuses on leveraging opportunities made available through the ACA influencing both provider and payer sectors of healthcare delivery to expand work previously designated to public health.

Results: BD has identified partnerships between public health and health care delivery systems to maximize investments and broaden our prevention reach through three (3) specific IDPS strategies, examples include;

- Hepatitis C: Strategies for Hepatitis C aim to enhance and complement work underway by DOH to increase awareness, screening and linkage to care. BD worked in collaboration with both traditional and non-traditional partners to enhance service delivery;
- o Telehealth: Project ECHO.
- o Targeted Routine HCV Testing through the Healthcare Delivery System:
- o Increasing HCV Screening Efforts through Community Pharmacies:
 - Pre-Exposure Prophylaxis (PrEP): BD efforts have been focused to identify and strengthen provider capacity to screen for, prescribe, and monitor PrEP for high risk individuals in WA State. Collaborative efforts with healthcare providers have yielded strategies that have influenced the accessibility of PrEP through innovative community pharmacy models and community based PrEP clinics.
 - Drug User Health: BD actively engage leaders from syringe service programs (SSPs) to help modernize their current service delivery model to leverage new opportunities identified through the ACA. BD also worked to help position community based SSPs by highlighting their value using the triple aim framework as a guide to strengthen overall program sustainability.

Lessons Learned: Dialoging with health care systems, provider networks, and payers about public health priorities is essential to ensure the availability of services is available for prioritized populations.

Public health strategies can be enhanced and strengthened by leveraging existing health care systems and provider networks.

Abstract 2401 - FQHC Learning Collaborative: An Effective Tool for Implementing Routine HIV Testing
Author(s): *Debra D'Alessandro, Alexandra Sheller, Ann Ricksecker*

Issue: In 2013, the U.S. Preventative Services Task Force (USPSTF) granted routine HIV testing a grade A designation for all patients age 15 to 65 regardless of risk, adding additional policy weight to the CDC's 2006 recommendation for routine HIV testing in health care settings. However, national testing data indicates the majority of Americans have not been HIV tested. Innovative methods are needed to assist primary care settings in implementing opt-out HIV testing.

Setting: Federally Qualified Health Centers (FQHCs) are an ideal setting to improve rates of routine HIV testing in an effort to implement the National HIV/AIDS Strategy goal to increase from 79% to 90% the percentage of people living with HIV who know their serostatus by 2015. The local performance site of the Pennsylvania/MidAtlantic AIDS Education and Training Center (AETC) is based in the Health Federation of Philadelphia, a community network of FQHCs -- an ideal opportunity to build on existing partnerships to pilot a Learning Collaborative focused on improving HIV offer and testing rates.

Project: During a 12 month period from October 2013 to September 2014 a Learning Collaborative platform was piloted to implement routine HIV testing in three FQHC settings in Philadelphia, PA. All three FQHCs are members of the Health Federation of Philadelphia, and are recipients of Ryan White funds for HIV care, simplifying issues of connection to care for positives.

Results: Learning Collaborative sites demonstrated higher and more sustained improvement in HIV testing rates than sites within the same organizations which were not engaged in the Learning Collaborative. All pilot sites requested AETC continue to facilitate quarterly meetings for sharing progress and lessons learned regarding routine HIV testing. Systemic changes post-pilot include: 1) Site A transitioned from 96% of their tests being rapid tests (purchased via a time-limited grant and not billed to insurance) to having 65% of the site's HIV tests be lab-based and billable to insurance; 2) Site B switched to ambulatory phlebotomy to improve patient flow and reduce patient wait time which was resulting in blood draw orders not being completed.

Lessons Learned: Factors associated with the Learning Collaborative success included: aligning project goals with existing policy requirements, intensive technical assistance and onsite provider trainings from local AETC performance site, and building upon participation in a Health Center Controlled Network (HCCN) Health Information Technology (HIT) grant. Other lessons learned: 1) A financial incentive of \$10,000, while small in the context of the health centers' budgets, was reported by participants as important to garnering management support for participation in the pilot; 2) Incorporation of information technology (IT) assistance was critical to both data reporting and EHR changes -- the project's IT consultant was critical in assisting pilot sites with template change to their EHR and in configuring reports in order to define and export appropriate variables to measure and track offer and testing rates; 3) Testing models and patient flow need to be adapted to fit the culture and staffing of each site, i.e. varying role of medical assistants in the routine testing process at the three sites.

TUESDAY, DECEMBER 8 | POSTER SESSION B | 12:00 PM – 1:30 PM

BP92

Abstract 2430 - Prevention Research and Implementation Science

Author(s): *Robert Cook, Zhi Zhou, Nicole Whitehead, Christa Cook, Babette Brumback, Charurut Somboonwit, Willie Carter, Yolanda Martinez, Karalee Poschman, Kendall Bryant*

Background: Florida has the third highest prevalence of HIV infection and the highest number of newly-diagnosed HIV infections in the United States. Increasing the proportion of persons living with HIV (PLWH) who have an undetectable HIV viral load is a key aspect of the National HIV strategy. Several factors have been associated with viral load suppression in different populations. Using preliminary data from a new HIV cohort in Florida, we sought to identify demographic factors, substance use factors, and mental health symptoms that are associated with HIV viral load suppression.

Methods: This analysis included 213 PLWH who were recruited into the Florida Cohort between October, 2014 and March, 2015, from 5 rural and urban public health settings across Florida. Participants completed a confidential questionnaire, which was linked to information from their medical records and with laboratory results from the eHARS database managed at the Florida Department of Health. We identified persons with HIV viral load >200 copies/ml and determined the association of this outcome with demographic characteristics (age, gender, race), hazardous drinking (>14 drinks/week for men, >7 drinks/week for women), current marijuana use (at least weekly), depressive symptoms (PHQ8), and anxiety symptoms (GAD7). We also explored whether combinations of substance use and/or mental health symptoms were more strongly associated with having a detectable viral load.

Results: Of the 213 persons in this analysis, 55% were male, 69% and 9% were Black and Hispanic respectively; 34% reported hazardous drinking, 18% weekly marijuana use, 34% moderate to severe depressive symptoms; and 32% moderate to severe anxiety symptoms. Twenty percent had a detectable HIV viral load. Having a detectable viral load was more common ($p < 0.05$) in younger persons (age < 45 years), who used marijuana at least weekly, and who had moderate-severe depressive symptoms. Persons with both marijuana use and alcohol, depression, or anxiety symptoms were no more likely than those with marijuana use alone to have a detectable viral load.

Conclusions/Implications: These early results from the Florida Cohort are consistent with other recent reports indicating that demographic factors, substance use, and mental health symptoms are associated with successful HIV treatment outcomes. Gender, race, and alcohol consumption were not significantly associated with HIV viral suppression in this sample, although new associations may emerge as the cohort grows larger in sample size. Interventions may need to target substance use or mental health symptoms directly in order to improve viral load suppression in at-risk populations.

BP94

Abstract 1280 - Prevention Research and Implementation Science

Author(s): *Jeffrey Herbst, Deborah Gelaude, Neetu Abad, Monique Carry, Sharon Parker, Catherine Fogel*

Background: Incarcerated women are commonly exposed to multiple forms of violence (intimate partner violence, sexual violence, childhood abuse) that can increase their risk for acquiring HIV and other STDs prior to incarceration and post-release. This study examined how experience of violence plays a role in perceptions of HIV/STD risk among incarcerated women.

Methods: Individual, in-depth interviews were conducted with 25 current and 28 former women prisoners from two North Carolina correctional facilities. Women were asked about persons, places and situations outside of prison that placed them in harm's way by increasing their risk of acquiring HIV and other STDs. Interviews were independently coded using an iterative process, and analyzed using established qualitative methods. Nvivo 10 software (QSR International) was used to perform content coding and develop hierarchical nodes/clusters based on a calculated similarity index.

Results: The 53 participants ranged in age from 18 to 54 years (mean = 33.7 years); 57% were white and 42% black/African American. One-third of the sample (33%) reported living with a husband/boyfriend before incarceration. Over three-quarters (77.4%) had a felony conviction; the remainder were incarcerated based on misdemeanor charges. The cluster analysis identified four nodes linking violence experiences to perceived HIV/STD risk: (1) exposure to multiple and cyclical relationships involving intimate partner violence and abuse that limited protection (e.g., use of condoms); (2) failure to access needed social and mental health services in their home community to avoid violence and risky behavior (e.g., sex work, substance use and abuse); (3) life-long struggles to personally cope with abuse that occurred during childhood and that led to consequent risky sexual behaviors and relationships (e.g., affiliation with gangs); and (4) loss of personal control in intimate relationships associated with lowered self-esteem and limited choices but to stay in abusive and unhealthy relationships.

Conclusions/Implications: The findings from in-depth interviews with current and former incarcerated women suggest experiences of violence prior to incarceration are associated with behaviors that can increase perceptions of increased HIV and STD risk. Prevention programs for women with a history of incarceration and exposure to violence should address barriers to accessing needed services to enhance care. In addition to primary prevention of violence, improved identification and early intervention with victims of childhood abuse and intimate partner violence could help minimize risk for future incarceration and HIV/STD-related risk behaviors.

BP95

Abstract 1306 - Prevention Research and Implementation Science

Author(s): *Mary Ellen Mackesy-Amiti, Jeremy Young, Chad Zawitz, Lawrence Ouellet*

Background: Adherence to antiretroviral therapy (ART) is critical for maintaining viral suppression and for preventing transmission among people living with human immunodeficiency virus (HIV). Many factors can influence ART adherence, including economic, psychosocial and treatment variables. One factor particularly relevant for criminal justice populations is illicit substance use. A number of studies have reported lower rates of adherence among people who use illicit drugs. Recently, attention has focused on whether cannabis use, in contrast to other illicit drug use, may have a beneficial effect on adherence for some patients. This study examines associations between marijuana and other illicit

substance use and ART adherence in a sample of HIV-positive men and women detained in a large urban jail.

Methods: Men and women who self-identified or tested positive for HIV were interviewed in Cook County Jail, Chicago, Illinois. Interviews included questions about substance use, ART and adherence during the 3 months before arrest. We conducted logistic regression analyses to examine the relationship between marijuana and other illicit substance use and 1) being prescribed ART, and 2) having discontinued ART for at least 2 weeks before incarceration. Among subjects who had not stopped taking their medication but had missed doses, we examined associations between substance use and the self-reported number of doses missed in the 2 weeks before incarceration. We also examined the effects of homelessness, health insurance and substance use treatment on these relationships. Finally, among subjects with available viral load data, we tested the association of marijuana and other illicit substance use with viral suppression.

Results: Out of 276 subjects interviewed, 92% (n = 255) had ever been prescribed ART. Of these, 29% had taken no medication, 32% missed doses, and 39% reported no missed doses in the 2 weeks before arrest. There was no effect of substance use on having been prescribed ART. Compared to non-users, subjects who reported using illicit drugs but not marijuana were more likely to have discontinued ART (OR = 3.03, 95% CI 1.31 - 7.03). Subjects who used only marijuana or both marijuana and other illicit drugs had rates of ART discontinuation similar to nonusers. The effect remained significant when adjusting for gender, age, homelessness and substance use treatment, and was attenuated when adjusting for homelessness and health insurance. The number of doses missed in the subgroup of subjects who were not 100% adherent (n=71) was not significantly associated with illicit substance use. Among subjects with viral load data (n=166), non-marijuana illicit drug use was associated with decreased likelihood of viral suppression (OR = 0.46, 95% CI 0.24 - 0.88), while marijuana use had no effect. The effect was attenuated when adjusted for ART adherence.

Conclusions/Implications: Using illicit drugs other than marijuana contributes to ART non-adherence and lack of viral suppression among arrestees. The effect may be exacerbated by associated conditions such as unstable housing and lack of health insurance. Marijuana use, in contrast, did not contribute to ART non-adherence.

BP96

Abstract 1346 - Prevention Research and Implementation Science

Author(s): *LaStassia Williams*

Background: HIV/AIDS is a disease that has caused healthcare concerns for many years. African American women have the highest infection rate when compared to women of other ethnicities. Given the disproportionately high infection rate for African American women, and the fact that the primary means of infection is via heterosexual intercourse, a key part of reducing infection rates is developing a better understanding of African American women's attitudes toward their sexual behavior. This quantitative study was conducted to analyze the relationship between religiosity (organizational religious activity, non-organizational religious activity and intrinsic religiosity) and attitudes toward sexual behavior.

Methods: Self-identified religious African American women ages 18-25, anonymously completed surveys based on their religiosity and sexual behavior. Participants were recruited through in person presentations at various churches who agreed to participate and via social media. The surveys were paper format that were mailed back in and an online option was given as well. A multiple regression was used to analyze the relationship between the three independent variables (organizational religious activity, non-organizational religious activity, and intrinsic religiosity) and the dependent variable of attitudes toward sexual behavior.

Results: The analysis indicated that organizational religious activity, non-organizational religious activity, nor intrinsic religiosity are not statistically significant predictors of attitudes toward sexual behavior for this model ($R^2 = .047$, $p > .05$). An analysis of variance (ANOVA) was calculated, and did not show any statistical significance within the overall model $F(3, 121) = 1.968$, $p > .05$. When organizational religious activity was regressed with non-organizational religious activity and intrinsic religiosity, it was not a statistically significant predictor of attitudes toward sexual behavior. Within the multiple regression model, the unstandardized coefficient (.068) and the standardized coefficient (.131) are not statistically significantly different from 0 ($t=1.381$, $df = 121$, $p > .05$). When non-organizational religious activity was regressed with organizational religious activity and intrinsic religiosity, it was not a statistically significant predictor of attitudes toward sexual behavior. Within the multiple regression model, the unstandardized coefficient (.045) and the standardized coefficient (.146) are not statistically significantly different from 0 ($t=1.47$, $df = 121$, $p > .05$). When intrinsic religiosity was regressed with organizational religious activity and non-organizational activity, it was not a statistically significant predictor of attitudes toward sexual behavior. Within the multiple regression model, the unstandardized coefficient (-.011) and the standardized coefficient (-.016) are not statistically significantly different from 0 ($t=-.159$, $df = 121$, $p > .05$).

Conclusions/Implications: Even though organizational religious activity, non-organizational religious activity and intrinsic religiosity did not show a statistical relationship with sexual behavior, there is still a need for continued research. Being able to figure out the essence of their religiosity and the influence it may have over their sexual behavior will assist in HIV/AIDS prevention programs that can effectively help reduce the number of African American women infected.

BP98

Abstract 1551 - Prevention Research and Implementation Science

Author(s): *Romeo Galang, Dawn Smith, Maria Mendoza*

Background: Pre-exposure prophylaxis (PrEP) with daily co-formulated emtricitabine and tenofovir diphosphate is effective in preventing HIV acquisition. CDC recommends clinical visits every 3 months to provide periodic HIV, STI, and renal function testing, and support for medication adherence and maintaining lower risk behaviors. The optimal setting for deploying PrEP in clinical practice is yet to be determined. We assessed the preferred location for PrEP related clinical visits among respondents to a nationally representative consumer survey.

Methods: Surveys were conducted in 2012 and 2014 of a representative sample of U.S. consumers, ages 18 years or older. We calculated the percentage of respondents preferring each location (community health center, primary care office, HIV clinic, or other site) among (1) all respondents, (2) persons who reported medium to high risk of HIV acquisition, (3) persons who reported testing for HIV in the last 12 months, (4) persons who reported knowledge of PrEP, and (5) persons who reported willingness to take PrEP.

Results: Among the 7564 respondents, the majority (63%) prefer a primary care office for PrEP related visits. Responses for each location type changed by less than 6 percentage points between 2012 and 2014.

Among persons who reported medium to high risk of HIV infection, a plurality (45%) prefer a primary care office for PrEP related visits. Between 2012 and 2014, the percentage of persons who preferred a primary care office or an HIV clinic decreased by 16 percentage points and 4 percentage points, respectively. The percentage of persons that prefer a community health center for PrEP related visits increased from 8% to 24% (16 percentage point difference).

Among persons who reported being tested for HIV in the last 12 months, the majority (64%) prefer a primary care office compared to 8% and 10% for community health center and HIV clinic, respectively. Responses for each location type changed by less than 6 percentage points between 2012 and 2014.

Among persons who reported knowledge of PrEP prior to the survey, the majority (69%) prefer a primary care office compared to 8% and 13% for community health center and HIV clinic, respectively. Responses for each location type changed by less than 2 percentage points between 2012 and 2014.

Among persons who reported willingness to take PrEP, the majority (69%) prefer a primary care office compared to 7% and 10% who prefer to go to a community health center or HIV clinic, respectively. The percent of persons who prefer a primary care office increased from 65% to 74% (9 percentage point difference) between 2012 and 2014.

Conclusions/Implications: Delivery of PrEP at preferred care sites may contribute to achieving its potential to substantially reduce the occurrence of HIV acquisition. The results suggest that a primary care office would be a preferred clinical setting for deployment of PrEP for a majority of respondents to this U.S. consumer survey; however, an increased number of persons who consider themselves at medium to high risk of HIV acquisition preferred community health centers for PrEP related clinical visits.

BP99

Abstract 1575 - Prevention Research and Implementation Science

Author(s): *Aimee Campbell, Don Des Jarlais, Hannah Cooper, Christine Borges, Sarah Braunstein, Susan Tross, Laura Kersanske, Howard Newville, Kevin Jefferson, Laurel Weaver*

Background: Current treatment guidelines for HIV recommend initiating antiretroviral therapy (ART) with all infected individuals (“universal ART”). New York City Department of Health and Mental Hygiene

(NYCDOH) set an ambitious goal of reaching viral suppression for 80% of newly identified HIV infections in NYC residents within 12 months of diagnosis. The “ART for All” (AFA) study began in 2013 with the aim of providing “real-time” information to help achieve this goal. The study is conducted in partnership with the NYCDOH and a Collaborative Board comprised of providers, clinical researchers, and consumers to review data and make formal recommendations.

Methods: AFA uses multi-level datasets and analyses to assess barriers and facilitators of outcomes along the HIV treatment cascade. Patient-level clinical and service use data are being collected from four cohorts (2014-2017) recruited from NYCDOH STD clinics, and drug detoxification, who meet criteria for problem substance use. Questionnaire and interview data are being collected from NYC HIV primary care providers, while neighborhood level datasets have been created from existing data sources (e.g., Community Health Survey). The primary outcome is viral load suppression within 12 months of diagnosis measured using the NYC HIV Surveillance System.

Results: Data are currently available for cohort one (N=15), recruited April-December 2014, primarily from STD clinics (n=13, 87%). Cohort 1 is 100% male, mean age 32 years, and 53% (n=8) Hispanic/Latino. Fifty-three percent (n=8) identify as white and 33% black (n=5). Half (53%) did not have insurance; none reported insurance through the NY State Health Exchange. Fifty-three percent (n=8) are cigarette smokers. Most (n=10, 67%) met criteria for an alcohol use disorder, 47% (n=7) cannabis use disorder, and 33% (n=5) stimulant use disorder. Sixty percent (n=9) reported already meeting with a provider, while 33% (n=5) were either scheduled or planning to schedule an appointment (n=1 was not ready to begin care). Provider data collection is ongoing. Preliminary results (n=13) indicate most providers are highly experienced and support universal ART. Decisions to prescribe ART are made cautiously for patients with alcohol/drug abuse, however, greater emphasis is placed on motivation for treatment. Initial analysis of neighborhood data (e.g., socioeconomic composition) for 2009-2013 is underway.

Notable NYC environmental changes occurring during cohort 1 recruitment include a decrease in yearly HIV diagnoses, including within STD clinics (26% reduction 2013 to 2014), reduction in HIV prevalence among detox patients (currently <10%), and an increase in detox patients who are prescribed ART (approximately 75%). Further, the NY State Governor put forth a call to “end the epidemic” by 2020 by reducing yearly HIV diagnoses to 750. A 60-person task force was convened in 2014, including members of AFA, to submit recommendations to achieve this goal.

Conclusions/Implications: This innovative study is designed to provide real-time feedback in a rapidly changing environment to NYCDOH and other stakeholders. Early results suggest that most will receive early care and be offered ART but that substance abuse and lack of insurance could pose problems with retention in care and adherence.

BP106

Abstract 2398 - Prevention Research and Implementation Science

Author(s): *Ann O'Leary, John Jemmott, Deepti Chittamuru, Larry Icard, Robin Stevens*

Background: BRO enrolled 595 black MSM in an intervention trial in Philadelphia. While not the primary outcome, having had sex with multiple partners increases the risk of infection or transmission. The present analysis reports predictors of multiple partners among men in the trial.

Methods: Participants completed ACASI-delivered surveys of sexual behavior, demographics, and theoretical mediators related to multiple partners. We used data from the 6-month follow-up, controlling for treatment condition and baseline levels of the theoretical variables.

Results: The following results were significant amongst participants in the study. Participants who were HIV-positive and aware of their status were less likely to have multiple partners ($p < 0.03$). The likelihood of having multiple partners tended to decrease with increasing age ($p < 0.007$). Among the theoretical variables, adverse expected outcomes accruing to multiple partners was associated with being less likely to have multiple partners ($p < .02$), and perceiving peers as disapproving of multiple partners was associated with less likelihood of having multiple partners ($p < .03$)

Two results approaching significance were also found. The more pride participants had in their identities as black or African American men, the less likely they were to have multiple partners ($P < 0.06$). The likelihood of having multiple partners increased with increase in social connections ($P < .06$). This relationship between the degree of social support the participants have and the likelihood of their having multiple partners is believed to stem from increased opportunity thanks to increased connectivity with their social networks.

Conclusions/Implications: Modifiable factors, including the theoretical mediators, should be addressed in interventions for black MSM if decreasing number of partners is a goal of the program.

BP110

Abstract 1733 - Prevention Research and Implementation Science

Author(s): *Stephaun Wallace, Michele Andrasik, Denise Gaither-Hardy, Shelley Johnson*

Background: In 2010, HIV incidence among African Americans (AA) was almost eight times higher than that of Whites, and AA accounted for 44% of people living (CDC) while comprising approximately 14% of the total US population (US census). Among youth, particularly AA youth and young adults, specifically young men who have sex with men (YMSM), HIV infection rates have increased 48% (CDC). The National Medical Association has noted that the lack of involvement of AA and other people of color in clinical research has greatly contributed to such disparities. Research is fundamental to understanding diagnosis and treatment of disease and quality of life. Historically Black Colleges and Universities (HBCUs) provide development and education for over 5 million alumni, placing them in a unique position regarding attitudes and perceptions of HIV/AIDS, STIs, and HIV clinical research among students and faculty, yet these institutions have been absent in large-scale HIV prevention efforts. This study examined the range of knowledge, attitudes, and perceptions of HIV, and HIV clinical research among students and faculty of HBCUs which may serve to impact the epidemic in AA communities.

Methods: During this 2-year pilot study, 48 HBCU students from 2 HBCU campuses participated in 4 focus groups, and 25 HBCU faculty from 8 HBCU campuses participated in semi-structured one-on-one interviews. Participants were recruited using the quota sampling method, and received remuneration

for participation. Discussions explored barriers and facilitators to engaging HBCU students in preventive HIV services and programs, general knowledge and perceptions of HIV, and knowledge and readiness to participate in HIV clinical research among HBCU students and faculty. Atlas.ti was used to organize and synthesize the qualitative data.

Results: The mean age of students was 23.39, about 92% of students identified as AA, with 62.6% identifying as female and 36.1% identifying as male. Of HBCU faculty, there were 10 assistant professors, 11 associate professors, and 4 professors. HBCU students indicated receiving information regarding HIV/AIDS primarily from peers and online resources. The majority of students noted limited available resources and information on HBCU campuses, and many HBCU students indicated being receptive to learning about, and participating in, HIV clinical research after understanding trial goals and safety considerations. HBCU faculty generally reported limited awareness of resources or programs offered on their campus, and few faculty reported engaging in conversations with students about HIV/AIDS or HIV clinical research either generally or as a part of the course curriculum.

Conclusions/Implications: There is a continued need for focused, accessible, and culturally relevant HIV prevention and treatment information and services among HBCU students. Developing collaborative approaches that consider the perspectives of HBCU students, and that build on the strengths of HBCU campuses and faculty may be successful at engaging students in meaningful ways around sexual health. Current HIV prevention efforts, though limited, may be enhanced through development of strategic partnerships with CBOs and local and state health departments. Several strategies were identified that may provide opportunities for ramping up HIV-prevention education and service efforts on HBCUs and engaging HBCU students and faculty in HIV clinical research.

CP01

Abstract 2472 - Prevention and Care Programs

Author(s): *Debbie Mohammed, Maria Szabella, Prerak Shukla, Jason Dazley, Raymund Sison, Jihad Slim*

Issue: The risk of HIV transmission and disease progression increases with high viral loads. This study identified predictors for virologic failure (VF), (≥ 1000 copies/ml), from March 2013- August 2014 and report on efforts to decrease the viral load (VL) among patients receiving clinical care from January 2014-December 2014.

Setting: An Urban HIV Clinic located in Newark, New Jersey

Project: Virologic Failure: A retrospective chart review was conducted to determine the characteristics of patients with VF. Patients in this clinic were aged ≥ 18 years, attended at least one medical visit and had at least one VL measured in the study period, and were on anti-retrovirals for at least 12 weeks. Data were collected in rolling 1-year intervals, in two-month increments from March 2013- August 2014. Data are current as of December 2014. Patient characteristics included age, gender, race/ethnicity, transmission risk and insurance type. Logistic regression analysis was performed to determine predictors of VF.

Viral Suppression Intervention: Three teams were formed which included a clinician, medical case manager and nurse. Each chart was reviewed to ensure that the patient was on an appropriate

antiretroviral regimen. Medical case managers and nurses assessed barriers to adherence and implemented the appropriate corrective measure with patients. Differences between patients who achieved a VL \leq 1000 copies were evaluated by chi-square.

Results: Virologic Failure: A total of 1364 patients were included in the study. Overall, 352(25.8%) experienced VF. These patients were younger (aged 18-24(52.9%) or 25-34 (39.6%)), black (28.8%), with an unknown risk (38.1%) or Heterosexual (25.2%) and had public funding (27.5%). Gender was similar in patients with and without VF. After adjusting for patient characteristics, the most important predictors for VF were younger age (18-24 (Odds Ratio (OR): 6.23, 95% Confidence Interval (CI): 2.87-13.26), 25-34 (OR: 2.87, 95% CI: 1.8-14.56, or 35-44 (OR: 1.76, 95% CI: 1.20-2.57) and insurance type (Public: OR: 2.67, 95%CI: 1.68-4.26). Other predictors included transmission risk: Unknown (OR: 1.85, 95%CI: 1.20-2.85), and black race/ethnicity (OR: 1.81, 95%CI: 1.09-3.02).

Viral Suppression: Of the 328 patients with VF evaluated in this study, 82 (25%) were lost to follow up or moved, 20(6%) died and 145(45%) had a VL <1000copies/ml by December 2014. There were no statistically significant differences between those whose VL decreased and those who did not when evaluated by age, sex, race/ethnicity, transmission risk and insurance status.

Lessons Learned: Patients younger than 35 years or with public insurance were most likely to have VF in this inner city clinic. A high percentage of patients were not retained in care at this clinic or continued to experience VF failure, despite attempts by staff to improve adherence. Innovative interventions targeting patients younger than 35 years and with public funding are needed to prevent transmission, decrease HIV-associated mortality and morbidity and improve virologic outcomes in this clinic. Interventions can include intensive case management with enhanced personal contact, evidence-based adherence interventions and designated clinic time with extended clinic hours. The results of this study may not be applicable to other clinical settings and data were available on a limited number of predictors.

CP02

Abstract 2188 - Prevention and Care Programs

Author(s): *Angela Johnson, Nhan Truong, LaDaryl Watkins*

Issue: Hospitals, corporations and industries have all recognized the importance of linking performance and quality measures to desired outcomes. However, process monitoring and evaluation are frequently overlooked as an integral part of project management in community-based organizations. Outcome evaluation conducted at the conclusion of the intervention is often the only method used to track and measure the success of the programs and interventions. This practice can result in the misuse of limited resources, but more importantly, it can result in unintended negative consequences on the targeted population(s).

Setting: Process monitoring and evaluation activities were incorporated in 17 community- and clinic-based HIV/AIDS awareness programs implemented by My Brother's Keeper, Inc. The activities were conducted via in-house site visits with key program staff including program managers, coordinators, outreach workers, CTR staff and evaluators.

Project: My Brother's Keeper, Inc. strategically incorporated performance monitoring and evaluation measures into the planning and implementation phases of a total of 17 community-based and clinic-based HIV/AIDS prevention and awareness projects. The purpose was to track the integrity and increase the impact of HIV/AIDS prevention and awareness activities, specifically in low-income, underserved MSM communities. The strategies included: (1) identifying benchmarks and activities that lie on each project's critical path; (2) assigning measures of quality and effectiveness based on funders specifications and targeted outcomes; (3) identifying common strategies among projects and assigning common quality measures; (4) conducting quarterly process monitoring and documentation audits; and (5) evaluating and disseminating results and recommendations for continuous quality improvement.

Results: Over a 5-year period, 115 programmatic activities were monitored on a quarterly basis (every 3 months) to assess effectiveness and integrity of implementation. As a result, 93% of the programmatic activities were determined as being implemented with high-impact and high integrity as evidenced by supporting documentation and results of participant evaluations. Findings also revealed an increase in overall client satisfaction by at least 40% as evidenced by the results of client satisfaction surveys disseminated during counseling, testing and referral (CTR) services in both community-based and clinical settings.

Lessons Learned: (1) It is imperative to educate program staff on the purpose and importance of including process monitoring and evaluation in all phases of community- and clinic-based HIV/AIDS prevention and awareness programs; (2) Gaining organizational buy-in from decision-makers and program staff in the earliest stages of process monitoring is key to continuous quality improvement; and (3) By strategically aligning performance measures with common programmatic activities across multiple projects, community- and clinic-based HIV/AIDS prevention and awareness programs can maximize resources and are more likely to make a measurable impact on reducing the incidence of HIV/AIDS among MSM living in underserved communities.

CP03

Abstract 1196 - Prevention and Care Programs

Author(s): *Taran Pierce, Joelle Atere-Roberts, Adanze Eke, Renata Ellington, Renee Stein, Gary Uhl, Carolyn Wright*

Issue: CDC funds 34 community-based organizations (CBOs) to provide HIV prevention services to young men of color who have sex with men and to young transgender persons of color through funding opportunity announcement (FOA) PS11-1113. Since July 2013, CDC has disseminated five Rapid Feedback Reports (RFRs) to these grantees, describing their program achievements and areas for improvement related to HIV testing and linkage to care.

Setting: The 34 grantees receive an RFR semi-annually. The RFRs report grantees' individual and collective progress towards national-level targets, providing a snapshot of each grantee's outcomes as well as grantees' performance overall. Data reported include number of HIV tests provided, HIV positivity, and percentage of clients linked to HIV medical care.

Project: CDC is interested in grantees' perceptions of the RFRs and how they use the RFRs at their agency. During site visits to 24 of the 34 PS11-1113 CBOs in summer 2014, CDC obtained feedback from CBO staff on the format, content, and use of the RFRs.

Results: CDC staff reviewed and summarized the feedback received during these site visits. Most CBOs found the RFRs useful and appreciated being able to compare themselves with other PS11-1113 CBOs. They reported that seeing how other CBOs were performing motivated them to do better. They also appreciated seeing that other CBOs were facing similar challenges. CBOs liked the fact that the individual assessment allowed them to see how their performance changed over time. Many CBOs thought that the RFRs help to hold CBOs accountable for their performance, with one CBO stating that the RFRs made them feel that CDC is paying attention to the work they are doing. CBOs shared the RFRs with internal program staff, their executive board and youth advisory board, and state and local health departments. CBOs also extracted information from the RFRs and posted it to their agency's websites.

CBOs used information from the RFRs for program improvement purposes. For example, some CBOs networked with other CBOs to share strategies and best practices. A few CBOs used the RFRs to help them plan, evaluate, and identify new program strategies in areas such as HIV testing priorities, outreach and recruitment, and staffing structure and job descriptions. CBOs also used the RFRs to help inform funding applications, monthly reports to their jurisdiction's health department, and their monthly calls with their project officers.

A few CBOs provided feedback on ways that the RFRs could be improved. For example, one CBO suggested that CDC present success stories from CBOs that met the performance goals. Another CBO wanted the RFRs to present performance data on FOA activities beyond HIV testing and linkage.

Lessons Learned: CDC would like grantees to use the RFRs to determine where to focus their capacity-building and quality improvement efforts, and to assist them in identifying best practices. Gathering feedback from grantees about the RFRs including their perceptions of it, how they use it, and how it can be improved will help inform and refine future RFRs, and ultimately increase their value to grantees.

CP04

Abstract 2224 - Prevention and Care Programs

Author(s): *Deanna Sykes, Kolbi Parrish*

Issue: In California, approximately 5,000 people each year are diagnosed with HIV infection. To meet the goals of the National HIV/AIDS strategy with limited prevention funding, High-Impact Prevention (HIP) strategies must be used. However, successfully identifying HIP strategies is not enough to ensure successful implementation. Program administrators must also provide clear local objectives and easy-to-use tools to assess local progress towards those objectives in order to establish a platform for success.

Setting: Evaluation tools developed by the California Department of Public Health (CDPH) Office of AIDS (OA) were distributed to HIV prevention providers located in 19 local health jurisdictions (LHJs) in the California Project Area (CPA) receiving HIV prevention funds from CDPH OA.

Project: The goal of this project was to communicate clear HIV prevention objectives specific to each participating LHJ in the CPA, along with a companion set of tools that could be utilized locally to assess progress towards these goals and identify the need to make mid-year adjustments to meet established objectives. Starting in 2012, OA used the goals and objectives outlined for the CPA in the Comprehensive Program Plan (CPP) for prevention activities to create LHJ-specific goals for key HIV prevention activities, including the number of newly-identified positive individuals who tested, received results, attended an initial care appointment, and received partner services. Goals were set for each LHJ based on the local HIV burden, and communicated via an interactive MS Excel worksheet that included both statewide goals established in the CPP and the proportion of those goals for which each LHJ was responsible. To facilitate local evaluation of progress towards these goals, OA created a set of tools and resources for LHJ use. These included an automated report to show performance on key indicators, a companion worksheet to compare performance to goals, and a data-driven communication to reinforce the efficiency of targeting for HIP.

Results: The evaluation tools are used by LHJs to focus their semi-annual progress reports on performance indicators measuring progress towards CPP and NHAS goals and objectives. LHJs have shown steady progress towards statewide goals and objectives since 2012, suggesting that these tools help focus local efforts in ways that maximize the impact of prevention efforts consistent with strategies outlined by CDC's HIP approach. Incremental improvements include newly-identified confirmed HIV positivity yield (CY 2011 (baseline)= 0.61 percent, CY 2012 = 0.69 percent, CY 2013 = 0.87 percent, and CY 2014 = 0.88 percent) and the percent of test events provided to high-to-moderate risk populations (CY 2011 (baseline)= 47 percent, CY 2012 = 47 percent, CY 2013 = 49 percent, and CY 2014 = 56 percent).

Lessons Learned: Clear communication of locally-relevant goals that are consistent with state-wide and national strategies, and easy-to-use tools for evaluation of progress towards those goals, can have a positive effect on the ability of frontline providers to maximize the impact of their HIV prevention efforts.

CP05

Abstract 2212 - Prevention and Care Programs

Author(s): *Lori Jones, Lisa Asmus*

Issue: For over a decade, HIV service providers in San Diego County have been contracted to offer Partner Services (PS). Staff reported frequently “we offer it but they don’t want it.” In 2014, the County of San Diego contracted with the Institute for Public Health (IPH) at San Diego State University to conduct an evaluation as part of a quality improvement project for Partner Services (PS) across the HIV continuum of services. The goal of the project was to identify methods and strategies to increase acceptance rates of dual and third-party notification and ensure the adequacy of local data systems for reporting on key data related to PS.

Setting: PS is delivered as part of Risk Reduction Activities (RRA) conducted by the three community clinics that serve the large geographic area of San Diego County: Family Health Centers of San Diego, San Ysidro Health Center and Vista Community Clinic. PS data were collected by providers and entered into

databases developed by State and local evaluator. PS education is delivered as a part of Targeted Prevention Activities, outreach in person or online and skills-building Group Level Interventions; PS screening and offers are provided during Individual Level Intervention risk reduction education, referrals and support.

Project: The evaluation included: establishing baseline measures (January – December 2013), conducting provider interviews, submitting additional baseline measures (January 2013 – September 2014), analyzing data collected, developing a Partner Services Quality Improvement Plan (PS QI), presenting results to the health department and Evaluation Committee, and producing a final report. Additional activities included: conducting a literature review of PS efforts and results in the United States; monitoring plan activities; revising data collection form, reporting instructions, and reporting format; and facilitating a roundtable at the 2014 United States Conference on AIDS to learn about best practices from other health jurisdictions. The health department supported the PS QI project by: holding team meetings, providing input for the plan, monitoring activities, assessing data quality, assisting in data cleaning, conducting quality improvement activities with providers and implementing new strategies and recommendations.

Results: To address acceptance levels that were lower than desirable, three strategies were employed: 1) screening for the appropriateness of offering the service, 2) developing and offering partner service skills building workshop based on motivational interviewing to contracted provider staff and 3) requiring the development of agency-wide plans for delivery of PS across the continuum of HIV services. All findings have been considered by the health department and the joint Grantee and HIV Health Service Planning Council's Evaluation Committee. Data showing improvements in acceptance rate for RRA will be presented.

Lessons Learned: In addition, the presentation will include a summary of findings reported in the Partner Services Quality Improvement Project 2014 Final Report. Lessons learned and recommendations will be presented. A representative from the community clinics and outside evaluator (IPH) will be invited to participate and respond to questions from the audience. Replication of screening for partner service, partner services skills building workshop and agency-wide plans will be provided and considered. Audience participation and interaction will be encouraged.

CP06

Abstract 1385 - Prevention and Care Programs

Author(s): *Kyle Monroe-Spencer, Traci Thomas, Greg Bautista, Angie Walston, Larry Lehman, Tomi Stultz*

Issue: In Georgia, African American women and Latinas experience disproportionately high rates of HIV infection and are less likely to experience prompt linkage to care and viral load suppression when compared to other groups. In 2011, women accounted for 26% of Georgia's HIV prevalence. HIV prevention interventions developed specifically for women are urgently needed yet scarce.

Setting: An HIV prevention intervention for women living with HIV, WILLOW (Women Involved in Life Learning from Other Women) was implemented by a community-based HIV/AIDS service organization in

Metro Atlanta that provides primary care and supportive services for approximately 800 persons living with HIV and prevention services for persons living with HIV or at risk of infection.

Project: WILLOW is a small group, skill-training intervention for women living with HIV consisting of four 4-hour sessions over four weeks. Eight to ten women are recruited per cycle and sessions are implemented by a trained female health educator with co-facilitation by a female peer educator living with HIV. WILLOW promotes principles of gender pride and the importance of developing healthy and constructive social support networks. Participants practice communication skills, safer sex negotiation and condom use. Participants also learn about HIV transmission myths and facts, services available for women in abusive relationships and the connection between domestic violence and HIV risk.

Results: From April 2013 to July 2014, 16 complete WILLOW cycles were implemented with a mean average of 9 participants per cycle and 136 unduplicated clients total, of which 92% were African-American, 5% were White and 3% were Latina. The median age of enrolled clients was 40 years (range 21-72). 90% of clients completed all four sessions of the intervention and 10% completed three. In qualitative written feedback from clients, the most common remarks fell into three categories: "group is beneficial" (51%); "no improvements needed" (18%) and "more groups and/or longer sessions" (16%). In post-session evaluation surveys of agree/disagree statements, all respondents selected favorable options ("agreed" or "strongly agreed") with statements assessing factors such as session utility.

Lessons Learned: Key informant interviews were conducted with the program implementation coordinator, prevention manager and peer educator who identified the following key challenges: fewer than the desired minimum number (8) of attendees during the first two cycles (mitigated primarily through incentives, word-of-mouth promotion and intentional over-enrollment to allow for the possibility of no-shows) and clients' reluctance to end the intervention at the allotted number of sessions (mitigated by forming a social group for WILLOW alums). Overall, the agency had a very positive experience implementing WILLOW and is now adapting the intervention for transgender women of color who are living with HIV.

CP07

Abstract 1351 - Prevention and Care Programs

Author(s): *Amy Krueger, Patricia Dietz, Michelle Van Handel, Lisa Belcher, Anna Satcher Johnson*

Background: Approximately 1.2 million persons are living with HIV infection in the United States, of which 14% are estimated to be unaware of their infection. The Centers for Disease Control and Prevention (CDC) funds health departments and community-based organizations to provide HIV testing for persons disproportionately affected by HIV. Testing identifies persons infected with HIV and can lead to early treatment, decreased risk behaviors, and reduced risk of transmission. Blacks/African Americans, Hispanics/Latinos, and gay, bisexual, and other men who have sex with men (MSM) are disproportionately affected by HIV. We compared the demographic and risk characteristics of persons tested and identified as HIV-positive by a CDC-funded test with those of all persons tested and newly diagnosed with HIV in the United States (US) in 2013.

Methods: The 2013 percentage distribution for HIV testing and diagnoses by demographics and transmission risk group (diagnoses only) were compared between CDC National HIV Prevention Program Monitoring and Evaluation System (NHM&E) program data and national data from the Behavioral Risk Factor Surveillance System (BRFSS) for HIV testing and the National HIV Surveillance System (NHSS) for HIV diagnoses. Race/ethnicity was defined as Hispanic or Latino (regardless of race); white, black/African American, and other (including Asian, American Indian, Alaska Native, Native Hawaiian, Pacific Islander, and persons of multiple races). Transmission risk groups are hierarchical categories: male-to-male sexual contact, injection-drug use, male-to-male sexual contact and injection-drug use, and heterosexual contact. Statistical testing to assess differences between characteristics of persons tested and diagnosed, nationally and by a CDC-funded test, was not possible because the data are not mutually exclusive.

Results: In 2013, nearly 3.1 million CDC-funded tests were provided to persons aged ≥ 18 years and an estimated 21,273,880 (10.9%) persons aged >18 years in the United States reported testing for HIV in the last 12 months. Compared with the national distribution of persons tested for HIV in the last 12 months, the percentage with CDC-funded tests was higher among persons aged 18-24 years (28.8% versus 22.8%), blacks/African Americans (46.0% versus 27.4%), Hispanics/Latinos (21.5% versus 20.9%), and persons residing in the South (56.1% versus 42.9%). CDC-funded tests led to 15,695 newly diagnosed persons aged ≥ 13 years, approximately 25% of the estimated 47,165 persons diagnosed nationally in 2013. Compared with the distribution of all persons diagnosed with HIV in 2013, the percentage with CDC-funded tests was higher among persons aged 20-29 years (40.3% versus 33.7%), blacks/African Americans (55.3% versus 46.0%), and persons residing in the South (59.1% versus 51.4%), and lower among Hispanics/Latinos (20.2% versus 21.4%) and males whose diagnoses were attributable to male-to-male sexual contact (58.9% versus 65.3%).

Conclusions/Implications: With the exception of MSM, CDC-funded tests are reaching a larger percentage of persons in populations disproportionately affected by HIV infection than those tested and diagnosed nationally, specifically young persons and blacks/African Americans. CDC-funded HIV testing programs should continue to target young people and blacks/African Americans and improve efforts to reach Hispanics/Latinos and MSM.

CP08

Abstract 1281 - Prevention and Care Programs

Author(s): *Margaret Lampe, Jessica Thompson, Lauren Fitz Harris, Erin Schneider, Anne Statton, Jodi Shaefer*

Issue: Despite medical advancements to prevent HIV/AIDS, there are still approximately 150 annual cases of perinatally acquired HIV across the United States. These sentinel events signal larger systems issues contributing to sexual and perinatal HIV transmission and gaps in the continuum of HIV care. Pregnancy provides an opportunity to examine missed opportunities for prevention and care for both women living with HIV and their families. To do just that, CDC, CityMatCH, the National Fetal/Infant Mortality Review, the American College of Obstetricians and Gynecologists, and the Pediatric AIDS Chicago Prevention Initiative adapted the Fetal and Infant Mortality Review to examine cases of

perinatal HIV exposure and transmission and activate local systems change. This methodology adaptation is referred to as FIMR/HIV.

Setting: Thirteen cities/counties, located across eleven states with elevated rates of diagnosis of HIV among women, are implementing FIMR/HIV to improve systems of care for women living with HIV. The FIMR/HIV Methodology National Resource Center serves as a capacity-building entity to promote and support implementation of the methodology in local communities across the nation, especially those conducting FIMR-HIV as part of CDC's flagship health department funding opportunity announcement.

Project: Multidisciplinary Case Review Teams (CRT) review data from medical records and interviews of HIV-infected mothers with HIV-exposed infants to identify systems issues and make recommendations to Community Action Teams (CAT) of local leaders. The maternal interviews provide not only an opportunity to gather information about the woman's experiences, but also a means for reengaging women and children in much-needed HIV care.

Results: Thirteen sites across the country are at various stages of implementing this low-cost methodology. Of these thirteen sites, two are in the pre-implementation phase and eleven sites are identifying and reviewing cases for systems gaps. The eleven sites reviewing cases have experienced immediate positive outcomes, such as reengagement of women in care during the maternal interview process and improved community partnerships through the CRTs. Commonly identified issues among case reviews include mental health/substance abuse and lack of repeat HIV testing in the 3rd trimester, poor retention in HIV care post-partum, poor management of complex medical comorbidities, lack of family planning services and inter-conception care, gaps in provider education about proper clinical HIV management and sub-optimal antiretroviral regimens prescribed. Of the eleven sites reviewing cases, five have moved into the community action phase. Actions taken by these five sites include organizational policy changes and state-wide legislation to improve HIV testing and care, including the mandated offering of repeat 3rd trimester HIV and syphilis testing.

Lessons Learned: The FIMR/HIV methodology is a low-cost means for community-level quality improvement for maternal and child health and HIV systems of care. Outcomes based on FIMR/HIV site actions have implications for preventing HIV transmission and improving women's health. Site-level findings demonstrate a need for interdisciplinary local support as well as national-level action to support healthier systems for women, children, and families affected by HIV.

CP09

Abstract 1641 - Prevention and Care Programs

Author(s): *Karen Schneider, Julie Hook, Molly Higgins-Biddle, Mira Levinson*

Issue: The central goal of the Affordable Care Act (ACA) is to reduce the number of individuals who are uninsured and do not have continuous access to prevention, care, and treatment for chronic diseases, including HIV. Given that people living with HIV (PLWH) are poorer than the population at large, and that the Ryan White HIV/AIDS Program (RWHAP) is a payer of last resort, efforts are underway by RWHAP-funded providers to enroll PLWH in newly available healthcare coverage options. Outreach and enrollment are the first steps in an ongoing process to link, engage, and retain clients in care and

treatment. It is important for RWHAP grantees to routinely track and evaluate their outreach and enrollment efforts to assess their progress over time in enrolling eligible PLWH in coverage options, targeting those communities most in need, and demonstrating “vigorous pursuit” of clients to the Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB). In particular, clients of color, who are disproportionately affected by HIV, may be harder to enroll due to compounding language or cultural barriers, as well as other social determinants and may benefit the most from enrollment in health coverage. Grantees may need assistance developing a process to identify, target, and track clients for enrollment, including those hard-to-reach clients of color.

Setting: Funded by HRSA/HAB, the Affordable Care Enrollment (ACE) Technical Assistance (TA) Center helps RWHAP grantees and providers enroll diverse clients, especially people of color, in health coverage.

Project: The ACE TA Center conducted a systematic literature review to identify existing outreach and enrollment metrics and best practices to use data for identifying eligible clients, monitoring enrollment efforts, and targeting client specific populations. We also conducted interviews with high capacity grantees that have had success with identifying and enrolling clients into health coverage. Based on this research, we then developed a list of outreach and enrollment metrics and a corresponding guide, geared towards RWHAP grantees and subgrantees, to walk them through steps to routinely document and monitor their outreach and enrollment efforts.

Results: The systematic literature review and formative interviews informed the development of a guide that will help HIV grantees and providers make decisions about documenting enrollment activities through discussion, questions and examples. The guide walks users through a process to clearly define the agency’s goals and target populations; document their outreach and enrollment strategies; identify metrics and their data sources that can be used to determine effectiveness of outreach and enrollment; and determine how results will be shared and how they will be used internally for quality improvement and demonstration of “vigorous pursuit.”

Lessons Learned: HIV grantees and providers may not have systems in place to document and monitor outreach and enrollment activities. The ACE TA Center Outreach & Enrollment Metrics Guide can help providers identify their enrollment goals, review their data systems to identify fields that may need to be added, and generate reports on key metrics that can be shared or used internally for quality improvement.

CP104

Abstract 2330 - Prevention and Care Programs

Author(s): *Marylin Merida, Barbara Szelag*

Issue: Despite enormous medical advances in HIV therapy, approximately 70% of the 1.2 million HIV-infected persons in the United States have not achieved virologic suppression (CDC). Florida Family AIDS Network’s (FAN’s) HIV Care Continuum data showed 81.5% of women and youth were prescribed antiretroviral treatment, yet only 73.8% were virally suppressed. The 8% who were not virally suppressed represents over 200 clients, who are thus in danger of becoming resistant to antiretrovirals

(ARVs). In response to this HIV care continuum gap among women and youth residing in Hillsborough and Pinellas Counties, FAN implemented a Patient-Based Treatment Adherence intervention, “In the Mix,” targeting clients who were prescribed antiretroviral therapy (ART), but had fluctuating viral loads (VL). Recent research has shown that “reducing viral load to minimal levels through antiretroviral treatment of those infected can lead to dramatic reductions in transmission at both the individual and population levels”. (<http://www.hivpwp.org/about-pwp>).

Setting: The presenters will discuss “In the Mix” Intervention, a CDC evidenced-based, peer-facilitated, interactive model used to target groups of women and youth living with HIV to address social, personal, and medical issues that affect medical adherence and sexual risk behaviors in familiar community-based settings.

Project: The presenters will share FAN’s HIV Care Continuum data generated from CAREWare software and define terms for selecting the study population, for example, fluctuating viral loads--those who did not maintain a VL of less than 20 copies/ml as of January 1, 2014. The presenters will present on the study population of 60 patients; 20 HIV-infected youth (13-24) and 40 HIV-infected adult women (25+) and their level of engagement in the intervention. Specific activities in group (7- 3 hour) sessions included: videos, tailored decisional trees, MAPS (mood, alcohol, people, situations) analysis, negotiation skills, goal setting, and prevention and treatment goals.

Results: FAN projected that 75% of project participants will register viral load suppression in subsequent lab tests. The presenters will discuss baseline metrics such as self-reported pill counts of prescribed HIV medications for youth and women; adherence percentages based on calculations using a pill count tabulator. These baseline data will be compared to data collected in two recordings following the completion of the intervention. Data were analyzed by race/ethnicity, age, gender, and transmission risk within the 2014 calendar year. Participants will examine SPSS data analysis to determine if there was a statistically significant improvement as a result of the intervention.

Lessons Learned: The presenters will highlight aspects of the active and successful engagement of 60 study participants, and report on the preliminary clinical and pill count data, and the impact of In the Mix at reaching and / or exceeding its stated objective---maintaining viral load suppression. The session will conclude with an interactive discussion of lessons learned, and discuss the potential benefit of integrating a qualitative data analysis to gain a better understanding of the facilitators and inhibitors to achieving sustainable viral load suppression.

CP11

Abstract 1678 - Prevention and Care Programs

Author(s): *Jane Mezoﬀ, Shailondel Benton, Ekaterine Shapatava*

Issue: As limited resources continue to challenge community-based HIV prevention and care providers, an increasing emphasis has been placed on how those resources can be best used to achieve the greatest impact. Conducting evaluation of both the processes and outcomes of prevention and care activities should be considered at all phases of program development and implementation. The term

“Evaluation Planning” describes a focused intention to describe the expected outcomes and metrics, and determine to what extent they have or have not been achieved.

Setting: CDC funds a large number of community-based organizations (CBOs) across the United States. Most program announcements focus on those areas with the highest rates of HIV infection, and their target populations vary slightly by funding announcement. Target populations include men who have sex with men (MSM), young MSM, MSM of color, injection drug users (IDUs), high risk heterosexuals, and transgender persons.

Project: PS 15-1502, CDC’s new five year flagship funding announcement for CBOs represents a new funding cycle detailing DHAP’s new program activities. Previous rounds of CDC funding to CBOs has focused on the delivery of evidence-based effective behavioral interventions (EBIs). This new funding cycle includes significant changes in the approach, including a requirement to create partnerships with local HIV care and other providers in order to identify new HIV positive individuals, and to provide their target populations with accessible clinical and other essential support services. As part of their first-year start up activities grantees will be asked to develop an evaluation and performance measurement plan. Our goal was to provide grantees with clear and concise guidance on how to develop and use an evaluation and performance measurement plan. We first surveyed other CDC national programs in order to identify grantee training or materials in order to 1) determine if there was consistency among them and 2) adapt these materials for use by CBO grantees funded under the new PS 15-1502

Results: We will present a mock evaluation and performance measurement plan for a fictitious CBO in order to demonstrate how to operationalize the concepts in the evaluation and performance plan guidance. We will also share evaluation planning materials that have been specifically adapted for CBOs conducting HIV prevention and care services.

Lessons Learned: Lessons learned during the development and adaptation of the evaluation planning materials will be translated into technical assistance to be made available to grantees during and after the National HIV Prevention Conference.

CP12

Abstract 1201 - Prevention and Care Programs

Author(s): *Raymond Pfeil, Tony Macheak*

Issue: Monitoring and evaluation (M&E) of HIV prevention programs is vital for ensuring that programs are addressing the needs of priority populations and that HIV-positive clients are being linked to HIV medical care. Agencies are often unable to make data-driven program decisions because their data systems lack the appropriate reporting tools.

Setting: All CDC-required National HIV Prevention Program Monitoring & Evaluation (NHM&E) data are entered into or uploaded to EvaluationWeb, a secure, browser-based data entry and reporting application. EvaluationWeb contains a variety of useful canned reports that are helpful for routine monitoring of HIV prevention programs.

However, EvaluationWeb also has an integrated ad-hoc query tool, Reflexx, that can be used by health departments or community-based organizations to easily answer questions about HIV prevention interventions and their success in referring and linking HIV-positive or high-risk HIV-negative clients to HIV medical care and prevention services.

Project: We have accumulated several scenarios from a variety of agencies that have used Reflexx for monitoring and evaluation of HIV prevention programs and referral and linkage to HIV medical care and prevention services. The scenarios focus on improving the success in returning HIV test results to newly-identified, confirmed HIV-positive clients, evaluating the success of HIV testing programs for priority populations, and evaluation of how well linkage to care objectives are being met.

Results: Health departments and community-based organizations created Reflexx reports that enabled them to quickly and easily determine whether the programs were meeting their objectives. In all cases, the grantees successfully put measures in place to improve the efficacy of their programs.

Lessons Learned: With minimal initial instruction, jurisdictional health departments and community-based organizations have employed Reflexx to create custom reports on an ad-hoc basis. Subsequently they were able to interpret the data in the reports and apply them to HIV prevention program monitoring and evaluation activities with the goal of program improvement.

CP13

Abstract 1905 - Prevention and Care Programs

Author(s): *Angela Merges, Nana Mensah, Shruti Ramachandran, Jessica Klajman, Zoe Edelstein, Julie Myers*

Background: In the past ten years, non-occupational post-exposure prophylaxis (nPEP) has been increasingly recognized as a tool for HIV prevention, especially for individuals at risk such as MSM. In 2013, the New York City Department of Health and Mental Hygiene began providing nPEP through newly-funded, sexual and behavioral health (SBH) programs. The goal of SBH programs is to provide holistic, co-located sexual and behavioral health services to uninsured/underinsured MSM and other priority populations. In addition to nPEP services, all SBH programs provide mental health and substance use counseling, HIV testing, STI screening, viral hepatitis screening and vaccination, social service resource linkages, and HIV risk reduction education. We examined associations with having initiated nPEP among SBH clients.

Methods: Data were from intake of MSM who enrolled in the SBH program in 2014. Socio-demographic information (age, race, and country of birth) was collected from the client at intake. Clients completed the Generalized Anxiety Disorder Assessment (GAD-7), Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test short form (DAST-10), and the Patient Health Questionnaire (PHQ-9). Clients with a score greater than five on the PHQ-9 were considered to have screened positive for depression. In addition, clients were asked about their behavior in the past 30 days, specifically transactional sex, diagnosis with a sexually transmitted infection, and use of cocaine/crack, methamphetamines, or ecstasy. Food insecurity and housing stability was also assessed. Descriptive statistics and bivariate analyses were conducted to identify factors associated with nPEP initiation. A multivariate logistic

regression model was built using a backward stepwise selection procedure; the bivariate probability value to enter the model was set at 0.2. The model was additionally adjusted for program site.

Results: A total of 593 MSM clients were enrolled in the SBH program in 2014; 53% were black or Hispanic and the mean age was 31 years. In 2014, 303 (51%) of the clients were enrolled in the SBH program through initiating nPEP. In bivariate analysis, the odds of nPEP initiation were greater among clients who had more than a high school education, used methamphetamines in the past 30 days, and reported food insecurity in the past 90 days. NPEP initiation was inversely associated with a positive depression screen. In the multivariable model, having more than a high school education (adjusted odds ratio (aOR) =1.65, 95% confidence interval (95% CI =1.05 – 2.58), and crystal meth use in the past 30 days (aOR =2.46, 95% CI =1.18 – 5.14) remained positively associated with nPEP initiation. Depression remained inversely associated with nPEP initiation (aOR =0.61, 95% CI =0.41 – 0.89).

Conclusions/Implications: In a patient population at high risk of HIV with barriers in access to clinical preventive services, clients who initiated nPEP had greater odds of reporting behaviors that would benefit from substance use counseling. Findings highlight the importance of continued efforts to increase awareness and use of biomedical interventions among those of lower socio-economic status and of providing nPEP as part of a holistic sexual and behavioral health strategy.

CP14

Abstract 1480 - Prevention and Care Programs

Author(s): *Carole Treston, Jeffrey Kwong, Jason Farley*

Issue: Approximately 50,000 people in the United States still becoming infected with HIV each year. In 2014, the USPHS and the CDC released guidelines recommending that Pre Exposure Prophylaxis (PrEP) be considered for people who are HIV-negative and at substantial risk for HIV. Despite this, the uptake of PrEP has been slow, and individuals most at risk may not be aware of or have access to PrEP as an HIV prevention option. Staff at clinical settings where HIV negative individuals interact with the healthcare system may not be aware of or prepared for this opportunity. Structural limitations, organizational barriers and scarce resources, including physician availability, may be viewed as high barriers to PrEP program implementation. Nurses can lead in education and advocacy, policy change and provider education and support for PrEP in their communities.

Setting: Professional development, education and skills building for nurses and other clinical providers in HIV, primary care, STD, substance abuse and reproductive health care settings.

Project: In 2015, the Association of Nurses in AIDS Care identified best practices in nurse managed PrEP programs in settings across the country. A series of instructional webinars for nurses (RNs and Nurse Practitioners) was developed and delivered. Content includes advocacy strategies, patient education and program implementation checklists, clinical tools, sample protocols, model standing orders and illustrative case studies. Faculty includes leading Nurse Practitioner PrEP prescribers, RN care managers and PrEP patients. Highlights of these webinars will be shared.

Results: Innovative approaches that focus on expanding the role of RNs and Nurse Practitioners can facilitate PrEP access in various settings. We will describe nurses' role in advocacy within the clinical setting, patient & community education, program design & implementation, nursing education and staff training, establishing clinical protocols, including model standing orders for routine monitoring and follow-up, navigating insurance/patient assistance programs, intake /pre-visit evaluations, PrEP visit, risk and adherence assessment & education, on-going clinical monitoring, and patient communications.

Lessons Learned: Throughout the health care system, nurses play a key role in implementation and evaluation of new programs, staff training, and infrastructure function. As more people become aware of PrEP, PrEP programs must be established in a variety of settings. Nurses can contribute to better PrEP access through traditional and expanded roles that focus on health advocacy, organizational design, patient and staff education, and patient visit satisfaction.

CP16

Abstract 1657 - Prevention and Care Programs

Author(s): *Terry Stewart, Dustin Wagner, Patrick Piper*

Issue: Today, an estimated 1.2 million people are living with HIV in the United States. New biomedical interventions are offering effective ways for others to avoid infection. Pre-exposure prophylaxis, or PrEP, can reduce the risk of HIV infection by over 90% among those at high risk of infection, if taken daily. As PrEP becomes available and prescribed for use among gay, bisexual, and other men who have sex with men (MSM), persons who inject drugs (PWID), or persons in serodiscordant relationships, behavior change interventions are necessary to model healthy behavior and to diffuse healthy norms related to PrEP utilization among at risk networks. A community-level intervention, like Community PROMISE, is a widely adopted intervention that focuses on using role model stories (RMS) to change the social norms that guide risk behaviors and can communicate theory-based messages to an at-risk community about how PrEP can effectively support remaining HIV-negative.

Setting: Since the early 90s, the Community PROMISE model has been in use with several at-risk populations, including gay and non-gay identified MSM, PWID, high-risk youth, and sex workers. PROMISE has also been adapted for use in clinical settings, where it is used to support persons living with HIV through the HIV continuum of care and high-risk negatives with theory-based messages for PrEP.

Project: Given the theoretical foundations of Community PROMISE and the focus on ethnographic data to inform the RMS used as the heart of the intervention, PROMISE is highly adaptable to different populations and can successfully guide the behaviors needed to support the uptake of PrEP. Recent efforts have focused on adapting training curriculum to support high impact HIV prevention, with an emphasis on the implementation of PROMISE to target seronegative partners of PLWH about the importance of PrEP. There also continues to be an important role for distribution of RMS to high-risk negatives in the community that model and promote PrEP.

Results: A new training protocol has been developed to work with two specific intervention populations: 1. PLWH in clinics and 2. High-risk individuals in community settings; each through identifying and

diffusing PrEP messages utilizing stages of change theory. PROMISE training will include discussions, examples and materials about where and how the intervention can be implemented. While there will continue to be a focus on how to construct strong theory-based RMS targeting PrEP and the importance of engagement in care, there is also a compendium of RMS for PrEP that has been developed to demonstrate the utility and flexibility of the PROMISE model in terms of PrEP.

Lessons Learned: PrEP is a powerful HIV prevention tool and can be combined with condoms and other prevention methods to provide even greater protection than when used alone. Modeling behaviors in terms of PrEP norms and acceptability in the social network can provide an effective way to disseminate this prevention method. Distribution of RMS on PrEP by persons at high-risk of infection and PLWH within their social networks may provide support for the successful and effective uptake of PrEP in the community.

CP17

Abstract 1605 - Prevention and Care Programs

Author(s): *Marianne Buchelli, Ramon Rodriguez-Santana*

Issue: A large number of Connecticut HIV prevention services providers did not know who was providing PrEP services within their communities, or how they could refer HIV high-risk clients to a PrEP provider.

Setting: The 2014 Connecticut Department of Public Health (DPH) PrEP Implementation Summit was held in Meriden, Connecticut. Summit participants included, HIV Support Service Providers, HIV Specialist Providers, HIV Prevention Program Managers/Directors, Non-HIV Specialist Medical Providers (MD, APRN, RN, PA), HIV Prevention Providers, and other participants such as Disease Intervention Specialist (DIS), researchers and HIV/AIDS programs administrators. The goal of the PrEP Summit was to educate the Connecticut HIV/AIDS prevention and care community regarding PrEP, especially on how to implement PrEP in their community and in an existing medical setting.

Project: On December 10, 2014 the CT DPH HIV Prevention Program sponsored a Statewide PrEP Summit. DPH staff presented an overview of DPH's PrEP strategy and action plan. In addition, there was a presentation from a representative of the Statewide PrEP Interest workgroup on a pilot survey and some preliminary findings of the use of PrEP in CT. Another presentation highlighted promoting equitable access to PrEP for African American/Black MSM and other marginalized groups. The CT DPH worked with New England AIDS Education and Training Center (NEAETC) to coordinate a panel that included providers at different stages of implementing PrEP in practice that shared their protocols and experiences in the community.

Results: The PrEP summit gathered Connecticut HIV/AIDS prevention and care providers interested in community PrEP implementation and PrEP research initiatives. 110 registered and participated in this PrEP summit with 69.1% (n =76) completing the PrEP summit electronic survey evaluation. Of the 76 participants completing the electronic survey, 28.9% (22) worked for a 'Community Based Organization (CBO),' 17.1% (13) for a 'HIV/AIDS Service Organization (H/ASO),' 13.2% (10) for a 'University,' 11.8% (9) for a 'Community Based Clinic,' 5.3% (4) for a 'Hospital,' and 23.7% (18) from 'Other Public Health Organization.' For the community PrEP implementation panels presentations 89.5% (68) of participants

'agreed' that presentations improved their knowledge on the subject. For the PrEP research Initiatives panel presentations 96.1% (73) of participants 'agreed' that presentations improved their knowledge on the subject. Overall, 84.9% (62) of participants reported to be 'satisfied' with the PrEP summit.

Lessons Learned: There were positive benefits as a result of the PrEP summit. For instance, DPH will be researching how to access state funds for the development of a PrEP drug assistance program (PrEP DAP). The DPH reached out to and connected with Washington State Health Department's HIV Prevention and Ryan White Program staff to discuss their PrEP Drug Assistance Program (DAP). In addition, another lesson learned was the need to create a PrEP providers contact list and a PrEP public awareness advertising campaign targeting the general public and healthcare providers. A few weeks after the summit, the first active list of PrEP providers was compile and distributed. Two months after the summit, the plan and development of the PrEP public awareness advertising campaign was completed.

CP18

Abstract 1452 - Prevention and Care Programs

Author(s): *Julie Eichhorn, Francisco Nanclares*

Issue: New HIV infections in the United States and its territories have remained steady for well over a decade and there is need for innovative models of effective interventions and strategies to address this stagnation. With the emergence of HIV pre-exposure prophylaxis (PrEP) as an important tool to reduce HIV acquisition among those at risk, the Centers for Disease Control and Prevention (CDC) and its Capacity Building Assistance (CBA) partners have developed models for integrating PrEP into various Effective Behavioral Interventions (EBI) and Public Health Strategies (PHS). This session will describe how the EBI, Personalized Cognitive Counseling (PCC), and PHS, Couples HIV Testing and Counseling (CHTC), can enhance the promotion and utilization of PrEP.

Setting: Both PCC and CHTC have been widely diffused and implemented in a variety of community-based organizations (CBOs), health departments and health-care organizations throughout the U.S. and its territories. Both PCC and CHTC are designed to be delivered as part of HIV counseling and testing services. PCC is a single session cognitive-behavioral counseling intervention that focuses on those at highest risk, MSM who have had a recent episode of condomless anal intercourse and are HIV repeat testers. CHTC targets 2 or more persons who are in or are intending to be in a sexual relationship who wish to receive all elements of HIV testing and counseling together. CHTC has greater impact in geographic areas and among populations with high HIV prevalence because in some high-risk groups, HIV transmission occurs primarily as a result of sex between main partners.

Project: CDCs High-Impact HIV Prevention (HIP) approach calls for targeting the most cost-effective and scalable interventions to populations with the greatest need to reduce HIV incidence. PCC and CHTC provide the opportunity for making referrals and linkages to PrEP. Likewise, those who are seeking PrEP treatment may be referred to PCC and/or CHTC. This presentation will describe procedures for PCC and CHTC counselors to support their programs with assessing for PrEP eligibility, conducting health promotion focused on PrEP, motivating PrEP candidates to initiate treatment, linking those candidates to PrEP treatment, and providing support to those on PrEP treatment.

Results: The very people PCC and CHTC target are largely those at greatest risk who PrEP is intended to benefit. PCC and CHTC have integrated PrEP into their key messages and core components, and therefore it can be expected that there will be greater PrEP promotion and uptake by clients who receive these services.

Lessons Learned: In order to achieve HIV prevention goals and outcomes as outlined in the National HIV/AIDS Strategy (NHAS) and through CDCs HIP approaches, we must integrate new information about proven biomedical approaches such as PrEP into existing evidence-based behavior-change interventions and strategies.

CP19

Abstract 1271 - Prevention and Care Programs

Author(s): *June Holmes, Kelly Williams, Wynnett Stewart, Onyema Ogbuagu, Michael Virata*

Issue: With 50,000 new HIV infections occurring each year in the U.S, and unavailability of a cure or vaccine, prevention efforts must be incorporated in public health strategies to impact this trend. As a biomedical intervention, Pre-Exposure Prophylaxis (PrEP) can provide a high level of protection against HIV acquisition, and is even more effective when combined with condom use and other prevention tools (1).

Setting: The Yale-New Haven Hospital (YNHH) PrEP Program comprises two outpatient HIV clinic sites. Modes of referrals include self-referrals, at-risk partners of HIV patients, and eligible clients of Post-Exposure Prophylaxis (PEP) programs within the YNHH system and the New Haven community.

Project: In the YNHH protocol, PrEP indicates use of daily oral tenofovir /emtricitabine in high-risk individuals to prevent HIV infection. At our program sites, PrEP includes risk reduction and adherence counseling; also evidence-based behavioral interventions. We utilize the CDC's Choosing Life, Empowerment, Action, Results (CLEAR) intervention in order to support HIV prevention behaviors. Patients are encouraged to participate in CLEAR as a strategy to making healthy life choices. Our program is consistent with CDC PrEP protocol and goals of the National HIV/AIDS Strategy.
PROGRAM PLANNING:

Phase 1 (Program conception)

- A multidisciplinary team of key stakeholders met to discuss the need, feasibility and possible incorporation of PrEP within the HIV clinic services at YNHH
- Reviewed published PrEP literature including 2014 CDC guidelines/protocol, also evidence-based recommendations and tools for HIV risk reduction and adherence counseling
- Conducted survey to determine risk behaviors/practices of our current HIV positive patients and their willingness to refer partners/community contacts for PrEP; 28% said they would provide referrals
- Defined initial target population and eligibility guidelines
- Set targets for protocol completion and program roll-out

Phase 2: (Implementation)

- Conducted Infectious Disease provider and staff educational sessions
- Obtained educational materials for providers and for patients
- Created local HIV PrEP protocol
- Outlined logistics of referrals, scheduling and billing

Results: : The PrEP service at YNHH began in November 2014. In the first 3 months of the program, we enrolled 6 patients. All participants have engaged in risk reduction/adherence counseling; 5 have reported safer sex practices since enrollment. Five have been adherent to medications and medical appointments. One patient is participating in CLEAR; 1 patient is in process of doing the same. Demographic breakdown of enrolled patients: 5 male/1 female, 2 Hispanic/2 Black/2 White, 4 MSM/2 Heterosexual, age range 19 - 43.

Lessons Learned: • One of 6 patients has been non-adherent. This highlights the need for adherence support. An adherence counselor is one strategy that is effective in achieving success

- HIV risk reduction counseling is an essential component of PrEP and often leads to positive behavior change
- All providers and staff must be educated regarding PrEP and involved in its implementation to ensure its success
- PrEP may prove to be an excellent referral source for CLEAR
- Efforts need to be expanded to increase referrals

CP20

Abstract 1401 - Prevention and Care Programs

Author(s): *Philip Chan, Leandro Mena, Tiffany Glynn, Catherine Oldenburg, Rupa Patel, Kristen Pfeiffer, Kenneth Mayer, Amy Nunn*

Background: Pre-exposure prophylaxis (PrEP) has demonstrated efficacy in preventing HIV among men who have sex with men (MSM), but uptake in clinical settings across the United States has been slow. We assessed barriers to PrEP implementation at the only publicly-funded sexually transmitted disease (STD) clinic in Rhode Island.

Methods: All MSM presenting to the STD clinic in Providence, Rhode Island from October 2013 to November 2014 were offered a brief educational session about PrEP, irrespective of self-reported HIV risk factors. Following the session, men who completed the educational session were asked if they were interested in PrEP. Those declining PrEP were asked reasons why, and men who expressed interest were contacted to set-up an appointment with a medical provider. Demographic and behavioral data were reviewed. A PrEP implementation cascade was used to describe gaps in uptake including number of MSM who were: 1) educated about PrEP, 2) interested in taking PrEP, 3) successfully contacted for follow-up, 4) able to schedule an appointment, 5) able to make an appointment, and finally, 6) prescribed PrEP. Two multivariable logistic regression models were used to examine associations between all men who were educated about PrEP and likelihood of being prescribed the medication which included: 1) Perception of HIV risk (Likert Scale ranging from 1-no risk to 5-high risk), perceived efficacy of PrEP (Likert Scale ranging from 1-does not prevent to 5-prevents all the time), overall understanding of PrEP, and any concerns about PrEP; and 2) Behaviors in the last 12 months including

any condomless anal sex, anonymous partner(s), five or more partners, HIV-positive partner(s), and partner(s) of unknown status.

Results: Of the 234 MSM who underwent the PrEP educational session, 71% were <35 years old, 77% White, and 18% Hispanic. Eighty-seven percent had >1 partners in the last 12 months, 58% reported having one or more anonymous partners, 59% had a partner of unknown HIV status, and 29% reported having a prior STD. Fifty-six percent (130) expressed interest in PrEP after the educational session. Foremost reasons why men were uninterested included perceived low-risk (44%), needing more time to think about it (12%), concern for side-effects (6%), and insurance/financial reasons (3%). MSM who reported no interest in PrEP had similar behaviors to men who were interested. Among men who were interested, 53% (69/130) were successfully contacted for follow-up; of these, 51% (35/69) scheduled an appointment. Key reasons why men did not schedule an appointment included: perceived low-risk (38%) and needing more time to think about it (15%). Among men who scheduled an appointment, 77% (27/35) made the appointment, and of these, 93% (25/27) were prescribed PrEP. Higher risk perception of HIV (OR=1.79, 95% CI 1.14-2.81) and engaging in sex with an HIV positive partner (OR=5.68, 95% CI 2.12-15.31) had significantly higher odds of being prescribed PrEP. Other variables in our model were not associated with PrEP uptake.

Conclusions/Implications: We successfully implemented a PrEP program for MSM at a publicly-funded STD clinic. Low perceived risk among men was the primary barrier to PrEP uptake among many patients.

CP21

Abstract 1953 - Prevention and Care Programs

Author(s): *Jesus Barrios, Summer Stephaos, Pedro Carneiro*

Issue: As patients increase their access to biomedical interventions such as PEP and PrEP, our clinic experienced a simultaneous surge in interest for STI screening. Our STI screening model provides this service to all of our patients regardless of their ability to pay. However, we continued to run into issues of cost and labor. While our clinic increased its capacity and started to see unpaneled patients for PrEP and STI screenings, issues emerged that compromised the ability of the clinic and of medical providers to operate optimally. These issues included increased cost to see uninsured patients and limited availability of already overbooked providers. Callen-Lorde revamped its system for STI screening by integrating a multidisciplinary team comprised of medical providers, nurses, and HIV counselors. The HIV counselors served as the navigator of our sexual health services: low cost or free access to STI screening and treatment, PrEP, and nPEP.

Setting: High volume lgbt health center in NYC, NY
Callen-Lorde Community Health Center

Project: Callen-lorde's testing alongside brief risk reduction counseling with an HIV counselor. Within the risk reduction conversation, the HIV counselor discusses nPEP and PrEP with the goal of the patient understanding our facility is set up to respond to their sexual needs. After the visit with the HIV counselor, the patient is seen by the medical provider to address screening for HIV NAAT, oral/anal/urine gonorrhea and chlamydia, hepatitis a/b, and syphilis. If a patient presents symptoms of

STIs during their initial visit, same-day treatment is available. Follow-up is facilitated by the HIV counselor, who reviews charts and communicates with the provider about any abnormal result. Additionally, the nursing team provides any treatment prescribed, which helps to ease the burden from the medical provider while also decreasing costs.

Results: Implementation of an inclusive STI screening program for the uninsured requires a multi-disciplinary approach that reshapes and reformats professional roles. Programs like this are extremely popular with patients and more funding should be allocated to cover STI screenings for the uninsured. There is a need to increase access to STI screening and treatment, especially at a time when patients are being presented with more HIV prevention options.

Lessons Learned: Our prior model of screening uninsured patients caused monetary issues for both the clinic and patients. Additionally, the model discriminated against unpaneled patients, because they increased the caseload for medical providers and compromised the quality of follow-up. By including and expanding the role of the HIV counselor, we were able to expand our system, obtain clinic-wide buy-in, and successfully serve uninsured, unpaneled patients. By involving the nursing team on follow up, we were also able to avoid overbooking providers. Overall, the system was integrated seamlessly, and we have been able to find and treat a significant portion of patients who were positive for STIs, non-immune to Hepatitis A and/or B, and would perhaps not seek care otherwise.

CP22

Abstract 1882 - Prevention and Care Programs

Author(s): *Emily Klukas, Miriam Vega, Evelyn Ullah*

Background: As the US is leading the way in “rolling out” pre-exposure prophylaxis (PrEP), it is important to elucidate this process at an organizational level to support. In order for PrEP to be implemented effectively, local agencies must incorporate a variety of services (education, referral, adherence counseling, prescription and labs), as well as educate staff on clinical trial findings, CDC guidelines, avenues to access PrEP, and financial support options. The objective of this pilot project was to examine readiness for PrEP rollout at an organizational and service provider level.

Methods: A self-administered survey assessed 3 dependent variables, PrEP knowledge among HIV service providers, ‘self-efficacy’ (measured using 6 variables) of providing PrEP services, and availability of PrEP services at the organization. Respondents were recruited at the 2014 USCA Exhibition Hall and compensated with a small trinket (n=75). Composite scores were calculated for all 3 dependent variables. Descriptive statistics, chi-square and ANOVA were conducted using SPSS.

Results: The most common PrEP services available were ‘providing PrEP information to clients’ (46.7%) and ‘providing information in the community’ (30.7%). Less than 1 in 5 reported their agency having protocols, lists or maps of PrEP providers in the community. Eight of these variables were compiled into an Organizational Services Score; the average score was 2.3. (SD=1.66). The majority (73.6%) of respondents noted that their agency offers 1 or 2 PrEP-related services. In terms of self-efficacy, while 50.3% report ‘knowing the process of getting on PrEP,’ only 45.3% feel they can ‘explain the process,’ and even less (30.7%) feel they ‘know how to make PrEP more affordable for those without insurance.’

The average self-efficacy score was 12.7 (SD=3.7), of a possible score of 18. The average PrEP knowledge score was 1.8 (SD=0.8), of a possible score of 3.

The Organizational Services Score was positively correlated with self efficacy ($r=4.76$, $p=.001$), meaning that those reporting more PrEP services in their agency were more confident of their PrEP-related skills. Self-efficacy and PrEP knowledge were also positively correlated ($r=3.44$, $p=.005$). Respondents whose agencies serve transgender individuals had a significantly higher knowledge score ($F(1,68)=7.25$, $p=.009$); for those whose agencies serve men who have sex with men (MSM), there was a trend toward higher knowledge ($F(1,68)=3.75$, $p=.057$) and more organizational services ($F(1.51)=10.45$, $p=.051$).

Conclusions/Implications: Based on these pilot data, organizations appear to be engaged in the early stages of developing PrEP-related services. Many organizations have begun adding PrEP-related services, and it appears that those who serve possibly “high risk” populations are trying to enhance their knowledge. PrEP knowledge and self-efficacy of staff go ‘hand in hand’ and should be considered crucial elements of developing effective PrEP services. Organizations should consider protocol and tool development, staff development, and community needs, in terms of clinical or support services.

CP23

Abstract 2521 - Prevention and Care Programs

Author(s): *Dobromir Dimitrov, Benoit Masse, Deborah Donnell*

Background: Four randomized clinical trials (RCT) have shown that tenofovir-based pre-exposure prophylaxis (PrEP) significantly reduces HIV acquisition. However, efficacy strongly depends on consistency of PrEP use. The trials demonstrating efficacy had varying levels of adherence, however two other trials had low adherence and showed no evidence of PrEP efficacy. We aim to explore how patterns of pill-taking combined with different waning of PrEP protection may affect PrEP effectiveness.

Methods: We used individual-based mathematical models to study the impact of pill-taking patterns on individual HIV risk and observed efficacy in RCTs. HIV transmission in a 2-arm RCT was simulated assuming that prescribed daily doses were taken regularly, randomly and in blocks. Risk-driven adherence, in which PrEP was more likely taken in days when sex is expected, was also investigated. Three temporal PrEP protection waning profiles were explored: long (over 5 days), intermediate (over 3 days) and short (over 24 hours) period of protection after a pill was taken. PrEP coverage was estimated as the average fraction of days of any PrEP protection over the entire evaluation period. PrEP efficacy for each simulated RCT was estimated as one minus the ratio of observed HIV incidence in the active vs placebo arm. Results from these models were then compared to the observed efficacy of the completed clinical trials.

Results: Expected PrEP efficacy was 60% with regular, 50% with random and 34% with block adherence assuming that PrEP with a long protection profile was 70% effective, and pills were taken only 50% of the days. The overall proportion of days with at least some PrEP protection was 99.7%, 96.7% and 62.3% under these scenarios. Differences between pill-taking patterns decreased when protection waned more rapidly and became irrelevant if PrEP reduced HIV risk only in days when it was taken. The high PrEP efficacy (63%-75%) observed in Partners PrEP and CDC Botswana trials suggested long-lasting protection

combined with high overall adherence and very limited block pill-taking; the moderate efficacy observed in iPrEx and Bangkok trials (44%-49%) was best explained by the 50% adherence scenarios with random pill-taking under long-lasting protection. Two scenarios of risk-driven pill-taking resulted in 29% and 37% daily pills taken and effectiveness of 43% and 51% for long protection.

Conclusions/Implications: Pill-taking patterns may have a substantial impact on the protection provided by PrEP even when the same numbers of pills are taken. Regular pill-taking behaviors are associated with the highest protection while block adherence is associated with low effectiveness. The effectiveness of risk-driven pill taking depends on the ability of the PrEP users to predict their sexual activity. When PrEP retains protection for longer than a day, pill-taking patterns can explain different efficacies observed in PrEP RCTs.

CP25

Abstract 2287 - Prevention and Care Programs

Author(s): *Maribel Rosas, Adrian Evans-Moore, Fabiola Vega*

Issue: Division of Human Immunodeficiency Disorder (HIV) and Sexually Transmitted Disease (STD) Program (DHSP) initiated the MCC program in efforts to address barriers with a HIV positive population regarding medication adherence and detainment in healthcare services. Despite increased education and medical advances, there's still a large population that is not medically adherent consequently increasing the spread of HIV. According to Epidemiology Program (2009), approximately 42,000 people were known to live with HIV/AIDS in Los Angeles County in 2009, while an estimated 2,000 to 2,500 new HIV infections occur every year.

Setting: MCC is a state funded program stationed at various HIV clinics in Los Angeles County. The program focuses on the coordination care to aid in the prevention of transmitting HIV by addressing psycho-social and biomedical barriers that prevents patients from medication compliance and medical care adherence. The goal of MCC is to increase patient autonomy so that they can take control of their care and eventually become self-manage.

Project: MCC is an interdisciplinary approach that encompasses Primary Care Provider, Patient Care Manager (Master Level Social Worker), Medical Care Manager (Registered Nurse), and Medical Case Worker to work closely with patient. Main components of MCC that helps in alleviating barriers such as: Homelessness, drug addiction, mental disorder and education deficits. The process of alleviating such barriers consist of linking patients to housing agencies, brief interventions, referrals, reassessment of care, and referrals to drug rehabilitation centers. Monitor patients through screening and assessment, assessment and care plan development, multidisciplinary team case conferencing, implementation and evaluation. Brief Interventions include engagement in care, adherence, and risk reduction via face to face or telephone contact.

Results: According to DHSP, Case watch, Year 22-23 and Assessment data, Baseline Characteristics in active MCC from March –November 2013 (N=1,001) included the following Race Latino 499 (50%), African-American 266 (26%), White 199(20). Other Characteristics included Patient demographics, Psychosocial, Risk behaviors, and health status. The viral suppression of MCC patients prior to starting

the MCC program revealed 72% had a viral load more than 200 copies/ml and 28% had a viral load less than 200 copies/ml. After 6 months of MCC services it revealed 42% had a viral load more than 200 copies/ml and 58% had a viral load less than 200 copies/ml. At MLK OASIS there are 200 patient enrolled in the MCC program. Of those enrolled in the MCC program it showed that 33.5% patients are considered to be self-manage indicating that their viral load is less than the 200 copies/ml after receiving services for six months.

Lessons Learned: Providers are able to build relationship with patient.

Multidisciplinary care team approach was effective.

All MCC team members played an important role in assisting to aid in the improvement of service and most of all patient care.

CP26

Abstract 1331 - Prevention and Care Programs

Author(s): *RW Powell, MA Coker, GS Felzien, MJ Jackson, EB Williams, RJ Donnelly, HP Katner*

Issue: Clinical chart reviews across a network of providers are one systematic method of monitoring the care continuum for PLWHA who have been linked to care (e.g., retention in care, prescription of ART, viral load suppression). Chart review findings can be used to initiate, evaluate and prioritize data-driven continuous quality improvement (CQI) activities. Periodic chart reviews allow progress to be monitored and may reveal trends over time in the quality of care provided. Additionally, adjustments to quality management (QM) plan goals can be made accordingly.

Setting: Since 2006, statewide periodic chart reviews have been utilized to monitor performance and inform CQI activities in Georgia Ryan White Part B (RWPB) funded clinics.

Project: At least one clinic in each of 16 public health districts was selected for each review year: CY2006 (22 sites, 820 charts), CY2009 (18 sites, 697 charts) and CY2012 (20 sites, 812 charts). Reviews were conducted by a physician and 2 nurses. The chart review tool included both HAB and GA RWPB performance measures (PM). When available, national goals for PMs were used as benchmarks. The 2006 HIVQual Project Sampling Methodology was utilized and females were oversampled. Clinic-specific and RWPB summary reports of findings and recommendations were sent to each clinic. Findings from 2006 were used to set priorities for CQI activities. Cervical cancer screening and dental examinations were specifically incorporated into clinic QM plans. In 2009 and 2012, the chart review reports included a comparison to previous review findings.

Results: Rates improved for most PMs from 2006 to 2012, including viral load suppression (74 to 88%), viral load monitoring (76 to 89%), ART according to DHHS guidelines (91 to 98%), syphilis screening (76 to 84%), alcohol counseling for HCV/HBV-positive patients (26 to 76%), and PCP (95 to 97%) and MAC (93 to 96%) prophylaxis. Moderate increases were seen for dental examinations (20 to 24%) and cervical cancer screening (70 to 76%). Areas that need improvement include annual complete physical exam, resistance testing of unstable clients, TB screening, HBV vaccination and fasting lipid panel.

Lessons Learned: Providing PLWHA with quality care and services is imperative. Findings from the 2006 chart review were used to set priorities for CQI activities and goals were specifically incorporated into local and state QM plans. In 2012, the priority measures of cervical cancer screening and dental examination showed moderate improvement, as did most performance measures. Candidates for future QI activities include disparity analyses, TB screening, resistance testing for unstable clients, fasting lipid panel and HBV vaccination. Limitations include charts not randomly sampled, clients needed 2 medical visits for inclusion, the clinic reviewed in each district may have changed between reviews and reviews are labor and resource intensive. The 2015 Clinical Chart Review is currently being planned to address limitations and align with HAB's revised core and clinical PMs. Chart review can highlight areas of excellence and opportunity, which can be utilized to inform CQI activities. Conducting periodic clinical chart reviews is one method that can be utilized to monitor performance and drive quality improvement.

CP27

Abstract 2097 - Prevention and Care Programs

Author(s): *Alexia Eslan, Karen Schneider, Monetha Gaskin*

Issue: In March 2012, the Centers for Disease Control and Prevention (CDC) awarded a total of nearly \$20 million to state and local health departments for HIV prevention demonstration projects under PS12-1201 Category C. The awards are part of CDC's new high-impact approach for HIV prevention, and align resources with the epidemic. Category C funds were provided to health departments to develop demonstration projects to implement and evaluate innovative, High-Impact HIV prevention interventions and strategies.

Setting: The South Carolina Department of Health and Environmental Control (SC DHEC) received an award under PS12-1201 Category C to increase linkage to care (LTC) throughout the state. The main objectives of their demonstration project were to increase the linkages to HIV care and treatment to 85% in 2015 from 48% in 2011; and, to decrease the proportion of people living with HIV (PLWH) who are out of care to 20% or less.

The SC DHEC partnered with seven community based organizations (CBOs) to implement the demonstration project. CBOs are located in both rural and urban areas, and together provide services to the entire state. They were each funded at \$65,000 yearly to provide linkage to care services. Each CBO has a linkage to care coordinator who links newly diagnosed HIV-positive persons. The goal was for each site to reach 65 persons living with HIV per year, 455 total per year for all sites.

Project: As part of the demonstration project, the SC DHEC was tasked with creating a cost analysis model to measure the impact of their linkage to care program. SC DHEC engaged JSI Research & Training Institute, Inc. (JSI) to assist them to create the model.

Working collaboratively with the SC DHEC, JSI developed a cost analysis model to measure the costs of getting persons linked to care early (within 90 days of diagnosis) versus later. The model also measures quality-adjusted life years (QALY), which give an idea of how many extra years of life of a reasonable quality a person might gain as a result of treatment, in this case from getting early versus late treatment.

Results: By the end of 2013, JSI developed the cost analysis model. The model includes a data dictionary and a detailed example of how to use it. Tracking of the data through this model allowed SC DHEC to get continuation funding from CDC for the last year of the demonstration project.

Data from 2014 shows that a total of 210 newly diagnosed HIV positive persons were linked to care within 90 days through this demonstration program. Results from the cost analysis model showed that compared to those entering care late, the 210 persons entering care earlier will live on average six years longer, have 1.4 years more QALYs, and have six additional years until AIDS onset. Further, 55 new infections will be averted due to early care.

Lessons Learned: The tool is easy to use and provides meaningful information to help make programming and funding decisions.

CP28

Abstract 2465 - Prevention and Care Programs

Author(s): *Lianne Urada, Jennifer Yore, Christopher Hucks-Ortiz, Fortune Society, Public Health Institute, IPHI, NJCRI, Ask4Care, WORLD, Anita Raj*

Background: HIV care acquisition, maintenance in care, and medication adherence of newly diagnosed and out of care persons living with HIV (PLWA) continues to be a major challenge, especially in minority communities disproportionately affected by the HIV epidemic. PLWA who are not retained in care tend to fall ill, maintain detectable viral loads, and die more quickly, as well as have a higher potential to transmit the virus to others.

Methods: The study collected 52 in-depth interview data from 33 PLWAs and 19 providers who participated in the intervention study arms of the Kaiser Permanente funded Community-Based HIV Test and Treat Initiative at seven community based organization (CBO) sites in the U.S. (starting in 2013) in California, Maryland, New Jersey, New York, and North Carolina. Each CBO implemented linkage to care interventions tailored to their populations (e.g. adapted ARTAS intensive linkage to care models, food security interventions, community outreach workers, video making enhanced motivational interviewing). Interviews were conducted by phone for up to one hour and were conducted annually to provide insight into intervention experiences, including successes and barriers to linkage and retention in medical care. Vulnerable minority and underserved populations living with HIV who participated in the study included MSM, transgender, substance using, prison releasees, low income minority, and/or rural residents. The providers interviewed were staff involved in implementing outreach and retention in care interventions.

Interviews were transcribed and text coded for themes related to linkage and retention in HIV care outcomes. A list of mutually exclusive, but possibly linked, codes were developed inductively and files coded with inter-coder reliability across codes reached through agreement between coders. Data were compared between and across the participants. Memos were written which reflect the questions, concerns and analytical insights emerging from the analyses, serving as a vital data-reduction and analytical function.

Results: Emergent themes related to linkage and retention in medical care successes included those facilitated by: 1) rapid and intensive response of outreach and linkage to care CBO workers, 2) one stop shop models, including providing peer group support and linkage to services related to other issues (e.g. food security, housing, child care, and substance use/harm reduction, group support, and mental health and other health issues), 3) Case manager/peer navigators' personal characteristics and intervention approaches, including emotional support/motivation and empowerment for PLWAs to take care of themselves, to get out of denial/reluctance to seek treatment, and to adhere to daily medication regimens. Participants described getting back into care or getting care for the first time facilitated by the intense support (daily or weekly) from these workers. HIV internalized and community stigma, emotional reactions to living with HIV, substance use, and community disparities were major challenges for both linkage and retention in care in the HIV care continuum.

Conclusions/Implications: HIV linkage and adherence to care interventions by CBO's, specifically those involving intense, one-on-one outreach connections in a community based setting where other group modalities for peer support and care are offered are vital for most vulnerable PLWA's to access medical services and stay on medication regimens.

CP29

Abstract 2412 - Prevention and Care Programs

Author(s): *Laura Martindale, Catherine Holdsworth, Aviva Joffe, Alex Ho*

Issue: Linkage & Retention in medical care for people living with HIV & AIDS is important to improve health outcomes. The CDC's Care Continuum illustrates distinct stages of medical engagement and identifies where improved efforts are needed to guide the national HIV & AIDS response and meet the goals of the national HIV & AIDS strategy. In 2011, the Care Continuum indicated that 86% of people living with HIV in the USA are diagnosed, 40% are engaged in care, 37% on Antiretroviral Therapy (ART), and 30% virally suppressed.

Setting: The Einstein Healthcare Network Immunodeficiency Center (IDC) provides outpatient medical care to approximately 750 adults living with HIV & AIDS in North Philadelphia annually. The IDC offers primary and specialty HIV care as well as support services, including social work, mental & behavioral health, nutrition and pharmacy adherence counseling.

Project: In 2014, the IDC developed an innovative project to guide patients across the continuum and increase the rates of engagement in care among people who are diagnosed with HIV. Associations between attendance at medical visit and multiple patient characteristics were explored to identify factors affecting retention. Analysis was conducted with 638 individuals that are HIV diagnosed and engaged in care at the IDC. Primary health insurance was associated with a gap in medical visits ($p = 0.012$). After controlling for patient's socio-demographic, HIV status and other risk factors, results from the multivariate model show patients who have had a gap in the last 6 months were positively associated with higher viral load ($\beta = 0.27, p = 0.017$). Based on the analysis, the IDC Linkage and Retention and Quality Improvement teams enhanced the existing clinic systems to augment outreach efforts and apply specific interventions to support, track, and retain patients at-risk of being lost to care. The project defined "at-risk" as newly diagnosed, lost to

care for over 135 days, or presenting with other risk factors such as homelessness, acute mental health or substance abuse issues, or intimate partner violence. Those patients were prioritized to receive increased support between medical appointments, as well as face-to-face social work and behavioral health interventions during medical encounters. Staff received training in Motivational Interviewing, a technique practiced to elicit internal motivation and address individual barriers to care.

Results: As of February 2015, 304 patients have been referred to the project; 217 (71%) patients attended one medical visit, 143 (47%) attended two visits, and 70 (23%) attended three visits. Medical visit frequency rates increased from 64.4% in 2014 to 68.5% one year later.

Lessons Learned: Integrating additional layers into the existing clinic system rather than establishing new interventions has been paramount to the success of improved retention and reducing gaps in medical care. Further research on attendance and engagement in medical care will inform best practice protocol to keep patients engaged in medical care so they can move across the continuum and live healthier lives.

CP30

Abstract 1853 - Prevention and Care Programs

Author(s): *Amy Leonard, Jason Black, Michael Webb*

Issue: In the Houston Area, among MSM newly diagnosed in 2011, a majority (82.1%) were MSM of color, with 42.6% African American, 36.8%, Hispanic/Latino, 18.1% Caucasian and 2.8% Other. Of newly diagnosed HIV+ individuals diagnosed in Houston, 65% are linked to care within 90 days following diagnosis. To support efforts to increase HIV testing and linkage to care among MSM in our community, Legacy Community Health teamed with Abt Associates as part of a CDC-funded MSM Testing Initiative (MTI). The purpose of MTI was to identify MSM, particularly African American and Hispanic, with undiagnosed HIV infections and link them to HIV medical care.

Setting: Legacy is a FQHC, with roots in the GLBT community in Houston, TX. Founded in 1981 by a group of gay physicians to treat STDs in gay men, Legacy has tested more than 130,000 people since that time. Hispanic and African-American MSM leave their geographic neighborhoods to come to Legacy for their health care needs with the knowledge that Legacy respects their complex cultural backgrounds.

Project: Legacy's approach to HIV prevention included condom distribution, information & referrals, group presentations, HIV/STD testing, and dissemination of social marketing campaigns. Outreach is conducted at well-known gay establishments located in high prevalence areas. The Mpowerment community center was established as a safe place where YAAMSM congregate and HIV prevention activities take place. Community partners were approached to help raise awareness. Legacy explored utilizing incentives leading up to events that are popular among YAAMSM. Legacy's linkage to care process was redeveloped to ensure newly diagnosed individuals are contacted by patient navigators within 48 hours of their initial diagnosis to link to primary care.

Results: Legacy began testing for MTI in October 2013. This partnership resulted in an uptake of HIV testing among MSM in our community. In 2014, Legacy's provided 5,000 HIV tests over all contracts with

a 4% positivity rate. Additionally, as an MTI partner Legacy has facilitated a stronger, streamlined linkage to care process resulting in an overall consistent 85% linkage to care rate. Through February, 2015 a total of 1,191 eligible men were tested for HIV at Legacy with 88 previously undiagnosed men confirmed as HIV positive (7.4% positive), and 76 of those HIV positives linked to HIV medical care within 90 days (86% linked). To increase testing efforts the use of social networking during outreach testing hours was utilized to identify undiagnosed HIV+ YAAMSM. Legacy incorporated MTI testing into all Mpowerment events. Additionally, VIP passes as incentives were used during episodic mass testing events leading up to two major events for minority MSM in Houston. Further, Legacy partnered with Houston Splash and the CDC Testing Make Us Stronger Campaign to host an annual mini-ball.

Lessons Learned: Successful HIV testing and outreach efforts should be multifaceted; 2) identify and secure non-traditional testing sites and partnerships; obtain community stakeholder buy-in; and strategically use incentives that are highly valued by the target population.

CP32

Abstract 1659 - Prevention and Care Programs

Author(s): *Abigail Hankin, Heather Freiman, Adam Barnette, Ngoneh Gaye-Bullard, Bijal Shah*

Background: Both the Centers for Disease Control and the U.S. Preventive Services Task Force recommend routine, non-targeted, opt-out HIV testing for patients aged 13-65 in all healthcare settings. Repeat testing is recommended annually for “patients likely to be at high risk for HIV.” However, little research exists to guide policy decisions or clinical guidelines about optimal frequency for repeat HIV testing, especially in high-prevalence geographical areas or in clinical settings that may see a higher frequency of undiagnosed HIV, such as the Emergency Department (ED).

Methods: In July 2013, we implemented routine, non-targeted, opt-out HIV screening in the ED of an inner-city safety-net hospital in a metropolitan area with high HIV prevalence. HIV testing was conducted via 3rd generation EIA testing with reflex Western Blots for EIA positive samples. Trained HIV medical social workers met with newly diagnosed patients to disclose test results and assist with linkage to care. During this intake session, patients were asked about when they were last tested for HIV and the result of that test, and information was recorded in a secure database (REDCap). Self-report data was supplemented by testing data from the electronic medical record (EMR). SAS 9.3 was used to conduct descriptive statistical analyses.

Results: Of 266 patients with a new HIV diagnosis in the first 19 months of routine HIV screening in the ED, 189 met with a social worker for an intake interview (71.0%). Of patients who met with a social worker, 121 self-reported ever having a negative HIV test (64.0%) and 47 of the 121 (38.8%) patients self-reported a negative test in the year prior to their new diagnosis. Of patients who self-reported at least one past-year test, the mean duration to new diagnosis was 168.4 days (95% CI: 137.8 – 199.0 days). The shortest duration since prior negative self-reported test was 3 days. Based on EMR data, there were 5 patients with a new positive diagnosis who were previously tested by the program with a mean of 243.8 days (110.0 days SD) between last test and new positive diagnosis (4 of these patients did self-report this prior test).

Conclusions/Implications: In high-prevalence settings such as ours, optimal time to retest may be significantly shorter than one year, and even biannual re-testing may delay time to entry into care for patients in high-risk populations or settings.

CP33

Abstract 2399 - Prevention and Care Programs

Author(s): *Catelyn Coyle*

Issue: In 2006, the CDC released recommendations to implement routine opt-out HIV testing. However, integrated opt-out testing is not commonly practiced as part of routine primary care. Community health centers are in an optimal position to lead an integrated testing model as they serve patients representing demographics disproportionately affected by HIV, including minorities and the impoverished.

Setting: In September 2013, National Nursing Centers Consortium integrated routine opt-out HIV testing into four federally qualified health centers located in Philadelphia, Pennsylvania. One of the health centers treats HIV on-site. The goal of the project was to routinize testing in an effort to diagnose people earlier and link positive patients to HIV care through intensive linkage services.

Project: The health centers adopted a Medical Assistant (MA) initiated opt-out, 4th generation laboratory-based testing model that included modifications to the shared electronic health records (EHR). Patients 13 years or older, without an established HIV-positive diagnosis or an HIV test ordered within the previous 12 months were eligible for annual HIV testing. Standing orders allowed MAs to begin the laboratory requisition for patients that agreed to be tested. A Linkage to Care Coordinator provided intensive linkage services to HIV-positive patients to facilitate the transition from primary to specialty care. This presentation will describe the testing and linkage to care model as well as lessons learned during the implementation and maintenance phases of the project.

Results: From September 2013 through March 2015, 8,287 HIV tests have been performed and 71 (0.9%) patients have been identified as HIV-positive, 25 (35.2%) were newly identified and 2 (2.8%) were diagnosed with acute HIV. Of the 71 HIV-positive patients, 67 (94.4%) have received their positive results, 62 (87.3%) were seen by an HIV specialist, and 43 (60.6%) have started antiretroviral therapy. Twenty nine patients had HIV viral load values in their medical chart; of those, 28 were virally suppressed (96.6%).

Lessons Learned: This integrated HIV testing and linkage to care model can successfully identify HIV-positive patients and engage them in specialty care. A project champion is necessary to ensure full testing integration and project progress. HIV related trainings are an effective way to educate health center staff on the importance of HIV testing and the difference between opt-out/opt-in offers. Primary care providers should be trained on how to disclose HIV-positive results and protocols for linkage to care should be written prior to the start of the project. Staff turnover and loss of enthusiasm for testing can cause drops in testing numbers. This identified the need for more rigorous project maintenance and ongoing oversight. Training new staff on the model and providing all-staff trainings, which include CEUs, can help reinvigorate the testing initiative.

CP34

Abstract 1576 - Prevention and Care Programs

Author(s): *Eunice Casey, Alejandra Poma, Donna Dowie*

Background: New York City (NYC) Health and Hospitals Corporation (HHC) is the largest public hospital system in the country and serves over 1.4 million New Yorkers annually, of which over 475,000 are uninsured. HHC has had an established HIV screening program since 2005 and has worked to expand integrated HIV screening throughout clinical practice at HHC. HHC is one of the lead agencies in efforts to halt the HIV epidemic in New York State.

Methods: Starting in fiscal year (FY) 2013, the 11 acute-care hospitals and six community clinics of HHC established a quarterly linkage-to-care report consolidating detailed data related to time frame for linkage-to-care and indicators of linkage-alternatives for patients that delayed linkage. We analyzed data from FY2013 and FY2014 to review different time frames for linkage, and identify common linkage alternative groups for patients without confirmed linkage. To supplement this analysis we reviewed a sample of facility-data to identify frequency of hospital utilization for unlinked patients post HIV diagnosis and identify patients that linked to HIV care at least a year after diagnosis.

Results: Between FY2013 and FY2014 there were 2,629 HIV diagnoses made, 832 were newly diagnosed. The combined confirmed linkage rate (documented linkage at diagnosing facility or formal documentation from another HIV program) for the two years was 80.53% for newly diagnosed patients and 67.93% for all diagnosed. 73.08% of newly diagnoses and 62.19% of all diagnosed patients linked within 30 days of diagnosis. Newly diagnosed patients that link within 30 days are 2.7 times more likely to link to HIV care. 4.57% of newly diagnosed patients (15.94% of all diagnosed) reported that they sought HIV care at a different medical facility, and 11.90% of newly diagnosed patients (12.44% of all diagnosed) were reported as lost-to-follow-up. The 5 linkage alternatives indicators [awaiting appointment, deceased prior to linkage, remaining in inpatient care, incarcerated prior to linkage, discharged to a long-term care facility] accounted individually for <1% of patients, with the exception of patients discharged to a long-term care facility where the newly diagnosed and all diagnosed rates were 1.20% and 1.79% respectively. Facility-specific reviews indicate that patients that are listed as lost-to-follow-up continue to access services at the facility where their HIV was diagnosed, some link a year or more after diagnosis (11.39%) while 36.71% of patients remaining lost-to-follow-up sought non-HIV care at the diagnosing facility, with 68.79% of visits occurring in the ER and 13.87% related to psychological care.

Conclusions/Implications: Studies show lost-to-follow-up patients have an increased likelihood of poor health outcomes for the individual patient as well as increase risk of transmission. These data demonstrate that this population continues to seek non-HIV care and (engage in our health system) however resources are currently not in place to effectively re-engage these patients and work with them to control their HIV disease. Through better understanding of linkage and lost-to-follow-up, HIV programs are able to efficiently identify patients that are prone to delayed linkage, identify opportunities to re-engage patients not in care, and support community-wide surveillance efforts.

CP36

Abstract 1295 - Prevention and Care Programs

Author(s): *Jamila Ealey, Melanie Gwynn, Malembe Ebama, Delmar Little, William Lyons*

Issue: As of December 2012, 54% of the 46,495 persons living with HIV in Georgia were considered minimally engaged in care (Georgia Department of Public Health). In 2013, GDPH implemented the TLC Network in order to address the need for linkage services. In each area, Antiretroviral Treatment and Access to Services (ARTAS) linkage case managers aimed to link individuals to care, with a special focus on high risk and other vulnerable populations. This study examines the efficacy of using the TLC programmatic definition of linkage (one appointment with a HIV primary care provider) versus the surveillance definition of linkage (one CD4 or Viral Load within 3 months of diagnosis) as an indicator of access to care and the implications.

Setting: The TLC Network was implemented in the Atlanta area counties of Cobb, Douglas, Clayton and DeKalb.

Project: Georgia's TLC program strives to identify and promptly link to care persons who are living with HIV but not receiving care, including those who are unaware of, and those who are aware of their HIV positive status. Furthermore, the TLC Network strives to improve patient retention in HIV primary care through improved inter-organization collaborations. A standard electronic data system to capture client level linkage information throughout health districts is essential to monitor the true impact of linkage activities and performance measures as standards for effective linkage.

Results: Preliminary data from our 2013 TLC network showed 76% of newly diagnosed clients enrolled in ARTAS were linked to medical care within 90 days of enrollment and 59% of previously diagnosed clients were linked to medical care. Further assessment comparing ARTAS linkage with general linkage among sites not using the ARTAS model exclusively found that clients enrolled in ARTAS had a linkage to medical care rate of up to 80%, showing that a strength-based structured linkage process can improve the linkage and retention outcomes of clients both newly diagnosed with HIV infection as well as those previously diagnosed and either lost to care or newly engaged.

Lessons Learned: It is essential to work closely with linkage staff to ensure that an efficient networking strategy is being implemented to fidelity. Collaboration with prevention and care staff to capture client-level information and tailor the linkage process to clients' individual strengths and weakness enhance what can be a challenging process, due to stigma, ultimately improving linkage outcomes of HIV positive clients. Promptly linking clients to care through a structured quality improvement process and utilizing a network approach of traditional and non-traditional community based organizations, linkage staff, and health care providers can greatly impact patient retention in medical care resulting in better health outcomes and reduced disparities. Lastly, to improve monitoring and evaluation of linkage activities it is important to assess the limitations and benefits of linkage measures associated with clinic visits compared to measures associated with lab tests. The implications provide insight on how to strategically use lab data linkage definitions not as a gold standard for effective linkage but rather to improve data to care methods, linkage and retention efforts as performance benchmarks.

CP37

Abstract 1447 - Prevention and Care Programs

Author(s): *Lewis Mooney, Shaheda Iftikhar, James Tomarken*

Issue: How to develop and implement QI and CQI interventions to successfully improve VLS rates across a HCN caring for approximately 439 persons living with HIV/AIDS (PLWHA).

Setting: In Q-3, 2013, the Suffolk County (SC), New York, Department of Health Services (SCDHS) operated a 6 site HCN that provided comprehensive primary care services to adult, pediatric and pre-natal patients who had Medicaid or were uninsured or under-insured. The target population at the start of the QI/CQI intervention were the 439 PLWHA who were cared for by the HCN.

Project: In Q-3, 2013, the SCDHS developed and implemented both system-wide QI interventions and health center specific CQI interventions, all directed at improving VLS. The SCDHS had the external assistance of the New York State Department of Health AIDS Institute's (NYS AI) Community Health Center Quality Learning Network (CHCQLN) and the internal assistance of the SC PLWHA Consumer Advisory Board and the SCDHS administration. Employing these resources, the SCDHS HIV QI team used the following steps to develop and implement these successful QI/CQI interventions. These steps were to:

- Define an unsuppressed patient as any patient on anti-retroviral medications (ARV) for > 12 weeks with any VL > 200 copies/mL in 2013;
- Create a HC specific tracking register of all unsuppressed patients meeting the above definition;
- Initiate an intensive case conference with each unsuppressed patient and the HC HIV Team (i.e., HIV provider, HIV nurse and social worker);
- Offer all unsuppressed patients a weekly telephone call from a member of the HIV Team. If the offer was accepted a member of the HC HIV Team would call the PLWHA at least weekly;
- Decide on the health center-specific CQI interventions. Which were to:
- Begin a weekly HIV Team Huddle to discuss all unsuppressed PLWHA to be seen in the upcoming week;
- Do Drug Resistance Testing if VL > 1,000 copies/mL;
- Use a Pharmacy Tool/Medication Tool to assess barriers to obtaining or using ARVs; and
- Perform an Exit Interview that stressed HIV education and adherence using teach-back.

These QI/CQI projects were monitored weekly, with a detailed quantitative written narrative report produced, distributed and reviewed quarterly.

Results: When the QI/CQI interventions began in Q-3 2013, 50% (169 PLWHA) in the SC HCN had a VL < 200 copies/mL. In Q-1 2015, this improved to 92%, when 140* PLWHA had a VL < 200 copies/mL.

Note*: During the course of this project, 4 SC HCs were transitioned from SC to a Federally Qualified Health Center (FQHC)-operator. The Q-1, 2015 decrease in the absolute number of PLWHA achieving VLS reflects this transition.

Lessons Learned: The success of this project required the support and active engagement of external collaborators (e.g., the NYS AI), as well as the internal support from the SCDHS administration, the HC HIV teams and the unsuppressed patients, all of whom contributed to making these QI/CQI

interventions successful. Detailed quantitative written narrative reports that were produced quarterly were used to track the progress of these interventions. Overall, the intervention was successful in achieving and sustaining VLS in SC HC PLWHA.

CP38

Abstract 1334 - Epidemiology and Surveillance

Author(s): *Elliott Brannon, Jessica Fridge, Sam Burgess, DeAnn Gruber, Ashley Hoover*

Background: Although most cases of congenital syphilis and perinatal HIV can be prevented with adequate treatment, Louisiana has ranked first in the US for congenital syphilis case rates since 2012 and continues to have cases of perinatal HIV. Identification of syphilis and HIV through routine pregnancy testing is crucial for preventing mother to child transmission. The CDC recommends repeat HIV testing during the third trimester in areas with high HIV incidence (such as Louisiana) and the USPSTF recommends repeat syphilis testing during the third trimester in high-risk groups. In 2014, Louisiana enacted legislation requiring physicians to provide “opt-out” syphilis and HIV testing to women during the third trimester of pregnancy.

Approximately 65% of Louisiana deliveries (including prenatal care) are paid for by Medicaid. An analysis of Louisiana Medicaid testing data was conducted for 2012 and 2013 to better understand the proportion of pregnant women who receive third trimester testing for syphilis and HIV and provide a baseline of testing rates before the third trimester testing legislation was enacted.

Methods: A request for Medicaid data was completed by the Louisiana STD/HIV Program. All HIV or syphilis tests (based on CPT and HCPCS codes) were requested for women who delivered in Louisiana in 2012 or 2013. The request was completed using the Louisiana Vital Records Birth Registry to ensure tests from all deliveries were identified. The date of the woman’s last menstrual period and date of first prenatal care visit were obtained from the Birth Registry. Any tests conducted after 181 days gestation were considered to have been conducted during the third trimester, and a woman was considered to have timely prenatal care if her prenatal care began at least 60 days before delivery. This time period allows for adequate testing and treatment before delivery.

Results: In 2012 and 2013 in Louisiana, there were 126,665 deliveries and 80,836 (63.8%) deliveries listed Medicaid as a payment source. 71,322 (88.2%) Medicaid deliveries were to women who had timely prenatal care.

For 45,134 of the 71,322 (63.3%) pregnancies, Medicaid paid for an HIV test. For 11,814 of the 45,134 (26.2%) pregnancies Medicaid paid for an HIV test in the third trimester.

For 45,877 of the 71,322 (64.3%) pregnancies, Medicaid paid for a syphilis test. For 22,361 of the 45,877 (48.7%) pregnancies Medicaid paid for a syphilis test in the third trimester.

Conclusions/Implications: Syphilis and HIV testing rates for women during their third trimester of pregnancy were found to be low, 48.7% and 26.2%, respectively. These low rates suggest education about the importance of third trimester testing is needed in Louisiana.

Although syphilis and HIV tests during pregnancy may be paid for by sources other than Medicaid, women for whom Medicaid paid for a syphilis or HIV test during the first or second trimester and delivery would have likely used Medicaid as a payment source for a test during the third trimester. This analysis provides a baseline for understanding third trimester testing rates throughout the state.

CP39

Abstract 1522 - Prevention and Care Programs

Author(s): *Kelvin Walston, Tarita Johnson*

Issue: Nationwide African American adolescents 13 – 19 are disproportionately affected by the HIV epidemic. In 2009, African American youth ages, 13 – 19 comprised 17 % of the U.S. adolescent population, yet they accounted for 73% of HIV infections in this age group (CDC - HIV Surveillance in Adolescents and Young Adults). Georgia ranks fifth among the 10 states with the highest rates of diagnoses of HIV infection among adolescents aged 13 to 19 years (CDC, 2009.). In 2009 the estimated rate of diagnoses of HIV infection in adolescents, ages 13 – 19, but in Georgia it was 12.6 per 100,000 while the national rate is 8.7 per 100,000 population. African American youth ages 13 – 19 in Metro Atlanta, Georgia. African Americans comprised 31% of Georgia’s population in 2010, yet African Americans accounted for 78% of new HIV diagnoses;

Setting: The program targets three populations which include 1) Group Home Youth – A total of three sites, 2) Detention Center Youth – a total of three sites, and 3) Alternative School Youth – a total of four sites. The sites are: Incarcerated Youth Sites: Group Homes Sites Alternative School Sites Metro Regional Youth Detention Center Chris HomesDestiny AcademyDeKalb Regional Youth Detention Center Young Adult Guidance Center Muhammed School of Atlanta Rockdale Regional Youth Detention Center Allissa Rowley House

Create Your Dreams (After School Program) Substance Abuse Prevention Theatre (After School)

Project: The program format includes an eight hour program held one hour a week over an eight week period or three hours once week (1.5 per class) over a two week period. Both formats implement a total of 8 Street Smart HIV lessons over six hours. The eight week format also includes an additional 2 hours of social media art instruction. The shorter formats are administered to control for attrition at the juvenile detention centers (participants were released early or sent to serve long term sentences at other facilities).

Results: According the analysis: •95% of the participants who completed the post-test increased their knowledge of HIV/AIDS There was a 17% increase in condom use •There was a 25% increase the in participants perceived risk of HIV/AIDS •There was a 5% increase of refusal skills. The results of the pre/post-test analysis indicated several behavioral changes. During the period from pre-test to post-test, there was an increase in the participant’s knowledge about HIV/AIDS and participants significantly changed their views on the impact of drugs and alcohol on their sexual behavior.

Lessons Learned: The participants knowledge about HIV/AIDS improved from pre/post test. The CIR2 program has learned that shorter intervention sessions (4, 1.5 hours) lead to more impactful class time.

Coordinating HIV/AIDS testing with Universities and Colleges have been effective in the recruitment phase of CIR2. The participants have shared that they are more comfortable going to get HIV/AIDS tested from an off campus site versus visiting the school clinic. The implications for prevention programs should be focus on being flexible with their implementation program and to be able to adapt to any unforeseen circumstances that may arrive.

CP40

Abstract 2514 - Prevention and Care Programs

Author(s): *Timothy Kordic, Aaron Plant, Emily Wasson, Robert Renteria*

Issue: Los Angeles County (LAC) has the highest number of teen births, the highest number of chlamydia cases and the second highest number of people living with HIV or AIDS of any U.S. county. Youth in LAC experience very high rates of STDs, with Latinos and African-Americans disproportionately affected. While research has shown that access to comprehensive sexual health education is associated with positive health outcomes in youth, an increasing number of schools in the Los Angeles Unified School District (LAUSD), such as charter schools, have expunged comprehensive health education, including comprehensive sexual health education, from their schools. Innovative new programs are needed to reduce disparities in teen pregnancy, STDS, HIV, and associated risk behaviors by ensuring access to comprehensive and inclusive sexual and reproductive health information for all youth.

Setting: LAUSD is the nation's 2nd largest school district, with an annual enrollment of 655,716 students at 1,015 schools. Over 90% of LAUSD students are young people of color, including 73% Latino and 10% African-American students. According to the 2011 YRBS, 5% of male LAUSD high school students and 12% of young female students identify as either gay, lesbian, or bisexual.

Project: Launched in 2012, Project U uses mobile phone and web technology, youth leadership development, peer outreach, and social marketing to deliver both peer and professionally-created content and to promote local youth-friendly sexual health services to LAUSD high school students. Key features of Project U include: weekly health text messages, keyword search by text message, free condoms by mail, zip code clinic locator, and a website (<http://www.ProjectULA.org>) with health information and videos. Importantly, several Project U summits are held each year to train youth leaders to promote Project U in their schools. Program goals include increasing the percentage of LAUSD high school students who receive sexual health prevention-education and increasing condom use and HIV/STD testing. Data for a pilot evaluation included an anonymous evaluation survey completed by 77 participants at the Project U summit in March, 2015, HIV testing data from this summit, and Project U website data.

Results: Survey results demonstrated a high level of enthusiasm for Project U among summit participants. Nearly all (95%) said they planned to use Project U to launch a campaign at their school campus. The top issues they planned to address included bullying, STDs, HIV, safe sex, and gender issues. At this summit, 15 sexually active youth were tested for HIV. Website statistics have demonstrated high usage for Project U thus far, with 120 condom orders and 43,358 page views of articles, blogs, and videos.

Lessons Learned: Project U is highly acceptable to and utilized by LAUSD high school students, as demonstrated by both survey data and website usage statistics. Students have been very enthusiastic about using Project U to promote sexual health at their schools. To date, over 900 students have attended a Project U summit. Our recent experience also showed that summits are places where youth will participate in HIV testing.

CP41

Abstract 1637 - Prevention and Care Programs

Author(s): *John Wodarski*

Background: Background: The evaluated project consists of a program of outreach, pretreatment, and treatment services designed to reduce high-risk HIV-related behaviors among substance using young adults in the U.S. Virgin Islands (USVI). The program delivers an evidence-based program of culturally specific HIV and substance abuse interventions to one of the groups of US citizens most dramatically affected by HIV, the youth of the U.S. Virgin Islands. The needs for HIV prevention programming in the U.S. Virgin Islands are tremendous. The incidence of HIV/AIDS in the Caribbean region is the second highest in the world, second only to sub-Saharan Africa. Within the U.S. Virgin Islands HIV incidence has continued to increase, and the USVI leads the nation with the highest number of confirmed HIV cases.

Methods: Methods: The evaluation study utilized a single group design that investigated changes over the course of program participation with measures of program outcome indicators collected at program intake and 6 months post-intake. To investigate possible change in outcomes over time, a series of paired sample t-tests were conducted to determine statistically significant differences between the baseline and six month measures. Data was collected with the Government Performance Results Act Instrument (GPRA), an instrument originally based on items found on the Addiction Severity Index and the NIDA Cooperative Study Risk Behavior Assessment. During the project, a total of 553 individuals completed the initial intake process, became active clients in the program, and completed a baseline measure; 513 participants, completed a follow-up evaluation interview at 6 months post intake.

Results: Results: Results for the project were somewhat mixed. Most measurable changes were positive. Feelings of social connectedness increased 14.8%, crime was reduced 3.2%, employment increased 6.2%, consequences of substance use were reduced 2.9%, and housing stability increased 4.3%. While these changes were all positive, only a few individual items were statistically significant within the program's major goals. These results are suggestive of the idea that although positive, there were limited measurable effects of the program. Qualitative data collected over the course of the project does indicate a profound impact that the project has had on some individuals' lives.

Conclusions/Implications: Implications: The findings from the evaluation of can be potentially utilized in improving substance abuse and HIV outreach services to young adults in the Caribbean. The results suggest that individuals who participated in the described services showed some improvements in substance abuse and self-sufficiency with very limited rates of any new criminal justice involvement. The success of this integrated approach that combined substance abuse, mental health, and HIV prevention services to this population is an important finding. Similarly, this study provides data that is suggestive of the need for, the willingness and motivation of individuals to connect with these services; and is

demonstrative of the possible effectiveness of, services appropriately provided to a population that has been historically described as difficult to reach and/or non-adherent to traditional services.

CP42

Abstract 1199 - Prevention and Care Programs

Author(s): *Bronwen Lichtenstein, Cynthia Rodgers, Lauren Marefka, Marla Hinson, Dayna Cook-Heard, Stephen Rygiel, Marsha Sturdevant*

Issue: Teenagers who are living with HIV must disclose to sexual partners, a legal requirement that can be difficult to follow in the face of pubertal changes, HIV-related stigma, and the challenges of being newly diagnosed. This study identified barriers and motivators for sexual disclosure and developed strategies for counseling teenagers who resisted the idea of disclosure.

Setting: Two specialist HIV clinics for children, teenagers, and HIV-affected families in Alabama.

Project: Case files involving HIV-infected teens underwent systematic review at two dedicated clinics for family and adolescent HIV care in Alabama. Analysis consisted of identifying barriers or motivators to sexual disclosure according to the socio-sexual contexts of teenage clients. Six scenarios were selected from the aggregated data for illustrative purposes: three for perinatally-infected teens and three for behaviorally-infected teens. Targeted counseling strategies were developed, barriers and motivators for disclosure were tabulated, and outcomes were described in terms of positive or negative gains after counseling.

Results: Individual/family barriers included cognitive and physical delays, parental opposition, feeling suicidal and difficulties in overcoming a lifetime of secrecy in family. Social-contextual barriers included feeling fears of rejection, feeling suicidal, physical and sexual abuse, drug use, homelessness, and coming to terms with sexual identity.

Personal motivators included being in steady relationships, aging out of denial or reluctance to disclose, developmental maturity, and social or parental support. Institutional motivators included having close relationships with HIV clinic staff, using the clinic as a safe place to disclose, outreach services that include texting and telephone support, and having access to support groups of HIV-infected peers.

Lessons Learned: Sexual disclosure is a journey with an uncertain outcome, success can take a long time to achieve, and setbacks occur with a change in circumstances or partners. Counseling efforts can meet with failure despite significant allocations of dedicated staff and resources for support and outreach. Mandatory requirements for sexual disclosure, which can lead to prosecution in cases of non-compliance, should be reconsidered for teenagers whose personal challenges and life circumstances interfere with this goal.

CP43

Abstract 1195 - Prevention and Care Programs

Author(s): *Michelle Van Handel, Laura Kann, Emily O'Malley Olsen, Patricia Dietz*

Background: In 2010, persons aged 13-24 made up 17% of the US population but accounted for 26% of new HIV infections, the majority of which were among males and black females. Among persons aged 13-24 living with HIV infection, an estimated 50% are undiagnosed, the highest percentage of any age group. The Centers for Disease Control and Prevention, in 2006, and the United States Preventive Services Task Force, in 2013 released recommendations that all adolescents and adults be tested for HIV infection, regardless of risk. We assessed trends in HIV testing among adolescents and young adults, overall and by sex and race/ethnicity, to determine if HIV testing programs are increasing their reach of this population.

Methods: We used 2005-2013 National Youth Risk Behavior Surveys (YRBS) and 2011-2013 Behavioral Risk Factor Surveillance System (BRFSS) data to assess the percentage of high school students and young adults aged 18-24, respectively, who had ever been tested for HIV. Trends were assessed by sex and race/ethnicity. Separate logistic regression models for YRBS and BRFSS samples were used to assess linear time trends in the percentages ever tested for HIV, with year as a continuous linear variable and controlling for sex and race/ethnicity. We report the absolute difference, linear β , and associated p-value for HIV testing from 2005 to 2013 (YRBS) and from 2011 to 2013 (BRFSS). Statistical analyses were conducted on weighted data and accounted for the complex sampling design.

Results: During the study period, 22% of high school students who ever had sexual intercourse had ever been tested for HIV and 33% of young adults had ever been tested. In YRBS, there was no change during 2005-2013 in the percentage of students who had ever been tested, regardless of sex or race/ethnicity. Approximately 17% of male and 27% of female students who ever had sexual intercourse had ever been tested; the highest percentage was among black female students (36%), and the lowest percentage was among white male students (15%). In BRFSS, HIV testing trends varied by sex. Among young adult males, approximately 27% had ever been tested and there was no significant change during 2011-2013 in the percentage ever tested overall or by race/ethnicity. However, for young white and black females there was a significant decrease in the percentage ever tested, from 37.2% in 2011 to 33.9% in 2013 (3.3% decrease, $\beta=-0.07$, $p=0.017$) for young white females and from 68.9% in 2011 to 59.9% in 2013 (9.0% decrease, $\beta=-0.20$, $p=0.002$) for young black females.

Conclusions/Implications: Less than one quarter of high school students who have had sexual intercourse and one-third of young adults have ever been tested for HIV, and no evidence of increased testing was found. Rather, decreases in HIV testing were found for young white and black females. No increase in testing among young men and decreased testing among young black females is of special concern given their increased risk of HIV infection. Multi-pronged testing strategies are needed to increase testing and reduce the percentage living with undiagnosed HIV infection.

CP46

Abstract 1509 - Prevention and Care Programs

Author(s): *Idia Thurston, Kathryn Howell, Robin Hardin, Kristina Decker*

Background: Women comprise more than a quarter of all new HIV diagnoses, with incidence rates among the highest of any risk group (Gielen, Ghandour, Mahoney, McDonnell, & O'Campo, 2007). A crucial aspect of this trend is the intersection of HIV and intimate partner violence (IPV). Specifically,

women who experience IPV may be disempowered to negotiate sexual decisions, which contributes to increased engagement in HIV-related risk behaviors (Campbell, Baty, Ghandour, Stockman, Francisco, & Wagman, 2008). Rates of IPV among HIV positive women are consistently estimated at or above 60% (Gielen, Ghandour, Mahoney, McDonnell, & O'Campo, 2007), yet little attention is directed at addressing IPV in HIV clinical care. Women living with HIV who experience IPV are likely under high rates of life stress, which collectively lead to lower quality of life, poorer treatment outcomes, and greater psychological distress (Catz, Gore-Felton, & McClure, 2002). One common form of mental health distress with significant rates of morbidity and mortality among HIV-positive women is depression (Remien et al., 2006). The current study examined the relationship between IPV, life stress and depression in HIV positive women. We hypothesized that women exceeding the clinical threshold for depression would experience higher rates of IPV and life stress.

Methods: Participants included 42 HIV positive women, aged 25-60 ($M = 41.2$, $SD = 8.9$), 93% of whom were Black. Using a community-based participatory research approach, women were recruited via HIV/AIDS service organizations in the southern United States. During in-person interviews, women responded to questions about their demographic characteristics and HIV testing history. Depressive symptoms were assessed using the Center for Epidemiologic Studies Depression Scale (score range= 0-60, clinical cutoff =16; Radloff, 1977). Violence victimization in intimate partner relationships was measured with the Revised Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Scores were dichotomized into high versus low rates of IPV based on the sample median split. Seventeen different stressful life experiences were examined using the Life Events Checklist (Gray, Litz, Hsu, & Lombardo, 2004). Responses were summed and examined continuously.

Results: Fifty-one percent of participants met or exceeded clinical cutoff for depression. Violence experiences in the past 6 months included: psychological aggression (80%), physical assault (32%), sexual coercion (29%), and injuries as a result of IPV (23%). Women endorsed between 0-16 stressful life events ($M = 5.5$, $SD = 3.4$). Logistic regression modelling revealed that women were more likely to be clinically depressed when they experienced high IPV ($OR = 9.74$, $95\% CI = 1.87, 50.82$, $p < .01$). Depression was not significantly related to life stressors in this sample.

Conclusions/Implications: Our findings suggest that IPV status is a prominent risk factor for clinical depression among HIV positive women, even after accounting for the effects of other life stressors. Prevention programs aimed at improving the mental health and overall functioning of women living with HIV must move beyond assessing individual risk factors. Comprehensive prevention programs that target the reduction of sexual risk behaviors among HIV positive women should consider the role of violence between these women and their partners.

CP48

Abstract 2321 - Prevention and Care Programs

Author(s): Denise Wade, Susan Gallagher, Tito Terry

Issue: Young MSMs are open to HIV prevention education but when it comes to substance abuse treatment as a significant factor in HIV prevention, the socially and culturally acceptable norms get in the way. Recreational substance use is part of the subculture. The MPower Project at New Horizons has

developed a creative way to deliver substance abuse treatment through a brief intervention we call “Risky Business.”

Setting: Located in a metropolitan area in west central Georgia, the MPower Project is a part of New Horizons Behavioral Health. Funded by SAMHSA through a TCE-MAI initiative, our target population is young African-American MSMs aged 18 through 29.

Project: The MPower Project is the first of its type in the area to specifically target minority, young, gay men. As such, the program is reaching out to all members of the community in an effort to reduce stigma and the associated health disparities for the target population

Our comprehensive, multi-strategy approach includes a number of culturally-competent strategies that include evidence-based practices like: (1) Screening, Assessment and Pre-treatment Planning integrating rapid HIV Testing ;(2) The Matrix Model; (3) Motivational Enhancement Therapy (MET); (4) Case Management; (5) Recovery Support Services; and (6) Mpowerment Project.

Results: While outreach, HIV testing and screening numbers served have been outstanding, maintaining our treatment numbers has been a struggle. The Matrix Model is a 16-week intensive treatment model designed for individuals who fully realize they have a substance abuse issue which impacts their daily life. The members of the target population have been resistance to committing to the Matrix Model as they see their substance use as a purely recreational activity or one that enhances the sexual experience. We have had to adapt the treatment model to focus more on Motivational Enhancement Therapy (MET) and to adapt the Matrix Model into a brief intervention therapy we call “Risky Business.”

Lessons Learned: Muscogee County, Georgia is an ultra-conservative community where the LGBT population, while in existence, is difficult to forge relationships with. The MPower Project has been extremely successful in building strong, culturally-competent relationships with this underserved population through mutual respect. This respect and cultural competence on the part of MPower Project staff has developed adaptation to existing treatment models that are acceptable to the target population. The major lessons learned have been to LISTEN to the individuals being served, to get their INPUT regarding program development, and to be OPEN to doing things in a different manner. DIFFERENT is not bad. DIFFERENT is just DIFFERENT.

CP49

Abstract 1512 - Prevention and Care Programs

Author(s): *Alison Johnson, Meredith Grantham*

Issue: Individuals engaged in prostitution exhibit a complexity of factors such as post-traumatic stress disorder (PTSD), trauma, and substance abuse which contributes to co-morbid mental disorders, medical problems, psychological symptoms, interpersonal problems, lower levels of functioning, poor compliance with aftercare and motivation for treatment, and other significant life problems (such as homelessness, HIV, domestic violence, and loss of custody of children).

Setting: This community-based intervention is currently being implemented in the South Texas, Coastal Bend Region of Texas. This abstract is intended for all audiences.

Project: The Red Cord Initiative (RCI) is a prostitution diversion program aimed to provide practical and emotional support for those involved in the sex trade. The Red Cord Initiative mobilizes and engages communities through partnerships. The Red Cord Initiative is focused on the behavioral, social, and contextual factors that influence HIV transmission among individuals engaged in prostitution. The program addresses the individual, social, and structural determinants of HIV among those selling sex for money and those purchasing sex. Red Cord has adapted the HIV prevention continuum from the HIV care continuum to target those who test HIV negative. In this HIV prevention continuum, clients receive the core components of HIV risk reduction and maintain wellness through consistent primary care and the coordination of social support and other ancillary services. The program also integrates sexual health advocacy as part of the continuum.

Results: Profile of the sex workers participating in the quarterly RCI field operation: 25% White, 74% Hispanic, 6% African American; 2 Transgender Male-to-Female clients; 67% reported being recruited or introduced to prostitution from someone close to them; 55% had less than a HS Diploma/GED; 80% reported prolonged sexual and physical abuse throughout their life; 26% reported being homeless at the time of arrest. Health Status of sex workers participating in the quarterly RCI field operation: 40% reported having a known chronic health disease; 53% reported no access to medical care services; 29% STD positive; 55% had a diagnosed mental health disorder; 2 clients identified as HIV+; 91% reported substance use at the time of arrest. Outcomes from diversion program: 31 sex workers voluntarily enrolled into diversion program, 23% referred to social services, 16 clients linked to substance abuse treatment services, 2 clients successfully graduated and charges dismissed

Lessons Learned: Red Cord Initiative reinforces the argument that the provision of services in lieu of a more punitive approach is an effective way to help individuals leave prostitution and subsequently reduce their risk for HIV. The complex web of circumstances which may lead an individual to engage in prostitution requires an aggressive, comprehensive approach to address such concerns. Red Cord Initiative is effective in changing social environment and individual risk behaviors thus resulting in a greater impact at the community level. Key community partners and support from law enforcement and judicial systems allows for a less restrictive and more fluid transition from prostitution to a more positive lifestyle. The complexity of circumstances and dedication it takes to make the necessary behavior changes to leave prostitution is too much for some to handle.

CP50

Abstract 1547 - Prevention and Care Programs

Author(s): *Kathryn Howell, Idia Thurston, Mollie Anderson, Jamie Padden*

Background: Women account for 25% of people living with HIV in the U.S. (CDC, 2015). Despite the challenges facing HIV positive women, many display remarkable resilience in the midst of this health condition. A prime target for HIV prevention efforts, resilience is significantly associated with better medication adherence and lower viral load (Dale, Cohen, Weber, Cruise, Kelso, & Brody, 2014). A number of factors may contribute to resilience. Specifically, spiritual well-being has been associated

with health-related quality of life (George Dalmida, Holstad, Dilorio, & Laderman, 2011), as well as lower rates of depression and improved self-esteem (Simoni, Martone, & Kerwin, 2002). Additionally, perceived social support is related to reduced loneliness, stress, and depressive symptoms (Serovich, Kimberly, Mosack, & Lewis, 2001). Finally, cohesive communities characterized by safety, unity, and shared values may be protective against poor psychological functioning and lead to enhanced resilience (Fullilove, 1998). The current cross-sectional study examined factors at individual, interpersonal, and community levels that are associated with resilient functioning in women living with HIV. We hypothesized that greater spirituality, social support, and community cohesion would predict higher levels of resilience.

Methods: Participants included 42 HIV positive women, aged 25-60 ($M = 41.2$, $SD = 8.9$), 93% of whom self-identified as Black/African American. Using a community-based participatory research approach, women were recruited via HIV/AIDS service organizations in a mid-sized urban city in the southern United States. During in-person interviews, women responded to questions about their demographic characteristics and HIV testing history. Resilient functioning was assessed using the Connor Davidson Resilience Scale (score range = 0-100; Connor & Davidson, 2003). Perceptions of spirituality were measured with the Daily Spiritual Experience Scale (score range = 0-75; Underwood, 2011). Social support from friends and family was examined using the Lubben Social Network Scale-Revised (score range = 0-72; Lubben, Gironde, & Lee, 2001). Six items measuring community safety and neighborhood connectedness were assessed using the Community Cohesion Scale (score range = 0-18; Sampson, Raudenbush, & Earls, 1997). Responses on each scale were summed and examined continuously; with higher scores indicating more resilience, spirituality, social support, or community cohesion.

Results: Women showed moderate to high levels of resilience, with total scores ranging from 35-100 ($M = 78.5$, $SD = 11.8$). Participant's mean perceived spirituality was 62.6 ($SD = 11.2$), mean social support was 33.2 ($SD = 9.5$), and mean community cohesion was 9.4 ($SD = 5.6$). A linear regression model predicting resilience from spirituality, social support, and community cohesion was significant ($F(3,35) = 5.42$, $p = .004$, $Adj R^2 = .26$). Higher resilience was associated with more community cohesion ($\beta = .49$; $p = .003$). Spirituality and social support were not significantly related to resilience.

Conclusions/Implications: By identifying community level experiences that enhance resilience, this study offers unique insight into how the positive functioning of women living with HIV may be improved. Researchers and clinicians alike should broaden their perspective beyond an individual focus to include relevant socio-ecological experiences. Furthermore, these neighborhood and community factors should be considered when developing risk assessments and implementing prevention programs.

CP51

Abstract 2296 - Prevention and Care Programs

Author(s): *Mary Mbaba, Omoro Omoighe, Terrance Moore*

Background: HIV-positive Black men who have sex with men (MSM) may experience significant structural and psychosocial barriers that prevent access, engagement, and retention into quality care. While current behavioral and clinical studies emphasize existing racial HIV health disparities between Black MSM and MSM of other racial/ethnic groups, few studies identify promising strategies for

successful care engagement designed specifically for Black MSM. This qualitative study 1) assessed community-based clinical health practitioners' attitudes, perceived barriers and challenges that prevent successful linkage and retention into care among Black MSM and 2) identified innovative HIV care strategies and best practices for enhanced engagement of Black MSM.

Methods: From February to August 2015, NASTAD engaged primary and HIV care clinical practitioners (i.e. physicians, nurse practitioners, and physician's assistants) from U.S. community-based organizations (CBOs) and/or Ryan White service clinics in focus groups and in-depth interviews to assess barriers to care for Black MSM and successful strategies that mitigate these barriers. MAXQDA 11 qualitative data analysis software was used to summarize, code, and categorize qualitative data for further analysis and interpretation.

Results: CBOs, health departments, and privately and publicly funded health clinics discussed the complexities facing Black MSM as a combination of challenges interfacing with clinical care systems and other barriers including low socioeconomic status and difficulty meeting basic needs; limited health insurance; low health literacy; acute physical and psychological trauma experiences; substance use; and mistrust of medical providers and stigma surrounding disclosure of sexual orientation and HIV status. Findings suggest that work, school, and other commitments often conflicted with Black MSM maintaining HIV care appointments. Limited clinical resources necessitated the importance of tailoring services for Black MSM with use of peer advocates/navigators and the offering of ancillary social support services. Enhanced strategies for improved engagement also involved leveraging digital communication to foster treatment adherence; utilizing social media strategies/platforms; and creating a sense of community by engaging family members and partners in patient care.

Conclusions/Implications: Reducing psychosocial barriers and engaging social network strategies are key components for active HIV care engagement and retention among Black MSM. Leveraging CBO providers is critical given that new patients will seek health care under the Patient Protection and Affordable Care Act in the coming years. Engaging medical providers who work at the community level can yield practical, targeted, and readily available strategies to increase HIV care retention among Black MSM.

CP52

Abstract 2407 - Prevention and Care Programs

Author(s): *Darrin Johnson, Maricus Gibbs, Delton Harris, Gerald Covington*

Issue: Although the HIV prevalence is high among Black men who have sex with men (MSM) and Transwomen populations, there are more immediate concerns that take precedence over HIV prevention, and care engagement. These populations have stressors due to identifying with African American ethnicity, being a Black male; and coping with same-sex sexual orientation in a heteronormative society. Other forms of oppression come from the religious community rejection of family when same-sex sexuality is publicly affirmed; and these stressors can lead to internalized homophobia and increased risk behavior.

Transwomen have similar stressors in addition to being rejected by the community they initially associated with; the gay community. Transwomen having to explain to not only the mass majority of the world; the heterosexual community, but also the gay community, how gender identity is not affiliated with sexual orientation. Sometimes, transwomen experience increased discrimination due to their gender identity. These discriminatory components transwomen face affect every aspect of their lives, from legal identification to health care, and can lead to internalized transphobia.

Setting: As part of a CDC funded research study, community members designed a new online HIV prevention intervention named Statusboiz/Statusgurlz for young (aged 18 to 45) Black MSM and transwomen who have sex with men in North/South Carolina, and other southeastern states (USA).

Project: As part of a CDC funded research study, community members designed a new online HIV prevention intervention named Statusboiz/Statusgurlz for young (aged 18 to 45) Black MSM and transwomen who have sex with men in North/South Carolina, and other southeastern states (USA). Data was collected via online surveys capturing attitudes and beliefs about ethnicity, homophobia and transphobia, and HIV infection. The results of this data will be presented for the first time at the HIV prevention conference.

Results: Over 200 surveys were conducted online with Black gay and bisexual men and transgender women.

Upon completing this workshop, participants will be able to:

1. Explain the barriers and concerns of each population that contribute to the lack of treatment maintenance.;
2. The correlation between Internalized homophobia or internalized transphobia , and risky behaviors of each population;
3. Identify layers of oppression on each population; and
4. Discuss differences between gender identity and sexual orientation.

Lessons Learned: There are many factors to consider when engaging MSM and Transwomen for HIV prevention. Their daily lives must be considered before inviting them to participate in prevention research and activities. The process of soliciting and integrating guidance and feedback from the focus population is time-intensive and more complicated than culturally adapting a pre-determined set of evidence-based practices. This method requires much flexibility and humility, because it is common for what developers/researchers assume will work to not be accepted by the focus community.

CP53

Abstract 1928 - Partnerships, Community, Communication, and Mobilization

Author(s): *Elizabeth Ortiz, Maureen Malavé, Amanda Moy, Benjamin Tsoi*

Issue: New York City (NYC) has one of the largest HIV epidemics in the United States, with the majority of newly diagnosed cases reported among men who have sex with men (MSM). To improve outcomes along the care continuum and reach populations at high risk, the NYC Department of Health and Mental Hygiene (DOHMH) developed a model for providing technical assistance (TA) to HIV testing programs.

Setting: NYCDOHMH Project Officers (POs) provided TA to agencies contracted to conduct outreach and testing for priority populations and to implement testing using the social network strategy (SNS).

Project: Since 2009, POs provided TA to contracted HIV testing programs focusing on 4 areas: 1) improving data quality, 2) reviewing performance, 3) building agency capacity, and 4) developing performance improvement plans.

To improve data quality, POs compiled reports to identify incomplete, inaccurate, or missing data and provided data management recommendations to agencies. Changes were made to the data reporting system to better track services. POs reviewed performance with agencies quarterly, highlighting program strengths and areas for improvement. NYCDOHMH provided TA on monitoring the clients targeted for testing and ensuring groups at high risk (MSMs and transgender [TG] clients) are targeted. To improve identification of new cases and linkage to care (LTC), NYCDOHMH also provided booster trainings on the SNS model, and trainings on LTC strategies. For underperforming agencies, POs worked with agencies to develop program improvement plans.

Results: Data quality has improved across contracts as a result of data management activities. For example, agencies did not report whether positives identified were newly or previously diagnosed. With TA and data reporting system modifications, the percentage of HIV-positive individuals with classification of newly or previously diagnosed increased from 17.9% in 2012 to 100% in 2014. Performance indicators (testing positivity rates, LTC rates, and proportion of MSM and transgender clients tested) also improved between 2012 and 2014. The positivity rate for SNS testing in 2012, 2013, and 2014 was 1.3%, 1.4%, and 2.1%, respectively. The positivity rate for priority population testing during those same three years was 0.5%, 0.6%, and 0.8%, respectively. The LTC rate for agencies testing priority populations in 2012, 2013, and 2014 was 58.8%, 66.7%, and 68.3%, respectively. The LTC rates for SNS testing did not improve over the interval. The proportion of MSM and TG clients tested by SNS contracts in 2012, 2013, and 2014 was 19.4%, 22.6%, and 30.4%, respectively. During the same period, the proportion of MSM and TG clients tested by priority population contracts was 7.5%, 8.7%, and 9.9%, respectively.

Lessons Learned: The NYCDOHMH used an iterative process to provide TA to HIV testing programs. Data quality checks, performance reviews, and improvement plans facilitated progress toward outcome expectations on key care continuum indicators. Continued adjusting of clients targeted for testing to include MSM and TG, coupled with trainings on model adherence and LTC contributed to improvements in performance. Moving forward, we will build on our robust TA model and support agencies to integrate other HIV prevention strategies, including pre- and post-exposure prophylaxis.

CP54

Abstract 1242 - Prevention and Care Programs

Author(s): *Miriam Phiels, Shawn Hirsch, Sherese Garrett*

Issue: One of the recommended actions of the National HIV/AIDS Strategy (NHAS) is to “establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.” To support steps being taken to carry out this action, the CDC Division of

HIV/AIDS Prevention, Capacity Building Branch (CBB) funds capacity-building assistance (CBA) services such as trainings that strengthen an organization's ability to conduct high-impact HIV prevention (HIP) interventions. Those trainings include interventions that address linkage and retention to care such as the Anti-Retroviral Treatment and Access to Services (ARTAS) and Partnership for Health (PfH) interventions. ARTAS aims to quickly link recently diagnosed persons with HIV to medical care, while the Partnership for Health (PfH) intervention assists retention to care by improving communication between persons living with HIV and their providers. Although these interventions have proven to be effective, the training experience and factors related to the implementation of these interventions have not been previously evaluated.

Setting: From January 2011 through March 2014, 984 participants attended an ARTAS training and 287 participants attended a PfH training. Most participants worked at a community-based organization or state/local health department as a health educator, community health worker, or social worker. Most participants served populations living with HIV or at increased risk of contracting HIV. Both courses were offered to organizations throughout the United States.

Project: Demographic data were collected from all participants prior to trainings. Course satisfaction data were obtained from participants on the last day of training, while intervention implementation data were obtained 90 days post training. The evaluation integrated constructs of the Kirkpatrick Model of Training Evaluation and continuous quality improvement to create an iterative evaluation process. Findings and recommendations have been developed for CBB and partners that provide the ARTAS and PfH training courses.

Results: Participants of the ARTAS and PfH trainings reported high satisfaction and strong motivation to implement the interventions in their communities. Participants also reported that courses were helpful at preparing them to implement the intervention, relevant to their current profession, and more than met their needs. The evaluation also identified barriers that prevented participants from implementing the intervention. When asked to identify implementation barriers from a pre-defined list, 32% of ARTAS participants selected lack of funding and 29% selected difficulty recruiting the target population. Among PfH participants, 30% selected lack of time and not part of their job, respectively. Other barriers were identified, but not as often as the ones reported.

Lessons Learned: The evaluation of training feedback data demonstrates there is a dedicated HIV prevention work force ensuring persons living with HIV link to medical care and experience better patient-provider communication. Leveraging communication platforms such as online capacity building resources, provision of one-to-one feedback, and development of supplemental barrier-specific materials are approaches in process to help ARTAS and PfH training participants overcome commonly identified barriers to implementation. Monitoring and evaluation of such interventions allows continuous quality improvement and supports national efforts to connect people to services and keep them in care.

CP55

Abstract 2070 - Prevention and Care Programs

Author(s): *Britney Johnson, Wenhui Feng, Feng Qian, Erika Martin*

Background: HIV partner services is a key public health intervention that has been shown to improve linkage to care for newly diagnosed individuals and effectively identify undiagnosed cases of HIV. Expanded Partner Services, a health department Data to Care pilot implemented in New York State, utilizes HIV partner services staff to investigate and relink individuals suspected to be out of care, with the goal of further enhancing linkage and retention activities. However, little is known about how HIV Partner Services case investigations are carried out in real world settings, or how new Data to Care strategies utilizing disease investigation specialists (DIS) differ from existing processes. Our study objectives were to: 1) evaluate time and effort allocation for new and out-of-care (OOC) case investigations and 2) assess differences in time allocation between the strategies and across local regions using empirical data.

Methods: A partner services time study instrument was developed and used by DIS to document time, in minutes, spent on various partner services investigation activities (such as medical provider and index case outreach, travel, and partner notification). Time allocation information was collected on 117 partner services assignments investigated by DIS (N=28) at eight regional sites across New York State between July and October 2014. This consisted of 48 newly diagnosed HIV cases (within the past 30 days), and 69 surveillance-generated OOC case investigations (no evidence of a CD4 or viral load lab test within last 13-24 months). Descriptive analyses summarized the time allocation for each intervention and 2-tailed t-tests were used to test differences in time allocation for each task between new and OOC HIV partner services investigations.

Results: Time allocation varied significantly between new HIV and OOC HIV case investigations, including the average time spent on the total case (new, 270min; OOC, 148min; $p=0.006$), index case investigation (new, 184min; OOC, 120min; $P=0.03$), and partner notification (new, 59min; OOC, 3min; $p=0.008$). In sites where both new HIV PS and OOC HIV partner services cases were concurrently being investigated, there were no significant differences in time allocation between the two types of intervention.

Conclusions/Implications: Initial results indicate that HIV OOC investigations may take less processing time than new HIV cases, but this variation was not present in sites conducting both types of investigations. This suggests that between-site variation may be a larger driver of partner services case processing time than the type of case being investigated. As New York expands its Data to Care project statewide, a more thorough understanding of regional differences will be essential to effectively allocate limited staff resources and accomplish public health goals. Our study findings indicate the importance of understanding variation in public health interventions, and the need for ongoing evaluation of newly implemented Data to Care initiatives. As different HIV PS strategies occur in a variety of practice settings, continuous efforts to improve effectiveness and efficiency of HIV partner services strategies should be pursued.

CP56

Abstract 1644 - Prevention and Care Programs

Author(s): *Abigail Hankin, Heather Freiman, Adam Barnette, Ngoneh Gaye-Bullard, Bijal Shah*

Background: Identifying individuals with undiagnosed HIV and rapid linkage to care are critical steps in the HIV Continuum of Care. Yet, linkage to care definitions vary: some organizations use a lab-based definition (documented CD4 count or HIV viral load within 90 days of diagnosis) while others utilize an appointment-based definition (e.g., attending a routine HIV medical care visit within 90 days of HIV diagnosis). Here, we present a comparison of lab-based vs. appointment-based linkage to care definitions among patients newly diagnosed via a routine HIV screening program at a large urban hospital in the Southeastern US with high HIV prevalence.

Methods: In July 2013, we implemented routine, non-targeted, opt-out HIV screening in the Emergency Department (ED) and primary care clinics of an inner-city safety-net hospital. Patients newly diagnosed with HIV received linkage to care assistance from dedicated social workers who maintained contact with patients through two HIV care clinical appointments. Lab and appointment data were extracted from the electronic medical record supplemented with information collected by social workers during patient interactions and communication with the county health department. Patients selected for comparison had a new HIV diagnosis at least 90 days prior to data extraction. Linkage to care was defined as follows, lab-based linkage: patients had a CD4 count or HIV viral load within 90 days of diagnosis, and appointment-based linkage: patients attended a clinical appointment with an HIV care provider within 90 days of diagnosis. Statistical analyses were conducted using SAS 9.3; frequencies were compared with the Z-test for two proportions.

Results: During the first 19 months of routine HIV screening, 34,170 patients were tested for HIV, identifying 292 patients (0.85%) with a new HIV diagnosis. 277 patients (94.9%) were diagnosed at least 90 days before data extraction: 43.3% (120) met the appointment-based linkage definition and 77.2% (214) met the lab-based linkage definition ($p < 0.0001$). 48.6% of patients with lab-based linkage (104) had the lab completed on the day of diagnosis. Among patients with lab-based linkage, 45.8% (98) did not attend a clinical appointment within 90 days of diagnosis. For the 116 patients who met both the lab-based and appointment-based linkage definitions, the first clinical appointment occurred an average of 36.7 days (21.7 days SD) after the patient was considered linked by lab-based criteria. 29 additional patients, who achieved 90-day linkage by lab criteria but did not have an appointment during this timeframe, saw an HIV clinician; for these patients, the average time from first lab to clinician appointment was 173.7 days (99.4 days SD).

Conclusions/Implications: Data from our large-scale routine testing and linkage to care program, based in a high HIV-prevalence metropolitan area, suggest that lab data may significantly overestimate the proportion of patients diagnosed with HIV who are linked to care with an HIV clinician, and may underestimate the time to entry into medical care for patients newly diagnosed with HIV.

CP57

Abstract 1896 - Epidemiology and Surveillance

Author(s): *Jennifer Cukrovany, Brenda Moncur, Joseph Kerwin, Britney Johnson, Megan Johnson, Bridget Anderson, James Tesoriero, Lou Smith*

Background: Persons living with diagnosed HIV infection (PLWDHI) and receiving continuous care are more likely to achieve sustained viral suppression, reducing the likelihood of transmission to uninfected

individuals. In September 2013, New York State Department of Health (NYSDOH) implemented a data-to-care initiative using routinely reported surveillance lab data to identify PLWDHI who appeared to be out of care (OOC). Individuals identified were targeted for an expanded partner services (ExPS) intervention, with the primary goal of re-engagement into HIV-related medical care. The ExPS initiative was piloted from September 2013 to August 2014 in Erie, Monroe, Onondaga and Westchester counties of New York State.

Methods: Using routinely collected HIV surveillance data, PLWDHI with no prognostic lab results (viral load (VL), CD4 or genotype) reported to NYSDOH in the prior 13-24 months were selected for ExPS follow up. Assignments for presumed OOC cases were generated monthly and directed to staff in the county of the last known provider of care for the case. Based on an assessment of initial outcomes, the algorithm was modified to reduce the number of highly likely to be out of jurisdiction (OOJ) or current to care assignments. In May 2014, the selection criteria were revised to assign OOC cases based on the location of the patient's last known residence rather than the location of last known medical provider. An additional efficiency was implemented to account for the routinely scheduled processing of lab data by the surveillance system, which caused some in-care-cases to look OOC, when in reality, lab results had been received by NYSDOH but were queued for processing.

Results: Using initial criteria, 890 OOC assignments were generated September 2013 to May 2014. 319 of these (36%) were closed as OOJ as the ExPS staff could not legally conduct follow up activities outside of the borders of their jurisdiction. Using the algorithm based on patient last reported residence, 532 additional OOC case assignments were generated. Of these, only 98 (18%) were closed as OOJ. Of the initial OOC assignments, 90 (7%) were determined to have new prognostic lab results reported within 14 days of the ExPS assignment generation. These changes resulted in the more efficient use of limited staffing resources to follow up on the higher priority truly OOC individuals.

Conclusions/Implications: Modifying the assignment algorithm to use the patient's last known address, rather than provider address resulted in more efficient follow up and improved the completeness of data, reducing by 18% the number closed OOJ. Modifying the ExPS algorithm to delay assignment generation by 14 days, reduced the number of assignments with recent lab results by 7%. Delaying the OOC case assignment generation by an additional 14 days has the potential to reduce the OOC cases by another 5%. Reassessing and adjusting the criteria used to identify purported OOC cases improved the efficiency and productivity of ExPS interventions. Implementing these efficiencies has allowed for the statewide expansion of ExPS activities, despite the limited staffing resources able to be dedicated to these interventions with OOC PLWDHI.

CP58

Abstract 2055 - Prevention and Care Programs

Author(s): Amy Kile-Puente, Deanna Sykes

Issue: The California Department of Public Health, Office of AIDS (OA) is responsible for CDC-funded HIV prevention in the California Project Area (CPA). In 2009, OA lost all state HIV prevention funding leaving only CDC funding, resulting in an 80 percent funding decrease. This, along with the introduction of High Impact Prevention (HIP) and the National HIV/AIDS Strategy (NHAS), required the OA to rethink their HIV

prevention strategy and required activities in order to provide the most efficient and effective HIV prevention to the areas of the CPA with the highest HIV prevalence.

Setting: The CPA is defined as local health jurisdictions (LHJ) not in Los Angeles or San Francisco MSAs which are directly funded by the CDC. The CPA is 150,707 square miles encompassing urban, suburban and rural areas. OA funds 18 of the 56 LHJs in the CPA. These funded LHJs represent 93 percent of the HIV prevalence in the CPA.

Project: HIV prevention in the CPA has evolved from a traditional HIV counseling and testing program to High Impact HIV Prevention (HIP) that targets those at highest risk for HIV acquisition and prioritizes linkage to care (LTC) and partner services (PS). LHJs are encouraged to stop testing at those locations that do not identify at least one HIV positive person each year. LHJs that struggle to identify any HIV positive people with their testing programs are encouraged to move their efforts exclusively to LTC services and PS and explore using HIV surveillance data for these activities. OA provides training and technical assistance (TA) to LHJs to work with their healthcare providers to incorporate routine, opt-out HIV testing for those not at highest risk for HIV acquisition.

Results: OA decided early in this transition to HIP to maintain our number of targeted HIV tests performed each year to 45,000 and work to increase the HIV positivity within those testing events. Over the last 3 years, OA has increased HIV positivity from 0.61 percent in CY 2011 (baseline) to 0.69 percent in CY 2012, 0.87 percent in 2013, and 0.88 percent in 2014. OA anticipates that HIV positivity will continue to increase over the next two years.

Lessons Learned: Moving HIV prevention staff at LHJs from traditional HIV counseling and testing has been challenging. Staffs view HIV testing as an opportunity for HIV prevention education as well as a case finding opportunity. The primary concern is that if people at low and moderate risk for HIV acquisition are discouraged from testing in targeted HIV testing sites those people who are unaware of their HIV risk, especially women, will not be tested. Identifying the most appropriate testing environment for these populations and establishing relationships with primary care clinics and other health care providers are key to this transition but can be difficult to initiate and create buy-in. Also, encouraging lower prevalence LHJs to focus only on LTC and PS, especially using HIV surveillance data, requires initial and ongoing training and TA.

CP59

Abstract 2294 - Prevention and Care Programs

Author(s): *Clark Marshall, Dennese Neal*

Issue: By the end of 2012, 134,158 Californians were estimated to be infected with HIV. This number includes an estimated 21,465 persons who were infected with HIV, but unaware of their infection. Of the total estimated number of HIV infected Californians in 2012, 52% were in care and 40% had achieved viral suppression. In California, only 50% of the HIV-diagnosed African Americans and 51% of HIV-diagnosed Latinos are in care. In 2010, the rate of new HIV diagnoses among African American men was almost four times that of white men, and the HIV diagnosis rate among black women was over 8

times that of white women. Hispanics and Latinos made up 39.0% of all newly diagnosed HIV infections in 2010, and were more likely to be simultaneously diagnosed with AIDS than non-Hispanics.

Setting: The Expanded HIV Testing Program (ET) funded five grantees in the CPA from 2011 to 2014. The five grantees provided services and/or subcontracted services to over 65 local federally qualified health centers (FQHCs), community clinics, hospitals, family planning clinics, emergency departments and jails. The funding required that health care settings selected must primarily serve African Americans, Latinos, men who have sex with men, or injection drug users (IDU).

Project: The goal of the ET Program is to identify individuals who are unaware of their HIV positive status who are unlikely to access Targeted Testing sites, and ensure linkage to HIV care and offer partner services and other prevention services. To achieve this goal, health care settings were identified by strategically targeting sites to implement routine HIV testing located in areas with high HIV prevalence and primarily serving the African American and Latino communities.

Results: From January 1, 2012 to December 31, 2014, ET program grantees tested 199,570 people, including 181 (0.09%) newly-identified HIV-positive people and 107 people previously diagnosed HIV. In the ET program, 8.9 percent of the tests were among African Americans and 56 percent among Latinos; by comparison, 6.6 percent of California's population is African American and 38.4 percent is Latino. Of the newly identified positive individuals, 114 (97%) have been referred to care and 95 (81%) were linked to care. Ninety (77%) individuals have been offered PS and 86 (74%) have been referred for prevention services.

Lessons Learned: The CA ET program provides HIV testing to patients at low or moderate risk for HIV acquisition. Providing routine, opt-out HIV testing in health care settings that have established relationships within the African American and Latino communities allows this program to be successful and reach long term sustainability. OA has found that each site must have a routine HIV testing champion to provide on-going technical assistance to the clinical staff and immediately accessible linkage to care staff to assist patients as they navigate engagement in HIV care.

CP60

Abstract 2023 - Prevention and Care Programs

Author(s): *Ann Ferguson, Lisa Espinosa, Marilyn Torres*

Issue:

In the Latino community, stigma surrounding HIV infection and high risk activities are prevalent. Overcoming the stigma surrounding screening is necessary to ensure decreased numbers of undiagnosed individuals, expanded linkages into health care systems and maximized treatment options for sustainability of health and quality of living. Our program has worked towards de-stigmatizing routine HIV/HCV screening in an urban ambulatory care clinic and educating individuals on the importance of being aware of their status.

Setting: Kensington Hospital serves a primarily Latino community, who are disenfranchised and often living below the federal poverty level. HIV and Hepatitis C has been found to be highly prevalent in Kensington and the surrounding neighborhoods of lower North Philadelphia.

Project: Kensington Hospital, in its first year of the Gilead Focus Project, instituted an opt-out testing system for HIV in its outpatient ambulatory medical clinic which provides primary care services to adults in the targeted minority community. This program has helped to incorporate efforts to normalize attitudes and de-stigmatize HIV screening within the Latino community with the use of culturally relevant, innovative educational tools, peer-to-peer trainings, larger community group presentations, and the development of peer counselors to best reach the intended target population. The hospital is now incorporating HCV screening into the opt-out process of an outpatient ambulatory medical visit as well. A patient navigator is integral to this project, ensuring seamless access to linkage to care and treatment options for those testing positive for HIV and or HCV.

Results: The current project year has seen the continuation of the routine screening for HIV in the outpatient ambulatory clinic. 4029 HIV tests were offered with a 69% acceptance rate, and a 1% positivity rate. 258 patients were screened for Hepatitis C with 10 testing positive (39%). These patients were linked immediately to care in the clinic and received education and counseling for Hepatitis C - and 6 of them will be receiving treatment in the clinic.

Lessons Learned: This program has been aimed at changing the hospital and community culture to impact the attitudes, beliefs and perceptions regarding the importance of routine screening and rescreening for HIV and Hepatitis C. The sustainability of routine this screening will be supported by increasing the engagement of clinical staff and implementing the institutional and operational changes which resulted in improved performance and quality outcomes. Standardization of best practices will be the goal, based on validated re-measurement of quality measures. Once routine HIV and Hepatitis has been established through this program as a standard preventative screening, the Affordable Care Act requirement to cover the cost of all screenings recommended by the by the U.S. Preventative Task Force, will allow for insurer reimbursement options. As routine screening will be conducted by the existing primary medical providers, all positives will be supported directly by referral into other existing HIV and Hepatitis services through the Early Intervention Services department.

CP61

Abstract 1866 - Prevention and Care Programs

Author(s): *Jennifer Olson, Matthew Willis*

Issue: Limited public health resources for HIV prevention activities in the California Project Area (CPA) have caused the CDPH Office of AIDS (OA) to strategically review the High Impact Prevention (HIP) activities of local health jurisdictions (LHJ). Core components include targeted testing, linkage to care (LTC) and partner services (PS). With the exception of San Diego, LHJs within the CPA include mostly smaller urban cities. LHJs within the CPA with moderate HIV prevalence must focus their resources on activities that are cost effective in preventing HIV transmission. Decreased funding has forced service providers to perform multiple roles and they are struggling to provide services at the same capacity. As a

result, local infrastructure has been compromised. Moderate prevalence LHJs need to prioritize efforts and will benefit from collaboration with healthcare settings to increase testing capacity.

Setting: Moderate HIV prevalence LHJs within the CPA.

Project: OA is working with our funded LHJs to create plans that decrease HIV testing of low-risk individuals at targeted testing sites while redirecting those clients to healthcare settings that provide routine, opt-out HIV testing. Focus groups have been conducted with county staff and healthcare settings have been solicited to participate. Program changes are anticipated to meet OA goals of increasing the effectiveness of targeting, expanding capacity of test counselors to provide LTC and PS, and increasing access to HIV testing in healthcare settings. For instance, OA will train medical providers regarding the increased cost in treating individuals who are not virally suppressed versus those who are to demonstrate the importance of implementing routine, opt-out HIV testing in medical settings as a means of early detection and initiating antiretroviral therapy as soon as possible.

Results: OA has distributed tools utilizing local testing data to show the efficacy of targeted testing in the CPA and provided a redefinition of high risk categories. Data show a decrease in test events to low-risk individuals and an increase in targeting high risk populations which has increased positivity yield. OA is working with moderate prevalence LHJs in the CPA to decrease their testing volume and increasing uptake of routine, opt-out testing in healthcare settings in communities impacted by the reduction of targeted testing efforts. Sacramento and Monterey counties have begun work in implementing this strategy.

Lessons Learned: This project has promoted cross-branch collaboration at OA between the HIV Prevention and Care Branches by examining the intersection of federal program goals at the LHJ level. This strategy maximizes HIV prevention across funding streams and has demonstrated the need for increased communication between OA, LHJs, CBOs and healthcare settings. Valuable opportunities have been discovered to coordinate and facilitate collaborations that will improve HIV prevention.

CP62

Abstract 1970 - Prevention and Care Programs

Author(s): *Lisa Khaleque, Janet Goldberg*

Background: Brooklyn has been profoundly affected by HIV/AIDS for the past three decades and has one of the highest prevalence rates in the United States. Approximately, 30,000 Brooklyn residents are living with HIV/AIDS as of June 30, 2013. Forty percent (40%) of Brooklyn adults have yet to receive an HIV test. With 723 people diagnosed in 2013, Brooklyn had the second highest number of new HIV diagnoses in New York City. Due to stigma and lack of community awareness, it has been a challenge to increase HIV testing rates among Brooklyn residents.

Methods: The Brooklyn Hospital Center implemented routine HIV screening in its Emergency Department located in a dense urban setting. The hospital leadership implemented a project to streamline and increase HIV testing in the ED by 1) Utilizing the Electronic Medical Record (EMR) to develop a structure for HIV consent forms; 2) Updating laboratory protocols to adapt the CDC's 4th

Generation testing algorithm; 3) Reviewing and updating the ED HIV Testing Policy and Procedure; 4) Creating non-compliance reports to keep track of labs ordered; 5) Developing an automated daily surveillance report of all HIV tests completed in the hospital; 6) Garnering support from stakeholders including hospital and departmental leadership to move forward with the changes in the ED; and 7) Tracking pending HIV tests through the EMR system. These changes have led to significant scale in HIV testing.

Results: Prior to the project, 205 tests were completed from 1/1/2013- 12/31/2013. After the project's launch on 1/1/2014, 6,290 patients were tested for HIV for the year. 56 patients in the Emergency Department were identified as HIV positive & 45 of those patients have been linked to care (80%). There has been an increase of over 3,000% in HIV testing in The Brooklyn Hospital Center's ED.

Conclusions/Implications: The project has led to upgraded changes at The Brooklyn Hospital Center and there has been a strong workflow throughout the ED. The model has been shown to significantly increase HIV testing and can be adapted to other clinical settings to increase testing.

CP63

Abstract 1735 - Prevention and Care Programs

Author(s): *Elizabeth Greene, Brett Hanscom, Theresa Gamble, Kate Buchacz, Andrea Jennings, Tammey Naab, Ralph Belloise, Wafaa El-Sadr, Bernard Branson*

Background: As part of the HPTN 065 (TLC-Plus) study to evaluate the feasibility of a "test, link-to-care, plus treat" HIV prevention approach, 7 participating hospitals in Washington, DC and 9 in the Bronx, NY sought to achieve universal offer of HIV testing in emergency departments (EDs) and inpatient admissions (IPs). From February 2011-January 2014, 3 EDs and 4 IPs meaningfully improved in HIV testing ("Improvers") defined as at least a 5 point increase in the percentage of patients tested, while 12 EDs and 11 IPs did not improve ("Non-Improvers"). We assessed the association between process indicators and observed improvements in HIV testing.

Methods: On two occasions (May 2012 and January 2014), all EDs and IPs reported progress on a set of 15 study-defined process indicators, divided into 3 categories: structural (n=6, consent modifications, routine offer of testing, standing orders, electronic health records for eligibility and testing prompts, tracking of test offer), buy-in (n=5, administrative, information technology and staff support; training and education; billing), and laboratory (n=4, lab support, lab-based testing, availability and use of multi-platform analyzer, assays/reagents purchased). These indicators were scored 0 for 'not yet completed/not planned,' or 1 for 'completed.' Scores were summed overall and by category. Changes in summed scores from 2012-2014 were calculated to determine progress. ED and IP mean scores and differences were calculated to compare Improver to Non-Improver subgroups. Logistic regression was used to determine whether changes in process indicators predicted improvements in HIV testing.

Results: EDs: Mean overall indicator scores improved from 5.0 to 9.7 (of a possible 15) for Improvers, versus 6.8 to 8.1 for Non-Improvers (Odds ratio [OR] (95% Confidence Interval [CI]) = 2.6 (0.97, 6.9), p=0.057). Improvers reported a mean difference of 2.3 for structural changes, versus 0.8 for Non-Improvers (OR=1.4 (0.75, 2.7), p=0.28). Improvers reported a 1.7 point improvement in buy-in score

versus -0.2 for Non-Improvers (OR=1.8 (0.79, 4.2), p=0.16). The mean change in laboratory indicators was 0.7 for Improvers versus 0.6 for Non-Improvers (OR=1.0 (0.42, 2.6), p=0.93).

IPs: Overall mean differences in process indicators were small but improved from 6.3 to 7.3 for Improvers and from 6.6 to 8.5 for Non-Improvers. Improvers and Non-Improvers reported modest advancements in structural indicators (mean difference of 1.0 for both). Both Improvers and Non-Improvers regressed in buy-in indicators (mean difference -0.3 and -0.1, respectively). Improvers reported a mean difference of 0.3 for laboratory indicators, versus 1.0 for Non-Improvers. Changes in IP process scores did not show any significant association with improvements in HIV testing.

Conclusions/Implications: Only modest changes were observed in the process indicators, more in the EDs compared to IPs. For EDs, the overall score suggests a possible association between changes in the indicators and increased HIV testing. Changes in IP process indicators were small and not associated with increased HIV testing. While use of the indicators facilitated monitoring of progress towards goals, more work is necessary to identify key strategies for increasing hospital-based HIV testing.

CP64

Abstract 2180 - Prevention and Care Programs

Author(s): *Ann Petru, Teresa Courville, Noami Spinazzi, Abigail Aldridge, Laguerre Roberta, Clint Steib, Neil Rellosa, Daniel Conway*

Background: The incidence of HIV infection in the United States is rising faster among youth than in any other age group. The CDC estimates that 59% of US youth aged 13-24 are unaware of their infection, compared with 16% in the general population. In 2006, the CDC recommended routine HIV testing in patients 13-64 years old regardless of risk factors, yet few pediatric hospitals have adopted this recommendation. St. Christopher's Hospital for Children (SCHC) in Philadelphia implemented routine opt-out HIV testing in January 2010 and UCSF Benioff Children's Hospital Oakland (UBCHO) began in May-June 2014.

Methods: Opt-out testing was implemented at different clinical sites: adolescent medicine, inpatient, primary care, and emergency departments. SCHC offered both point-of-care tests (Insti® and Oraquick®) and Abbott® 4th generation tests, while UBCHO provided Abbott® 3rd and 4th generation tests. Each hospital developed a network of physician and nurse champions to increase buy-in on the frontlines and incorporated prompts in their electronic medical record (EMR). We compared the data for the first year of implementation at the two sites.

Results: In the first year of the program, 2,321 at SCHC and 2,880 patients were tested at UBCHO – 16.8% and 25.2% of eligible patients, respectively. At UBCHO, this represented a 7.2% increase in the testing rate compared to the previous year. SCHC identified 3 new seropositive patients (0.14% of tested patients) one of whom was classified as acute HIV infection. UBCHO identified 4 new seropositive patients (0.14%); two of whom (50%) were classified as acute HIV infection. At UBCHO, 44.7% of testing was done using 3rd generation tests and 55.3% of testing was done with 4th generation tests. All of the acute HIV infections were identified using the 4th generation test. Rates of testing improved most in the ED and in primary care settings for UBCHO, and in inpatient and primary care settings for SCHP. All patients were successfully linked to care.

Conclusions/Implications: Hospital-wide implementation of opt-out testing is effective at increasing rates of HIV testing. Choice of tests offered was affected by insurance reimbursement and availability of phlebotomy. Use of the 4th generation test increased the likelihood of identifying acute HIV infection. There are many obstacles to implementing scale up of sensitive services in a young population. Protection of patient confidentiality was at times difficult, especially in the emergency room. Training of all staff at these large institutions is time-consuming. Staffing issues caused bottleneck limitations to testing, as phlebotomy often adds significant time to the visit. Alarm fatigue made EMR prompts less effective over time. A decline in enthusiasm for testing was noted a few months into the initiative, and was combatted with increased outreach to providers.

CP65

Abstract 1850 - Prevention and Care Programs

Author(s): *Samuel Gonzalez*

Issue: Since 2013, the U.S. Preventive Services Task Force (USPSTF) has recommended opt-out HIV testing of persons ages 15 to 65 years, younger adolescents and older adults at increased risk for infection, and pregnant women. Despite these recommendations, only 20% of patients 15 to 65 years of age who receive care at Federally Qualified Health Centers (FQHCs) are tested for HIV (Levinson, HIV Testing in HRSA-Funded Health Center Sites, 2013). HIV-infected individuals unaware of their status do not receive life-extending HIV care and treatment and are more likely to transmit HIV to others. FQHCs provide primary health care to millions of patients each year and are critical to efforts to test patients for HIV and reduce its spread.

Setting: St. John's Well Child and Family Center (SJWCFC) is a network of 13 FQHCs located throughout South Los Angeles and Compton. The intended audience for the routine-HIV testing intervention is SJWCFC's patients: Hispanic/Latino, youth and adults ages 15 to 65 years and those determined at increased risk for infection, uninfected/unknown HIV status, immigrants, and undocumented [P08, P18 (ages 15 to 65 years and younger or older depending on risk for infection), P33, P52, and P74 (undocumented)].

Project: SJWCFC's 'Best Practices for Integrated Routine HIV Testing Initiative' was implemented January 2014 at seven of SJWCFC's health centers, and focuses on the following: 1) Integrated Screening Process (blood draws as part of standing clinical flow for annual and initial visits); 2) Institutional Policy Change (Senior Leadership buy-in); 3) EMR Modification and Tracking (standing orders for routine HIV-testing); and 4) Provider and Staff Training (to follow the USPSTF recommendations and conduct the HIV test as a standard of care at initial and annual visits, rather than solely done in the context of patient's sexual history). SJWCFC conducted process evaluation (assess if the elements of the initiative were implemented as planned) and outcome evaluation (examine the impact of the initiative on HIV testing at SJWCFC's targeted health centers).

Results: In 2013, 6,924 HIV tests were provided at SJWCFC's targeted seven health centers and six new positives identified; after the new 'Best Practices for Integrated Routine HIV Testing Initiative' was introduced in 2014, 16,283 HIV tests were performed, and 49 new positives identified. This represents a

135% increase in HIV tests from the previous year and a 717% increase in new positives identified post implementation of the initiative.

Lessons Learned: Blood draws as opposed to rapid tests were instrumental in producing higher volume of tests performed and contributed to improved clinical flow; prior to this, SJWCFC was predominantly using rapid testing which was limited and erratic. With integrated, lab based screening, SJWCFC significantly increased volume tested and positives identified. Standing orders via the EMR facilitated routine HIV testing per practice-approved protocol. Lastly, it was critical to have leadership engagement at the outset in order to drive the initiative and successfully implement it. We found that having the CMO facilitate the provider and staff trainings helped build buy-in.

CP66

Abstract 2357 - Prevention and Care Programs

Author(s): *John Schneider, Nancy Glick, Patrice King, M. Taylor Parsigian, Brian Bragg, Randee Estes, Danielle Lazar*

Issue: Schneider, J.(U.Chicago), Glick, N.(Mt. Sinai Hospital; ACCESS Community Health Network), King, P.(ACHN), Parsigian, M.T.(ACHN), Bragg, B.(ACHN), Estes, R.(U.Chicago), and Lazar, D.(ACHN)

Background: Emerging data suggests that real-world implementation of PrEP faces several potential barriers, including significant racial disparities in PrEP utilization. Several of these barriers occur early in the PrEP care continuum around linkage to care stages. It remains unclear whether providers will screen existing patients for PrEP. At the same time, we do not know the effectiveness of public health outreach for clinical PrEP referral. We examine how candidate PrEP clients are referred for PrEP care at a Federally Qualified Health Center (FQHC) on the South Side of Chicago.

Setting: **Methods:** In the context of an ongoing four-site PrEP implementation study, Sustainable Health Center Implementation PrEP Pilot (SHIPP), data was examined around PrEP referral over a 10 month period at the Chicago FQHC. Referrals were categorized as: 1) internal if the client was an existing patient; and 2) external if the client was referred from another agency. Internal referrals were further categorized as whether they were a partner of an existing HIV client or not. External referrals were further categorized as to whether they were from external outreach programs, another provider or an STI clinic. SAS 9.3 software was used to calculate the frequency of PrEP visit scheduling and PrEP visit completion rates. Fisher's exact test was used to determine differences between referral groups.

Project: N/A

Results: Results: Thirty-nine clients were referred, of which the average age was 28.3, 66.6% were male (42% MSM), 33.3% female (7% transgender women) and 100% were African American. Internal referrals accounted for 46.2% of PrEP clients of which 61.1% were existing patients at the FQHC. The remaining 38.9% were partners or other contacts of existing HIV patients. 53.8% were external referrals, all of which were from external outreach programs. External referrals were equally as likely to schedule appointments as internal and patient referrals (90%, 92.86% and 85.71% respectively; Fisher's exact $p=1.0$), but were less likely to complete their first PrEP visit (61.11%, 100%, 100% respectively; Fisher's

exact $p=0.0170$). Nearly 100% of referred patients who completed their first PrEP visit were provided a prescription to initiate PrEP treatment.

Lessons Learned: Conclusion: Pending results.

Our initial findings show that there are nearly equal numbers of external and internal referrals for PrEP. The patients who are initiating PrEP are at high risk for acquiring HIV. The likelihood of completing a scheduled appointment, though, appears to be higher for internal referrals from within the clinic and partners of known HIV positive patients. Barriers to PrEP initiation for external referrals, most of whom are not partners of known HIV positive patients, requires additional investigation and potential intervention. Additional implementation research is required to help us better engage existing patients for an initial PrEP visit as well as those in the community.

CP67

Abstract 1848 - Prevention and Care Programs

Author(s): *Andre Maiorana, Tim Buisker, Julia James, Faye Malitz, Janet Myers*

Background: Effective HIV prevention requires both biomedical and behavioral interventions delivered in clinical settings. The Ask Screen Intervene Curriculum (ASI) was developed in response to 2003 guidelines recommending inclusion of prevention for PLWH in medical settings, otherwise known as prevention with positives (PwP). In the 3 ASI training modules, medical providers learn how to ask HIV-infected patients about risk behaviors, screen patients for STDs, and intervene by delivering risk reduction messages and facilitating referrals to other services (e.g., mental health and substance use). This qualitative study assessed ASI implementation in 8 Ryan White clinics funded by HRSA's HIV/AIDS Bureau to replicate ASI and support the integration of HIV prevention to the medical care of PLWH in 4 high HIV prevalence cities.

Methods: We conducted 31 qualitative interviews with 8 ASI trainers, and 24 staff (doctors, nurse practitioners, medical assistants, nurses, case managers and counselors) implementing ASI in the clinics. We summarized the coded interview transcripts in order to identify convergent and divergent themes within and across clinics.

Results: ASI implementation helped to develop a more formalized and clinic-wide structure to PwP, and to expand upon prevention services already available, providing tools to making them clinic-wide and less provider-specific. While ASI was designed for medical providers, the clinics tailored ASI, and both medical and non-medical staff implemented ASI. All clinics established procedures for medical providers to initiate PwP conversations with patients, to then refer them to other services. Thus, ASI implementation resulted in a more coordinated multidisciplinary approach that allowed non-medical staff to better follow-up with patients that needed more intensive prevention services. The ASI risk screener helped to enhance and formalize risk screening; with most of the clinics building that risk screener directly into electronic medical record (EMR) fields, creating a "common platform" that helped facilitate prevention conversations with patients. Interviewees at most clinics stated that the ASI risk screener would become part of the standard clinic protocols. ASI implementation helped to enhance STD testing, including screening for oral and rectal gonorrhea and chlamydia. Challenges to implementation also occurred. In some clinics, knowledge transfer and ongoing training to teach new

hires about ASI to support its sustainability were lacking. Specialized training beyond ASI to support prevention services to high risk patients was not in place. Separate documenting systems, whether manual or electronic, used by medical and non-medical staff for sharing patient information was a barrier to implementation.

Conclusions/Implications: The process of ASI implementation influenced clinic-level changes including better coordination of PwP services, improved risk assessments now built into EMRs, and enhanced STD screening. Different from earlier findings indicating that PwP was not routine practice in medical settings, our study shows that risk screening and prevention counseling with PLWH have become more integrated in those settings. Improving PwP delivery and STD screening for PLWH using ASI can complement existing prevention efforts and contribute to achieving one of the goals of the National HIV/AIDS Strategy to reducing new HIV infections in the US.

CP68

Abstract 1835 - Prevention and Care Programs

Author(s): *Jessica Klajman, Nana Mensah, Angela Merges, Zoe Edelstein, Demetre Daskalakis, Julie Myers*

Issue: Chlamydia and gonorrhea are two commonly diagnosed sexually transmitted infections (STIs) among men who have sex with men (MSM), and are considered co-factors for HIV transmission and acquisition. The CDC recommends 3-site (urethral, rectal, and pharyngeal) STI screening every 3 to 6 months for MSM at highest risk of HIV. However, 3-site screening is not consistent across providers, resulting in less than optimal care for this vulnerable population.

Setting: The New York City Department of Health and Mental Hygiene (NYC DOHMH) funds Sexual and Behavioral Health (SBH) programs at 6 clinical facilities. SBH programs provide holistic, co-located services to uninsured/underinsured MSM and other priority populations, with the ultimate goal of preventing new HIV infections. SBH services include non-occupational post-exposure prophylaxis (nPEP), HIV testing, STI screening/treatment, hepatitis screening/vaccination, behavioral health screening/counseling and HIV risk reduction education. NYC DOHMH uses data submitted by the SBH programs to track key indicators of programmatic success and regularly provides reports to the funded programs to support data-driven technical assistance.

Project: One primary goal of SBH programs is 3-site STI screening for MSM. NYC DOHMH developed performance indicators, including the proportion of STI screens among MSM clients where screening occurred at all 3 sites; these were introduced to SBH program administrators in November 2013. Aggregate and facility-specific progress reports were provided to each facility in June 2014. In February 2015, program administrators at each facility began receiving monthly quality assurance reports documenting progress in achieving STI screening indicators and other priority indicators. DOHMH Project Officers (POs) followed up with program administrators to discuss quality assurance reports, barriers to 3-site screening, and potential solutions.

Results: Between October 2013 and December 2014, 1642 clients were enrolled in SBH programs, of whom 57% (n/N=940/1642) identified as MSM; among them, 67% received at least 1 STI screen.

Overall, 98.1% of STI screens included a urethral screen and 69.0% included either an extragenital (pharyngeal and/or rectal) screen. Two-thirds (66.3%) of STI screening services included 3-site screening. Three-site screening increased significantly over the interval, from 62.9% in Q4 2013 (n/N=66/105) to 74.4% in Q4 2014 (n/N=151/203) (p <0.01). Overall, 8% (65/772) GC/CT screens were positive. In screens with multiple sites tested (urethral and ≥1 extragenital), 5% (n/N=30/557) were diagnosed through an extragenital site only.

Discussions between facility program administrators and POs revealed that common barriers to 3-site testing were medical provider concerns about impact on patient flow; perceived inconvenience to patients reporting exposure at fewer than 3 anatomic sites; provider preference for presumptive treatment over preventive screening; and patient refusal of rectal screening. This dialogue enabled DOHMH POs to provide follow-up support and monitoring of measures to address barriers.

Lessons Learned: Routine reporting on clinical indicators was an important tool for focusing attention on key clinical priorities for MSM and for provision of data-driven TA to support optimal sexual healthcare for populations at high risk for HIV transmission. In addition to providing access to critical clinical prevention services for vulnerable populations, emphasis on performance for these contracted programs can serve to improve practice among providers more generally.

CP69

Abstract 2044 - Prevention and Care Programs

Author(s): Carol Tyrell, Kirsten Rowe, Bethsabeth Deleonjustiniano, Kraig Pannell

Issue: The rate of new HIV infections has decreased within every group in NYS except among gay men (GM). The incidence of new infections among young gay men (YGM), 19-24 years, has increased significantly, especially among YGM of color. Recognizing the importance of faith/spirituality/religion to Lesbian Gay Bisexual Transgender (LGBT) people of color (POC), and that their experience with some faith traditions, is not always affirming, NYS AIDS Institute (AI) explored whether faith communities (FC) can be part of the coordinated collaborative response to reduce new infections among YGM of color.

Setting: The AIDS Institute (AI) Faith Communities Project (FCP), a community level intervention that is designed to advance HIV prevention (HIVP) and health care efforts (HCE) in FCs throughout NYS, in partnership with the LGBT Health & Human Services Unit (LGBT HHS), which addresses the non-HIV-related health disparities of LGBT persons in NYS; reviewed existing FCP activities/documents and, identified strategies, in alignment with the AI priorities, to integrate LGBT related topics in faith-based activities.

Project: The FCP and LGBT HHS implemented multiple strategies to integrate LGBT-related topics in FC programs/activities: 1) updated existing documents; faith-based ministries/services directory, to include LGBT ministries/services or task force, and sexual orientation and gender identity (SOGI) questions on surveys; 2) administered a survey to assess knowledge, attitudes, beliefs, and awareness of HIV/AIDS, NYS Testing Laws; whether FC should be open and welcoming to LGBT people and the readiness of their FC to welcome LGBT people; 4) included a SOGI overview in menu of programs; 5) explored the importance of faith/spirituality/religion to GM at the annual intersection of faith and health forum, and

webinar series. This presentation will describe the faith forum and the results of the strategies implemented.

Results: The FCP conducted 18 faith-based HIV-related programs reaching 754 persons. Of the 18 programs, 11 focused on LGBT and faith-related concerns/topics (n=476); 3 forums explored the Intersection of Faith & Health & Wellness of Gay Men (n=178); 8 were LGBT specific programs (n=298); and 7 addressed general HIV-related topics (n=278). Participant surveys were administered at all programs and 507 were returned/analyzed. Overall, the majority of participants were knowledgeable about HIV (88.9%) and over half knew that the highest rate of new HIV infections in NYS is among young Black (MSM (60.9%). 80.1% knew the impact of early treatment on reducing transmission. Only 19.9% indicated that their FC had a LGBT ministry or task force, 30.7% were unsure if their FC was welcoming to LGBT people, and 33.0% “strongly agreed” that their FC is welcoming to LGBT people, however, 69.8% “strongly agreed” that FC should be open and welcoming to the LGBT community.

Lessons Learned: Multiple strategies are necessary to address LGBT-related issues in FC.

Changing our narrative and perspective of FCs ability to address LGBT-related issues is essential in advancing HIVP and HCE.

Including SOGI questions on surveys administered in faith-based institutions, recognizes and affirms the existence and importance of LGBT people in FC.

“If “Mom and God” are OK! LGBT people of color are OK!” with who they are.

CP70

Abstract 2493 - Prevention and Care Programs

Author(s): *Dwayne Morrow*

Issue: HIV/AIDS has been an epidemic in the United States for the last 30 years. Gay, bisexual, and non gay identified men have been the most affected group. These populations are collectively referred to as men who have sex with men (MSM). While HIV mostly affected Caucasian MSM in the early years of the disease, MSM of color have seen rising rates of infection over the last 15 years. According to the CDC, among all MSM, black/African American MSM accounted for 36% of the new HIV infections in 2010 and Hispanic MSM accounted for 22%. The largest number of new infections among black/African American MSM (45%) occurred in those aged 13 to 24. The largest number of new infections among Hispanic MSM (39%) occurred in those aged 25-34. The high rate of HIV infection needs to be addressed through targeted strategies designed specifically for these populations.

Setting: Across the United States, gay pride events are held in cities to express solidarity and provide positive support to members of the GLBT community. Often times, community based organizations (CBOs) and health departments will have a presence at these events to provide testing, education, & safer sex kits. Some of these gay pride events cater to specific ethnic demographics. In Houston each spring, there is a gay pride event aimed at black/African American MSM called “Houston Splash”. Each year, this event is attended by thousands of MSM not only from Texas, but from all over the United

States. It provides an opportunity to engage a large concentration of the MSM of color community in order to provide them with HIV testing.

Project: Since 2010, AIDS Foundation Houston has partnered with Loud, Inc (the company that organizes Houston Splash) & provided HIV testing to participants attending Houston Splash. We begin our advertised testing approximately one month before the event and offer the incentive of a VIP pass to the Houston Splash events when a person gets tested for HIV & Syphilis. Clients who self identified as HIV positive were allowed to only be tested for syphilis. During the 4 days of Houston Splash, AFH provides testing at the venues hosting the Splash events such as the host hotel, clubs, and Galveston Beach.

Results: AFH has tested 408 participants attending Houston Splash for HIV. Of those 408 people tested 26 new HIV positive individuals were identified for a positivity rate of 6.4%. Additionally, we have an RPR reactive rate of 9.6%. We were also able to provide linkage to care services to individuals who were previously diagnosed back into to care.

Lessons Learned: Providing testing at gay pride events allows us the chance to reach a large number of previously undiagnosed individuals. Providing HIV testing in nontraditional, nonclinical settings also allows us to test those people who would not normally come to our CBO or go to the doctor's office for a test. Using these events as a strategy for HIV prevention allows us to increase the number of people aware of their HIV infection and link them into HIV care.

CP71

Abstract 1787 - Prevention and Care Programs

Author(s): *D'Metris Welters*

Issue: The CDC reports that in the U.S., inmates in jail and prison are disproportionately affected by multiple health problems, including HIV, other STIs, TB and viral hepatitis. When compared to non-incarcerated individuals, incarcerated individuals have more risk factors associated with acquiring and transmitting HIV; injection drug and other drug use, commercial sex work, untreated mental illness and lower socioeconomic status.

Setting: The U.S. Department of Health and Human Services, Office of Women's Health funded eight sites across the country through their Partners Plus program. WEST was designed to identify and discuss the health disparities and behavioral factors leading to increased risk for HIV and other STIs among women partners of incarcerated men; while examining the effectiveness of implementing a gender-specific intervention.

Project: WEST focuses on creating a positive view of self through the development of effective communication skills, relationship building, safer intimacy practices and negotiation skills to enhance the knowledge and self-efficacy of women with a male partner who is currently incarcerated or has been released within the past year. Once the women have demonstrated success in these core principles, they are trained to become peer educators within their communities. The multi modal, group level facilitation incorporates three evidence based interventions; Sisters Informing Sisters About Topics on

AIDS (SISTA), Video Opportunities for Innovative Condom Education (VOICES) and Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies). SISTA enhances communication and negotiation skills, VOICES focuses on increasing safer sex practices and Community PROMISE develops the peer leadership abilities of the participant.

Results: Distributed from March 2013 to December 2013, baseline, exit and follow up questionnaires were utilized to establish a baseline of knowledge and measure the maintenance of outcomes. The questionnaire was in partnership with The Bridging Group as part of the Women Partners Evaluation Study. It consisted of 36 questions to assess the knowledge, behaviors and beliefs of 66 participants at baseline. Almost $\frac{3}{4}$ of the participants (74%) completed an exit questionnaire while 48% completed the 30-day follow up questionnaire. Comparing baseline to exit, knowledge about HIV prevention, transmission and personal risk increased from 71% to 89%. Intention to make safer behavioral choices related to HIV and other STIs among women partners increased from 86% to 100%. Examples of this model of informed decision-making was exemplified by an increase in knowledge concerning safer sex barriers. Exit and follow up questionnaires displayed that almost $\frac{1}{4}$ of the participants (23%) engaged in the utilization of female condoms, up from 16% at baseline. Additionally, acquisition of new communication and risk negotiation skills also showed improvement from baseline to exit. An increase in the number of women partners receiving gender-based prevention education was noted; retention was greater than 75%.

Lessons Learned: WEST has enhanced the social support network among women partners while increasing community linkages and voluntary testing for HIV and other STIs. Women, being the gate keepers to households and their communities are the stepping stones to aiding in reducing the incidence of HIV and other STIs and enhancing the quality of life of their constituents.

CP72

Abstract 1939 - Prevention and Care Programs

Author(s): *Karen Connolly*

Issue: Approximately 20% of HIV positive individuals are unaware of their status, leading to further transmission and unknown infections. These unknowingly positive individuals do not receive medical care or counseling, both of which could prolong life and prevent further transmission. The CDC recommends routine HIV testing for all individuals between the ages of 13 and 64. Despite tests that are convenient, reliable, and produce fast results, routine testing for HIV in clinical settings is not standard practice. Having available and accessible testing in clinical settings, as well as numerous other accessible locations, can also help to decrease the stigma surrounding HIV testing, and help clinics adopt it as a routine test.

Setting: The ETI is a CDC program started in 2007 to increase the identification of HIV positive individuals who are unaware of their status, and aims to make HIV testing more available and accessible in areas with high-risk populations. Testing for this program occurs in five emergency departments in the Memphis area, as well as different outreach locations in the community. The goal of the ETI is to increase the number of tests conducted, helping to identify HIV positive individuals earlier, and connect them to care.

Project: The ETI focuses on high volume testing in clinical settings. All testers go through mandated training to become certified to test and counsel. Testers offer all patients in the ERs a free HIV test, targeting those between 13 and 64. If a test returns a reactive result, a navigator is contacted to come and meet with the patient, counsel them, and begin to connect them to care. Tests conducted in outreach locations are conducted by the navigators themselves. Some of the ETI funding also supports the Care and Prevention in the United States (CAPUS) program, a social networking strategy focusing on MSMs.

Results: From October 2011 to December 2014 a total of 47,691 tests were performed in clinics and at outreach locations. 62.86% of individuals tested were women, 37.11% were men, and .04% were transgender. 87.31% of individuals tested were non-Hispanic Black or African American. Since beginning in 2011, 256 positives have been identified, with 131 (51.18%) being new positives, and 125 (48.83%) were previous positives. The Regional One ED has the highest total positivity rate of all sites at 1.12%, and Germantown ED has the second highest positivity rate, with .4% of the tests returning a reactive result.

Lessons Learned: HIV testing in clinics has shown to help find new and out of care HIV positive individuals, and help get them into care. Collaboration with other programs, such as Anti-Retroviral Treatment and Access to Services (ARTAS) and organizations, such as St. Jude, is important in connecting clients to care, as certain programs and organizations can help specific age groups and populations. Education has also been indicated to be an important factor, and future partnering with school-based programs is planned. The need to reach more men is relevant in the results, and some future outreach events will specifically be geared towards men.

CP73

Abstract 1899 - Prevention and Care Programs

Author(s): *Kathleen Carey, Heidi Reukauf, James Tesoriero, Catherine Marra, Bethsabet Justiniano, Carl Koenigsmann*

Issue: An estimated 2,000 HIV positive persons are incarcerated in NYS's prisons on any given day. About half that number is known to prison officials and therefore able to receive HIV-related medical care and treatment, yet not all of these inmates are on treatment for HIV due to treatment refusal. Concerns about confidentiality, HIV-related stigma, and inaccurate perceptions about the quality of medical care are the primary reasons for treatment refusal. This study examined the likelihood of treatment initiation following the delivery of theory-based activity and concrete services to known HIV positive inmates not on treatment in prison.

Setting: Select male and female prisons in New York State

Project: On a bi-monthly basis (June 2014 - February 2015) a list of HIV positive inmates known to prison medical staff and not on treatment in 16 NYS prisons was generated. Inmates identified on the list were approached by prison medical staff to discuss the benefits of treatment, address any identified barriers to treatment initiation, and start an anti-retroviral regimen (if appropriate). Inmates refusing treatment

following this encounter were encouraged to meet with community based organization (CBO) staff providing linkage, navigation and retention support in the prison. These staff are trained in the delivery of the evidence based intervention, Anti-retroviral Treatment and Access to Services (ARTAS), which prepares HIV positive individuals for treatment readiness.

Results: A total of 46 HIV positive inmates known to prison medical staff and not on treatment were included in this study. One out of 5 initiated treatment for HIV following 1 or more encounters with prison medical or CBO staff. The treatment refusal rate among female inmates was 35.7% compared to 15.6% for males. Overall, there was a 50% reduction in the number of positive inmates known to prison medical staff and not on treatment in intervention prisons.

Lessons Learned: Collaborative efforts among prison medical and CBO staff to encourage treatment initiation among the known HIV positive inmate population is worthwhile, albeit resource intensive. A potentially more efficient use of prevention resources involves the use of HIV surveillance data to identify and link previously diagnosed but currently non-disclosing inmates to HIV-related medical care, slated to commence in June 2015.

CP75

Abstract 2461 - Prevention and Care Programs

Author(s): *Kevin Anderson, Jetaun Burgin, Jamie Simmons*

Issue: CDC recommends clients should be educated about the importance of follow-up medical care as well as what to expect ; clients who test positive for HIV antibody should be counseled, either on site or through referral, concerning the behavioral, psychosocial, and medical implications of HIV infection. Over the years finding adequate space to provide these services outside of the clinic setting has limited the ability to properly provide confidentiality.

Setting: AIDS Foundation Houston (AFH) Mobile Unit Testing is provided in a small 2 person vehicle that allows space for the client and the tester. The goal for mobile unit testing is to reduce testing stigma by expanding outreach and testing to areas of higher HIV prevalence. By establishing relationships with community gatekeepers, AFH has been able to gain access to areas that have often been challenging to establish space and confidentiality. By utilizing the unidentified mobile testing unit, AFH has gained entry into these underserved environments.

Project: AFH Mobile Unit Testing goal is to provide resources to the Houston/ Harris County communities in the following ways: 1) Promote HIV testing and awareness directly in the communities that are within areas of higher HIV prevalence; 2) Outreach to community and reduce HIV stigma by creating curb side appeal; 3)expand linkage capacity through the usage of the mobile unit; 4) Condoms and educational material dissemination; 4) Afford the opportunity to partner with other CBO's that are able to offer bi-lingual language services; 5) provide testing and education on street corners , outside of businesses and near major transit hubs with higher foot traffic; 6) provide a confidential setting that allows safety for both the tester and the client. This presentation will highlight the implementation, evaluation and outcomes of mobile unit testing.

Results: From January 2014 through December 2014, a total of 997 clients were provide HIV testing or a combination of HIV/Syphilis testing. During that calendar year were found a total of 13 newly diagnosed positives and were able to link 11 of the 13 clients; we were able to also link 3 clients that had fallen out of care. Due to our linkage program, AFH has been able to establish a relationship with the clients and further assess the socio-social portion of their care. Often during our drive with the client, AFH is afforded the opportunity to break through client stigma and address client concerns and needs. AFH has established HIV empowerment through community outreach.

Lessons Learned: During 2014, AFH was provided the opportunity to work with gatekeepers that showed a need for further education and stigma reduction conversations. In addition, through our mobile unit testing, AFH learned that additional educational opportunities needed to be established. Focusing on providing education to specific marginalized demographics, AFH launched a Community HIV 101 course.

CP78

Abstract 1277 - Prevention and Care Programs

Author(s): *Stephen Flores, Holly Fisher, James Carey, Monique Carry, Arin Freeman, Deborah Gelaude, Tamika Hoyte, Mary Spink Neumann, Nicole Pitts, David Purcell*

Issue: The US National HIV/AIDS Strategy (NHAS) set out ambitious 2015 goals to reduce HIV infection, improve outcomes for people living with HIV, and reduce disparities. Health departments have focused efforts on being increasingly resourceful in finding ways to support HIV prevention programs for populations most affected by HIV. Local jurisdictions continually seek approaches that maximize the impact of federal, state and local resources for HIV prevention.

Setting: The CDC responded to the NHAS with a demonstration project that supported health departments in 12 high-prevalence cities in the development of local plans to achieve these ambitious goals. The Enhanced Comprehensive HIV Prevention Planning (ECHPP) project was a CDC-supported demonstration project that prioritized health department HIV-related activities to maximize impact and accelerate scale-up of prevention and care efforts in 12 localities with the highest HIV burden in the US.

Project: ECHPP focused on applying principles of CDC's High-Impact Prevention, across all funding sources, by requiring health department grantees to define specific goals, strategies, and objectives for a variety of evidence-based interventions to decrease the local impact of HIV. These health departments were the first in the U.S. to adopt the principles of NHAS and High-Impact Prevention, which now are incorporated into CDC's health department cooperative agreement for all states as well as a small number of large cities and territories. ECHPP created new models for program monitoring and management at CDC that involved increased collaboration across multiple silos (e.g., program, research, evaluation, surveillance) and the leveraging of existing data systems. The project also created new opportunities to improve coordination at different levels of government.

Results: Quantitative and qualitative data will be presented to show the successful scale-up of key HIV prevention program activities that took place in these 12 cities during ECHPP. For example, number of condoms distributed among high-risk groups increased by 118%, number of newly identified HIV-

positive people interviewed for partner services increased by 54%, and number of HIV-positive people who participated in programs designed to increase retention/engagement in care increased by 28%. Qualitative data will also be presented that describe processes that occurred during these shifts in activities including how health departments reported ongoing education provided to partners about local policies and procedures, how they relied on local data collection and use, and ongoing challenges including staffing and funding. Examples will also be presented of how ECHPP has informed improvements regarding collaborations among federal agencies, within agencies, and in subsequent programs.

Lessons Learned: As a result of the response to the NHAS, health departments have been successful in making far-reaching programmatic shifts in an effort to increase the local impact of HIV prevention funds. Health departments have been successful in scaling up key HIV prevention activities during a time of change in the field of HIV prevention and increasing financial constraints. Successful strategies have been identified that support this work including use of data and local coordination among others. Successes have also been realized at a federal level between and within agencies.

CP79

Abstract 1800 - Prevention and Care Programs

Author(s): *Margaret Picard, Steven Aronin, Nadine Repinecz*

Issue: HIV patients receiving treatment are living longer and there is an increasing trend of other chronic diseases being seen in this population. Considering this trend, the Food for Life Program was created to provide an opportunity for low income, multicultural HIV patients with cardiac risk factors to improve their health.

Setting: The program is located at the Waterbury Hospital Infectious Disease clinic which is a Ryan White grant funded multidisciplinary program to provide comprehensive HIV care services to approximately 500 patients. The intended audience is multicultural HIV positive patients at or below 250% of the poverty level with at least one of the following elevated clinical indicators: Hemoglobin A1c, Glucose, Body Mass Index (BMI), cholesterol and/or blood pressure.

Project: Fifty-four multicultural HIV positive patients were enrolled in the Food for Life program over the course of twelve months. Clinic health providers referred patients into the program based on having one or more abnormal health indicators. The program was launched in February 2014. Participants were provided access to healthy foods through a food voucher system to a local farmers market, access to regular exercise (2-3 times a week) at the YMCA, along with mandatory counseling sessions with a registered dietitian and support from a medical case manager.

Results: Twenty nine of the total enrolled patients lost a combined total of 275.5 pounds with an average weight loss of 9.5 pounds. Weight loss ranged from 0.5 pounds to 53 pounds. Three participants changed from being morbidly obese (BMI>40) to obese (BMI 30-39), 2 patients went from an obese BMI to an overweight BMI range (25-29.9), and 1 participant went from an overweight BMI range to a normal weight range (BMI 18.5-24.9). Five participants showed an average decrease of 1.3% in Hemoglobin A1c values. Fourteen patients were evaluated for serum lipid changes and the results

varied in that 67% decreased their total cholesterol while 42% increased their total cholesterol; 62% trended down on their triglyceride levels while 38% had an increase; and 84% reduced their LDL level while 25% showed an increased trend in serum LDL. Twelve months into the program fifteen patients were actively participating. The average length of time of commitment to the program was 5.85 months with a range of participation between <1 month to 11 months.

Lessons Learned: The Food for Life program enabled a low income HIV population with chronic diseases to afford an opportunity to improve their overall health and lifestyles resulting in a decrease in their weight/BMI and trends of reduced HbgA1c and serum lipids. Lessons learned include the following: Patients had mixed results but were more successful when they met with the dietitian on a monthly basis and had regular contact with a medical caseworker. Participants were more motivated to participate when they had peer support. Incentives such as an emotional support group, onsite exercise, and gift cards for participation have improved retention of the patients in this program. The Food for Life Program has shown to be a success and continues to evolve.

CP80

Abstract 1549 - Prevention and Care Programs

Author(s): *Vince Aguon, Bernie Schumann, Esther Mallada, Laling Pangilinan, Grace Ibanez, Alan Mallari*

Issue: ELISA has been the standard routine HIV screening test in Guam. Once ELISA reactive, specimens were shipped off-island for confirmation via Western Blot (WB), averaging approximately 2 weeks. This contributed to a delay for clients receiving a confirmed HIV result that eventually caused a domino effect on the timely referral and linkage of these clients to care services. Although Guam is considered a low HIV prevalence jurisdiction, its close proximity to Asia and high rates of CT infections pose major the threats to the HIV epidemic on Guam. Thus, establishing innovative testing technologies and efficient testing algorithms are crucial to improving referral and linkage to HIV care services.

Setting: The STD/HIV Program (SHP) has utilized ELISA as a standard screening test for its clients. In addition to ELISA testing, SHP implemented rapid HIV testing on February 2012 and continued to submit reactive tests to off-island laboratories for Western Blot confirmation. By November 2013, SHP revised its HIV testing algorithm, utilizing 4th generation HIV testing in an effort to close the gap on the waiting period for HIV confirmation and ultimately, to improve referral and linkage to HIV care services.

Project: HIV testing (ELISA and rapid) data was collected and analyzed via Epi Info statistical software for the period of February 2012 through March 2015. Testing and laboratory information on confirmed HIV/AIDS cases was extracted and reviewed from HIV surveillance records, medical charts, and HIV/AIDS registry. To determine the amount of time from HIV screening to linkage to care services the total number of days was calculated between the date of HIV screening to the date of initial CD4 and/or viral load laboratory tests.

Results: Between February 2012 and March 2015, a total of 8008 tests were administered by SHP and other public-funded sites. 6110 tests were via ELISA and 1898 were via rapid HIV testing technology. 11 tests were reactive, with 7 confirmed using WB confirmation and 4 confirmed via the new testing algorithm.

A time study of these 7 cases was carried out and showed that prior to November 2013, confirmatory testing was completed in an average of 21 days (ELISA used as the screening test) to an average of 10 days (rapid HIV testing used as the screening test). Overall, it took an average of 69 days to obtain a CD4/VL test from these cases.

With the implementation of the new HIV testing algorithm in November 2013, HIV confirmation took an average of 3 days from time of HIV screening. It took an average of 14 days to obtain a CD4/VL test among these cases.

Lessons Learned: HIV testing algorithms utilizing newer technologies such as rapid HIV testing and demonstrated faster turnaround time of HIV confirmed results and which in turn enabled clients to be linked to care services in a more timely manner. Guam DPHSS should consider training providers in the island to utilize rapid HIV testing to clients with known risk behaviors and also to refer reactive HIV screening tests to DHPSS to improve referral and linkage to HIV care services

CP81

Abstract 2060 - Prevention and Care Programs

Author(s): *Caleb VanderVeen, Dana Rice, Indira Brar, Elyse Schultz, Sarah Atkinson, Jennifer Mendez*

Issue: Most physicians only interact with the medical management of HIV in clinical settings and rarely interface with community and public health interventions. Medical school provides a unique opportunity for future physicians to gain exposure to public health early in their training. Currently, the medical school curriculum focuses largely on the basic science and pharmacology of HIV, with limited exposure to the role of public health systems, diverse community settings and patient populations that impact, and are effected by, HIV. Ultimately, this gap in training leads to a disconnect between physicians and the public health resources that are required to alleviate HIV disease burden within any population.

Setting: Wayne State University School of Medicine (WSUSOM), based in the heart of Detroit, MI, operates programs and maintains relationships with a myriad of community-based clinical and public health organizations in the city. These partnerships create opportunities that enhance traditional medical school education. One WSUSOM program provides HIV prevention services to inmates housed in the Wayne County Jails (WCJ), allowing for novel public health learning activities for students. The HIV Clinic at the Henry Ford Health System (HFHS), a University partner, serves patients with HIV across the Detroit metro area.

Project: The Service Learning Elective (SLE) course furnishes an opportunity for fourth year medical students to design unique learning experiences outside of the traditional clinic setting. During the SLE course, students choose community organizations to work with for a month while providing direct services. A student with an interest and experience in HIV prevention designed a curriculum focusing on the intersection of medicine and public health for HIV prevention and care. Learning objectives were: 1) to engage in the provision of comprehensive care to HIV patients in the clinic, paying particular attention to the medical aspects of HIV care; 2) to integrate public health into the medical management of HIV, and; 3) increase exposure to the practice of medicine, specifically HIV prevention and treatment, with an incarcerated patient population. The student provided HIV prevention services, didactics,

conducted continuity visits, and presented cases to attending physicians. Evaluation of the course included quantitative assessments of patient contacts and qualitative assessments as measured by student reflections and a public policy analysis.

Results: During the SLE month, the student provided HIV prevention services to 44 clients in the jail setting and completed 4 didactics, participated in 12 continuity clinics and saw 36 cases in the community clinic setting. Additionally, the student developed a reflection paper on attainment of learning objectives and developed a policy review paper on the Ryan White CARE Act.

Lessons Learned: HIV-specific SLE courses can enhance medical education by offering a comprehensive learning opportunity in non-traditional community settings. Students should have prior training and experience in HIV and at the community sites to ensure a meaningful experience. Students' roles, expectations and learning objectives should be defined prior to the elective to ensure that they have adequate responsibilities commensurate with their training. Finally, community sites should reflect students' interest and the needs of the community.

CP82

Abstract 2551 - Prevention and Care Programs

Author(s): *Jannette Berkley-Patton, Carole Bowe Thompson, Erin Moore, Starlyn Hawes, Stephen Simon, Leshia Dennis*

Background: Only 45% of African Americans get tested for HIV each year; those who don't know their HIV-positive status significantly contribute to new HIV cases. The Black church is a highly influential institution that has the potential to increase the reach of HIV screening services in African American communities.

Methods: This pilot study examined HIV testing rates among church members and the community members served through church outreach ministries at 4 churches randomly assigned to the Taking It to the Pews (TIPS) HIV education and testing intervention and comparison (non-tailored HIV information) groups in the Kansas City, MO and KS metropolitan area. The study also examined implementation feasibility of: a) the TIPS intervention using religiously-tailored HIV Tool Kit materials/activities (e.g., pastoral sermons, printed/video/in-person testimonials on HIV testing, HIV education games), b) the comparison group's non-tailored HIV information tool materials (e.g., brochures, scripted announcements), and c) church-based HIV testing events by church liaisons at 6 months.

Results: Eight church liaisons (2 per church) delivered 1-2 tools per month. Most frequently used TIPS tools included sermons, brochures/church bulletins, and testimonials. Overall, church health liaisons coordinated a total of 11 HIV testing events over a 12 month-period. The church-based HIV testing events were conducted by the Kansas City Health Department providing rapid HIV tests during church services to increase access to members. Survey data were collected from church and community members (N=543 participants) at baseline, 6 months, and 12 months. Baseline findings indicated most participants were: female (mean age = 45 [SD = 13]), affiliated with their church > 7 years (mean membership = 14 years [SD = 12]), and in the previous 6 months had 1-2 sex partners and did not use condoms consistently. Twelve-month findings indicated TIPS intervention participants were significantly

more likely to receive an HIV test as comparison participants in the last 12 months (59% versus 42%; $p = .0009$). Also at 12 months, intervention participants were significantly more likely to: be motivated to get tested ($p = .001$), believe churches should offer HIV testing ($p = .000$), and feel supported by their pastors to get an HIV test ($p = .029$) compared to comparison participants. Finally, participants were very satisfied with how much HIV information was shared in their churches, how confidentially their results were provided, and the compassion in which church-based testing was provided.

Conclusions/Implications: Findings indicated that churches can increase reach and rates of HIV testing among church members and the community members they serve. Additionally, church leaders can be trained to deliver church-based HIV testing interventions and to coordinate HIV testing events with health agencies. Future expanded studies will assist in understanding feasibility of a scalable, church-based TIPS intervention and its impact on HIV testing rates in African American communities.

CP84

Abstract 2100 - Prevention and Care Programs

Author(s): *Kathleen Jacobson, Sanjay Arora, Sonia Jain, Sheldon Morris, Katya Corado, Michael Dube, Ricky Bluthenthal*

Issue: Social network recruitment may aid in identifying undiagnosed HIV cases. We evaluated the feasibility of social network recruitment and define factors that may aid in more successful recruitment.

Setting: This study was based in a county clinic in Los Angeles California.

Project: The California Clinical Trials Group(CCTG)596 provides a cash incentive to new/ returning to care HIV infected subjects as well as high risk HIV negative individuals to function as Index Peer Recruiters(IPR) to recruit individuals from their social networks for HIV testing (Network tested Subject NTS). We explored \$10 vs \$20 for incentives and recruiting only from existing study subjects vs the same general HIV clinic population.

Results: During the period we recruited from existing study populations we offered \$10 incentive few subjects agreed to participate as index peer recruiters and even fewer network tested subjects(NTS) came in for testing. (4.3 IPR/mo and 1.1 NTS/mo per month).Increasing the incentive to \$20 had a slightly higher enrollment of IPR (6.3, $p=0.4$)but only a small impact on those recruited for testing (NTS 3.3/mo, $p=0.32$). Expanding our Index Peer Recruiter pool from existing study subjects to the same clinics general population in at a Los Angeles County Clinic while maintaining the same \$20 incentive increased Index Peer Recruiters to (9/mo, $p=0.82$)and markedly impacted the number willing to be recruited for testing (17/mo, $p=0.27$).

Lessons Learned: Social network recruitment for HIV testing is somewhat influenced by amount of incentive but highly driven by finding the appropriate recruiter population.

CP85

Abstract 1945 - HIV-Related Policy, Economics, and Program Integration

Author(s): *David Katz, Julia Dombrowski, Elizabeth Barash, Roxanne Kerani, Cheryl Malinski, Gloriosa Afful, David Kern, David Heal, Matthew Golden*

Background: Men who have sex with men (MSM) with bacterial sexually transmitted infections (STI) are at elevated risk for HIV infection, yet only approximately half of such men are HIV tested at the time of STI diagnosis. Offering home HIV tests through STI partner services (PS) has the potential to reach MSM who were not tested as part of STI screening or care.

Methods: In Washington State, HIV testing is an explicit outcome of PS for MSM without a prior HIV diagnosis, and PS interviews are conducted primarily via phone. In December 2012, Disease Intervention Specialists (DIS) in King County, WA, began offering to mail HIV self-tests (OraQuick In-Home HIV Test) or self-collection kits (Home Access) to MSM who had not been tested for HIV at the time of STI diagnosis or treatment and who refused or were unable to attend a clinic for HIV testing after their PS interview. MSM were counseled regarding benefits of clinic testing, test window periods, and positive results. After mailing the requested kit, DIS contacted MSM to determine if they used the test, their test results, and to ensure linkage to confirmatory testing and care for persons with positive tests. We examined uptake and results of home HIV tests using STI PS data.

Results: From November 2012-January 2015, 3525 cases of early syphilis, gonorrhea, and chlamydial infection were diagnosed among MSM without a prior HIV diagnosis in King County, of whom 2770 (79%) were interviewed for PS. Among PS recipients, 2385 (86%) were HIV tested prior to receiving PS and 139 (5%) attended a clinic for HIV testing after the PS interview. Of the remaining 246, 70 (28%) were offered self-tests or self-collection kits, of whom 48 (69%) accepted a self-test and 1 (1%) a self-collection kit; 2 initially requested self-collection kits but had not used them and requested self-tests when DIS contacted them for results. No syphilis cases were offered home tests. Of the 49 men who accepted self-testing or self-collection kits, 1 (2%) reported testing positive, 37 (76%) negative, 10 (20%) could not be reached for follow-up, and 1 (2%) provided a non-working mailing address and the test could not be delivered. The individual with a reactive self-test linked to confirmatory testing and HIV care within 2 weeks of DIS mailing the test. Almost all (94%) of MSM accepting self-tests or self-collection kits reported having previously tested for HIV infection (compared with 98% of clinic testers); however, 20% had not tested in the prior two years.

Conclusions/Implications: Offering HIV self-tests as part of STI PS is a feasible and acceptable method for reaching MSM who would not otherwise test for HIV infection concurrent with their STI diagnosis.

CP86

Abstract 2061 - Prevention and Care Programs

Author(s): *Jared Hemming, Frank Barnett, Jennifer Hecht*

Issue: "Prevention fatigue" is a significant challenge among MSM in their 30s and 40s, as many grew up with HIV as a constant worry. Consequently, limited engagement in prevention activities and a reticence toward communicating with partners about HIV are not uncommon.

Setting: Bridgemen was developed in San Francisco for MSM aged 30-50. Events take place at service locations around the city.

Project: Bridgemen is an adaptation of Mpowerment, with four primary components: 1) service projects, 2) social events, 3) publicity and social norms campaigns, and 4) HIV/STI testing, education, and information.

In order to address prevention fatigue, Bridgemen focuses on community service and social support, with prevention messages carefully woven into each event. Service projects have included serving food to seniors, pulling weeds in parks, and cleaning up the beach. Staff members use creative techniques to ensure that conversations about sex, relationships, and partner communication occur at each event. Social events begin with a small group exercise that engages the participants in open and honest conversations about their sexual health and personal wellbeing. Ad campaigns developed by participants have focused on positive social norms relating to respect and communication.

HIV/STI prevention is included in two ways: one is a subtle and nuanced approach; for example, at beach clean up, staff initiate a game to find used condoms in order to begin a conversation about condom use. The other is through events that are carefully curated to address HIV/STI topics in an informal and comfortable way, usually over dinner conversation (MGroups) or through public forums that are fun and sexually charged like conversations featuring porn stars.

Results: Between 2011 and 2014, 475 men volunteered at service projects, over 2,000 men attended social events, and 320 men participated in MGroups. Among 119 men who participated in our evaluation, primary reasons for joining Bridgemen were to volunteer/give back (n=57) and to meet new people (n=46).

The program had a significant impact on factors that affect participants' HIV risk. Participants reported improvement in the following areas: ease of talking to men (50% of participants), ability to negotiate sex (30%), frequency of HIV/STI testing (40%) and knowledge of acute HIV infection (50%). In each of these areas, the percentage of men who reported improvement increased significantly among those who attended 7 or more events ($p < .05$). Greater than 50% of participants received a referral to additional prevention or care services.

We also measured outcomes related to community belonging and social support. Among the more engaged participants, 80% reported a greater sense of belonging.

Lessons Learned: Designing a program that engages and retains MSM through community service and social events and that skillfully includes HIV prevention has been highly successful in addressing prevention fatigue among MSM aged 30-50. The program has also had incredible success in strengthening community belonging. Programs that seek to engage MSM in HIV prevention should consider prioritizing community building while thoughtfully integrating information, referrals, and positive social norms into their program. Bringing MSM together in a united cause gives men additional support needed to prioritize their health.

CP87

Abstract 1748 - Prevention Research and Implementation Science

Author(s): *Chi-Chi Udeagu, Sharmila Shah, Magalieta Toussaint, Leonard Pickett*

Issue: There are missed opportunities by public health Disease Intervention Specialists (DIS) to interview HIV-diagnosed patients for partner services due to difficulties in arranging mutually favorable place or time for in-person meeting.

Setting: New York City (NYC).

Project: DIS staff in the NYC Department of Health and Mental Hygiene previously were issued smartphones to communicate with patients via email, text or voice-call, and to improve response time regardless of DIS location (clinics/office or field). In October 2013, one DIS was selected to pilot video-call, a smartphone feature that enables patients who refuse in-person meeting to “see who they are speaking with.” During voice-call or video-call, patients are informed that interviews are not being recorded, and that all information is confidential. DIS conducted a brief assessment of patients’ acceptability of video-call after interviews.

Results: From 10/2013-3/2015, DIS interviewed 201 HIV-diagnosed patients. Modes of the 201 interviews were: in-person at clinics (32%) or patients’ residence (32%); voice-call (7%) and video-call (30%). Video-call (59) and in-person interviewed (128) patients did not differ with being HIV-diagnosed (90% vs. 89%) in 6 months prior or black/non-Hispanic race/ethnicity (98% vs. 95%). Compared with in-person, the video-call patients were significantly more likely to be male (75% vs. 52%), men who have sex with men (54% vs. 21%), aged <30 years (64% vs. 23%) and college-educated (47% vs. 16%). Partner services outcomes for video-call were significantly better than for in-person interviews: partners named per patients interviewed) (1.1; [64/59] vs. [0.80; 103/128]; negative/unknown serostatus partners notified (58% vs. 49%); HIV-tested partners (68% vs. 57%), and new HIV-diagnosed partners (27% vs. 19%). Timeliness of patient interviews was comparable or better for video-call (3-median; 7-mean days) than in-person (3-median; 10-mean days). Ten (17%) of the video-calls were during non-business hours/days.

Forty-one percent of the 59 video-calls were initiated by patients. Patients’ locations during video-calls varied: residence (69%), workplace (12%), other locations (19%); 3 video-calls were with patients outside the United States (2) or NYC (1). Devices used by patients for video-calls included: smartphones (54%), laptops/personal computers (31%), tablets (15%); 95% of patients used Skype Internet platform. Most patients cited privacy concerns as reasons for choosing video-calls: not being seen with (90%) or visited at home (83%) by DIS; and 59% found it time-saving compared to travel-time for in-person meeting with DIS. All video-call interviewed patients found video-call acceptable and reported communicating with their family/social network via video-call daily or several times/weekly; 98% would prefer all future communication with DIS via video-call. DIS conducted video-call interviews while at home (39%), or in field locations (61%). DIS preferred video-call over voice-call due to ease of patient verification (“face-time”) as with in-person interviews and video-calls saved travel-time and lessened safety concerns for the DIS.

Lessons Learned: Early results indicate patient and DIS preference for video over voice-calls, especially in addressing privacy and safety concerns or time constraints. Video-call yielded comparable or better program outcomes as in-person interviews.

CP88

Abstract 1324 - Prevention and Care Programs

Author(s): *Linda Beer, Luke Shouse*

Background: Federal guidelines for HIV prevention have long recommended delivery of partner services (PS) to persons newly diagnosed with HIV. Surveys of health departments, HIV care providers, and HIV testing events suggest that delivery of these services is low, but there are no national estimates of how many persons are offered PS or of their acceptance.

Methods: The Medical Monitoring Project (MMP) conducts clinical and behavioral surveillance among a representative sample of HIV-infected adults receiving medical care in the United States. Using weighted MMP data collected 6/2009-5/2012 from 2,833 adults diagnosed with HIV in the past five years, we describe the prevalence of access to and acceptance of PS. We used bivariate logistic regression to identify characteristics associated with each outcome. We also examine reasons for not accepting PS among those who were offered PS.

Results: We estimate that 61% of patients were offered PS at the time of their HIV diagnosis. Hispanic women (48%), persons aged 40-49 (55%), and those who received their HIV test result in a private doctor's office (54%) reported being offered partner services less often than others. Of those offered PS, 46% asked for PS for all of their partners, 8% asked for PS for some of their partners, 34% refused PS for all of their partners, and 12% said they had no partners. Among persons offered PS who had partners, acceptance of PS for some or all partners was lower among white men (51%), and those with a gay or bisexual identity (56%), more than high school education (58%), and who received their HIV test result in a private doctor's office (54%). Among those who refused PS for all of their partners, the most common reason for refusal was that they wanted to tell their partner(s) personally (75%), followed by not knowing their partners' contact information (9%).

Conclusions/Implications: PS are essential prevention tools that can reduce HIV transmission and morbidity, and guidelines recommend they be available to all HIV-infected persons. However, we found that too few recently diagnosed persons with HIV were offered PS, and only a little over half of those who were offered PS accepted PS. Efforts may be needed to establish structural supports that allow for better coordination between providers of PS and private doctors. Given high HIV incidence among gay/bisexual persons, more information about the benefits of PS may be needed among this group. Although the most common reason for refusing PS was that the person wanted to tell their partner(s) about the possibility of HIV exposure personally, persons offered PS may also need to be informed about the other benefits of PS beyond HIV exposure notification. For the infected person's partners, these include access to HIV and STD testing, prevention services, medical care, and social services. Persons offered PS can also be informed that PS may benefit the wider community by providing a targeted means of disrupting HIV transmission chains and ensuring that the health benefits of early treatment are available to all those in need.

CP91

Abstract 1264 - Prevention and Care Programs

Author(s): *Puja Seth, Guoshen Wang, Lisa Belcher*

Background: In the United States, there are more than 1.2 million people living with HIV, of whom approximately 14% are not diagnosed. CDC recommends routine HIV screening in healthcare settings where prevalence is $\geq 0.1\%$, for all persons aged 13-64 years. In addition to identifying new HIV-positive persons, increased testing efforts have resulted in re-testing among previously diagnosed HIV-positive persons. Incentives, such as cash or gifts, offered through HIV testing programs may prompt HIV-positive persons to get re-tested. Additionally, some HIV clinics require documentation of a recent positive test result for clients to be enrolled into care. HIV testing and linkage to HIV medical care among previously diagnosed HIV-positive persons were examined to evaluate HIV testing programs on addressing the needs of previously diagnosed HIV-positive persons.

Methods: Data were submitted by 61 health department jurisdictions in 2013. CDC-funded HIV testing, HIV positivity, self-report of HIV status, if previously tested, and linkage to HIV medical care were described by client characteristics. Because of missing data, a range is presented representing the minimum and maximum percent achieved for linkage. Data to identify gay, bisexual, and other men who have sex with men (collectively referred to as MSM) are required data variables in non-healthcare settings and for HIV-positive persons only in healthcare settings.

Results: In 2013, CDC funded 3,343,633 HIV testing events, of which 28,682 (0.9%) were HIV-positive testing events. Of those, 8,561 (29.8%) were previously diagnosed HIV-positive persons, for a positivity of 0.3%. Only 401 (4.7%) reported already being in HIV medical care. After excluding those who reported being in HIV medical care, 63.0%-83.2% were linked to medical care within any timeframe, and 45.0%-87.1% were linked within 90 days. Previously diagnosed persons accounted for 29.4% of the HIV-positive tests among whites, 30.0% among blacks/African Americans, and 30.2% among Hispanics/Latinos, with 4.8%, 4.5%, and 5.7% reporting already being in care, respectively. In terms of linkage, 49.3%-91.5% of whites, 37.9%-82.0% of blacks/African Americans, and 60.0%-90.3% of Hispanics/Latinos were linked within 90 days. When examining target populations, previously diagnosed persons accounted for 22.8% of the HIV-positive tests among MSM, 25.7% among heterosexual men, and 29.1% among heterosexual women, with 5.3%, 4.3%, and 5.3% reporting already being in care, respectively. Additionally, 58.8%-85.2% of MSM, 55.0%-86.6% of heterosexual men, and 55.9%-87.1% of heterosexual women were linked within 90 days.

Conclusions/Implications: Approximately one-third of HIV-positive testing events were among persons who were previously diagnosed. However, less than 5% of these persons reported already being in HIV medical care. Linkage to HIV medical care is important, including among persons who may already know their HIV status because they were either never linked to HIV medical care or need to be re-engaged into care. The current findings suggest that linkage could be improved among this group. These findings also highlight the need for better understanding of the reasons for previously diagnosed individuals to re-test and for programs to ensure that all HIV-positive persons are linked into HIV medical care and receive other HIV prevention services.

CP92

Abstract 1377 - Prevention and Care Programs

Author(s): *Kathleen Irwin, R Luke Shouse, Jill Huppert, Andrew Margolis, Michele Owen*

Issue: Prompt linkage to HIV medical care hastens initiation of lifesaving antiretroviral treatment (ART) and reduces the risk of HIV transmission. Linkage to HIV care can be delayed when HIV testing providers do not provide linkage assistance or persons with HIV face barriers to care such as lack of health insurance, limited health system navigation skills, poverty, or mental illness. Delays in reporting or recognizing cases of early HIV infection that are most infectious may also delay valuable linkage assistance from HIV testing providers and health department staff.

Setting: During 2014, the Centers for Disease Control and Prevention (CDC) issued 3 evidence-based guidance documents that describe policies that can enable or expedite linkage to HIV care in the United States. These guidance documents are directed to laboratories, clinical providers, and nonclinical providers who provide HIV testing and/or patient navigation services; and health department staff who conduct HIV surveillance or offer disease investigation services.

Project: We analyzed these policy documents for guidance that can enable or expedite linkage to care.

Results: 2014 recommendations for laboratory HIV testing advise routine use of an algorithm that includes new combo antigen/antibody and nucleic acid tests that can detect HIV infection before HIV antibody response is fully developed. This algorithm can hasten the recognition of persons with acute infection who have extremely high viral loads, may be highly infectious, and may warrant expedited assistance with linkage to health facilities where ART and other clinical and preventive services are offered. The 2014 Revised Surveillance Case Definition for HIV infection added a new stage of HIV infection, stage 0, that indicates early infection based on the new testing algorithm. Routine monitoring of stage 0 cases can facilitate recognition of case-patients with early infection who may warrant expedited linkage assistance by health department staff. CDC's 2014 guideline for HIV prevention with persons with HIV recommends that HIV testing providers use proactive methods to link persons with preliminary or confirmed positive HIV tests to HIV medical care, aiming to start HIV care as soon as possible but no later than 3 months after diagnosis. Several resources support implementation of these recommendations. These include standard language for reporting results of preliminary and acute HIV test results; protocols and summaries of best practices for using HIV surveillance data to monitor cases with early infection; and compendia of effective, evidence-based interventions to provide appointment scheduling, transportation, or other navigation assistance and motivate persons to start HIV care. CDC also supports training of health department disease intervention specialists to expand their skills in providing linkage assistance.

Lessons Learned: New federal guidance and implementation resources provide a policy framework and practical tools that can enable or expedite linkage to HIV medical care. Through close collaboration, clinical, nonclinical, and public health professionals can put this new guidance into practice, improve the health and longevity of persons with HIV, and reduce their risk of HIV transmission.

DP02

Abstract 2131 - Partnerships, Community, Communication, and Mobilization

Author(s): *Michelle Scavnick, Michael Ruppel, Mara Michniewicz*

Issue: Scientific findings continue to emphasize the effectiveness of pre-exposure prophylaxis (PrEP), a strategy for people who don't have HIV to prevent HIV infection by taking a pill every day. Given the recent media attention of the drug, PrEP has become a hot topic around the country. In 2014, the Centers for Disease Control and Prevention issued guidelines on the use of PrEP for the prevention of HIV infection in the United States. Although the effort was to help support health care providers, there appears to be a major gap in knowledge and understanding of PrEP and information still needs to be distributed widely to ensure providers as well as the community have the most up-to-date facts about PrEP.

Setting: The AIDS Institute, in partnership with The Florida Department of Health (DOH) began working together to conduct a series of strategies that led to the development of a strategic plan for guiding implementation of specific biomedical interventions in Florida. Ultimately, the strategic plan will assist health care providers with implementation of PrEP and nPEP in Florida.

Project: The AIDS Institute (TAI) initiated a multi-level implementation and integration research project to review and assess biomedical and prevention research, including PrEP and non-occupational post-exposure prophylaxis (nPEP). Stakeholders began working on a series of strategies that lead to the development of a strategic plan for guiding implementation of specific biomedical interventions in Florida. The project was developed with the idea of other states being able to use the resulting plans as models to adopt in their states.

The AIDS Institute worked closely with DOH and key leaders to identify the right diversity of the key stakeholders. The stakeholders were engaged in multiple opportunities for education, data analysis, best practices, guidelines, and resources. They also committed to identifying people to "bring to the table" and through this project grew a network of consumers, providers, researchers, public health, insurance companies, public & private payers, and advocates.

Results: Participants will learn how they identified and worked closely with key stakeholders on the development of a strategic plan for guiding implementation of specific biomedical interventions in Florida. Participants will engage in discussion with presenters around barriers and other strategies used in the process that should be applicable to their areas or states. The presenters will discuss the planning, engagement, development and implementation phases of the multi-level research project and review a copy of the strategic plan that was developed.

Lessons Learned: The participants of this session will be provided the opportunity to review the process and steps taken, the products developed such as: PrEP/nPEP toolkit; presentations; resource materials; and other materials that would be useful to organizations or states looking to provide guidelines, clarify or education.

As a result of this session, participants will learn about The AIDS Institute's multi-level research project strategies that led up to the development of a strategic plan to guide implementation of specific

biomedical interventions, including PrEP and nPEP in Florida and how they can replicate these strategies in their respective areas.

DP03

Abstract 1699 - Partnerships, Community, Communication, and Mobilization

Author(s): *Brooke Montgomery, Alexandra Marshall, Nickolas Zaller, Sharon Sanders*

Background: Survivors of violence have higher rates of mental and physical illness, substance use, revictimization, poverty, and STIs including HIV. However, few HIV prevention interventions have been designed and tested to reduce sexual risk among survivors with unknown or negative HIV status. This leaves community-based agencies that serve this population without evidence-based interventions for their clientele.

Methods: This focused-ethnographic study examined qualitative data collected in 2013 from 33 purposively-selected community stakeholders from statewide agencies that advocate for or provide services to survivors of violence or populations who are disproportionately burdened by violence. Participants completed an online survey and an audio-recorded interview. Hour-long interviews focused on identifying ways community agencies could empower themselves around delivering HIV prevention services to survivors, expanding their role in HIV prevention efforts, identifying barriers and facilitators to HIV prevention among survivors, and developing sustainable participatory approaches to improving HIV prevention among survivors. The lead author conducted all interviews using a semi-structured interview guide. Interview data were transcribed verbatim and analyzed using constant comparison and content analysis.

Results: After reaching consensus on codes among the study team, 3 themes with accompanying codes emerged from the data. The first theme “intervention concerns” consisted of 2 factors: assessing readiness to participate and avoiding revictimization. Enthusiasm about HIV prevention for survivors was dampened by concern regarding the risk of potentially traumatizing the participants through the use of traditional sexual-risk reduction (SRR) approaches. Creating a program that taught trauma-informed SRR and thoroughly assessed readiness to participate were believed to be ways to reduce risk of revictimization. The second theme “intervention content” included 5 factors: (re)establishing self-esteem and power, teaching healthy sexuality, achieving trauma-informed SRR, building multiple types of skills, and the long-term impact of surviving violence. Despite concerns, all interviewees agreed there was a need for HIV prevention among survivors and that these efforts had to equip participants with new skills including negotiation, refusal, communication, relationship, parenting, condom use, and trauma-based coping skills. The third theme “intervention structure” included 5 factors: one-stop shop, intervention facilitator characteristics, assess personal needs to create individualized intervention goals, optional disclosure of personal narrative, and secure facility in a neutral location. A coordinated comprehensive long-term response to victimization that included HIV prevention and was located in a safe non-stigmatizing easily-accessible location (e.g., library or clinic) was believed to be ideal (i.e., the one-stop shop). Interviewees viewed STI and HIV testing as essential components and state-mandated partner notification as a necessary evil.

Conclusions/Implications: Findings suggest that appropriate adaptation of existing evidence-based HIV prevention interventions is necessary to address the specific needs of survivors, reduce the risk of revictimization, and expand the HIV prevention efforts of community stakeholders working with survivors. Data also revealed important recommendations for interventionists planning SRR interventions with similar populations. Intervention design implications, challenges, and future research are discussed.

DP04

Abstract 2404 - Partnerships, Community, Communication, and Mobilization

Author(s): *DaShawn Usher, William Nazareth Jr., Jonathan Paul Lucas*

Issue: Depending on the agency, funding, and staff, most organizations do not have the systems to fully support innovative health communication efforts. Understanding that people receive information in different ways is important to understand the benefit of visual media and live events. Our greatest effort to increase awareness, education, and advocacy around HIV/AIDS related issues is to utilize social media platforms that are both entertaining and informative. In addition to social media utilization, it is important to have live events and bring relevant educational events to underserved and underrepresented communities.

Setting: This workshop will educate participants in creating events, videos and photo campaigns to expand their current community mobilization, advocacy, and awareness reach. Participants will learn about the benefits of using entertaining programs to engage patients in a discussion about biomedical HIV prevention, risks and sexual behavior in clinical setting and non-traditional venues. Attendees will be encouraged to join in dialogue about the benefits of visual media as a prevention tool. By providing timelines, costs, and overall reach, participants are expected to have learned how they can replicate similar content in their respective communities locally.

Project: Vaccine-O-Licious, Do You Swallow?, #TrustYourImpulse, #SexPrEP Love, #SexLubeLove are just some of the innovative community education event efforts that the New York Blood Center's Project ACHIEVE and partner agencies have conducted over the years. These annual and newer events have reached thousands of gay men where they are... in bars, lounges, clubs, and social media raising awareness about PrEP, PEP, HIV vaccines, microbicides, treatment, and prevention in non-traditional ways. Lights, Camera, Action! Callen-Lorde, an LGBT Community Health Center, has CTV, a unique channel tackling various health issues and concerns through a growing collection of individual shorts, public service announcements, commercials, and short episode mini-series.

Results: In 2014 three live events took place in NYC, reaching 90 – 200 people. All events utilized social networks and social media. For the two Black Gay Twitter After Dark series the average exposure for the chats exceeded over 500,000 impressions and reached almost 40,000 twitter accounts in one hour. CTV's original content videos are viewed and screened in the community clinic's waiting room area, reaching several 100 clients daily and over 14,000 annually, as they wait for their appointments.

Lessons Learned: Each live event, twitter chat, and CTV content was successful in disseminating information and bridging the gap of between research and reality, especially in the Black gay

community. Having a collective impact on community engagement opens the door for facilitation of discussions around new ways to prevent HIV and other health disparities. Advocates are bringing the conversation to the kitchen table, to brunch, to the bars, waiting areas, and online.

DP05

Abstract 2417 - Partnerships, Community, Communication, and Mobilization

Author(s): *Catherine McCarthy*

Issue: Following a 2008 evaluation by the District of Columbia of the city's rapidly rising HIV/AIDS rates showed that the city was facing epidemic levels of infection with more than 3 percent of residents living with HIV.

Setting: In 2008, the DC Department of Health, HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) partnered with Octane Public Relations and Advertising (Octane). Together, these organizations developed strategic social marketing campaigns targeting demographics at the highest risk for HIV in DC.

Project: In 2014, HASTA and Octane conducted a survey of DC residents to gauge the visibility and effectiveness of the DC Takes on HIV (HIV awareness), Ask for the Test (HIV testing) and Rubber Revolution (condom use) campaigns. The purpose of the study was to determine if campaigns were visible by and resonating with target demographics in the city's eight wards, and if residents demonstrated the change in health behaviors promoted by the campaigns' messaging.

Results: The study found that the three campaigns assessed had high visibility throughout the city, with 44% recalling DC Takes on HIV, 39% recalling Ask for the Test, and 14% recalling Rubber Revolution (the last campaign being the newest and marketed for under half the time span of the first two campaigns). Behaviors were positively influenced by the campaigns, with more than half (55%) of respondents reporting that the campaigns made them think about getting tested for HIV, and 27% reporting they got an HIV test as a direct result of the campaign. More than one in four respondents (28%) reported that they used condoms more frequently. In terms of tactics, transit and TV ads were the most recalled channels across all three campaigns, with approximately one-third of respondents recalling both Rubber Revolution and Ask for the Test TV commercials, and as much as 44% recalling transit ads (Ask for the Test).

Lessons Learned: Overall, we learned that transit ads and TV commercials are the most effective platforms for campaign messaging in terms of both reach and recall, and instigating behavior change. We also learned that residents are exponentially more likely to recall messaging from brick-and-mortar or TV platforms over digital platforms (websites and social media). These results are leading to responsive shifts in our social marketing strategies, including more frequent refreshes of TV and transit creative, and emphasizing social media tie-ins to events and ad campaigns. Overall, we know that we can and will ask DC residents to step up their efforts to prevent HIV on a personal level. When we ask residents to learn more about their risk for HIV, get tested, and use condoms, they rise to the challenge.

DP07

Abstract 1341 - Partnerships, Community, Communication, and Mobilization

Author(s): *Antonio Ochoa*

Issue: High impact prevention solicits scalable and cost effective mediums to deliver HIV prevention, education, and awareness to priority populations. Given the multi-marginalization of high risk Hispanic populations, reaching them with HIV/AIDS messaging in a targeted, scalable, and cost effective manner, is often difficult to materialize and measure.

Setting: National Latino AIDS Awareness Day (NLAAD), an annual national social marketing and community mobilization effort, engages 250+ partners in organizing local events while delivering national HIV/AIDS health messaging to Hispanic/Latino communities. Pews Internet Research estimates 73% of online Hispanics utilize Facebook, a web-based social networking platform. Given Hispanics' level of engagement on Facebook, it was considered an ideal medium to deliver the national targeted HIV/AIDS messaging component and solicit individual level action.

Project: The Hispanic market/population was segmented into six sub-markets: 1) Spanish-dominant Hispanic women over age 35; 2) English-dominant Hispanic women over age 35; 3) Spanish-dominant Hispanic men over age 35; 4) English-dominant Hispanic men over age 35; 5) Spanish-dominant Hispanics between the ages of 13 and 35; and 6) English-dominant Hispanics between the ages of 13 and 35. Six custom Facebook advertisements were developed, one for each segment, and delivered by filtering outlined criteria (Hispanic, language dominance, sex, and age) within the 50 United States and Puerto Rico. Utilizing Cost-per-click versus impressions, the ads ran for one week leading up to NLAAD, October 15. The ad campaign objective was to reach at least 500k Hispanics and garner 10k unique clicks to the NLAAD website, across all six Hispanic segments, by October 15th.

Results: By October 15th, all six ads reached a total of 661,704 unique people with 9,584 total unique clicks to the NLAAD website. Impressions, the number of times the ads were served, totaled 1,102,017 with 11,005 total clicks. Unique click through rate (uCTR), the number of people who clicked on the ads divided by the number of people reached, was utilized as a secondary metric. Spanish-dominant women above the age of 35 showed the highest uCTR at 1.582% compared to 0.999% uCTR across all ads. The U.S. Hispanic market had a uCTR of 0.943% compared to 0.640% for Puerto Rico. Furthermore, the ads drove 8,150 actions, which included sharing post, Facebook page likes, posts likes and comments. In comparing actions across all six ads/segments, English-dominant youth (13-35) was highest at 1,388 actions. All data was collected, filtered, and analyzed using Facebook insights.

Lessons Learned: Developing a clear and realistic social marketing objective enhance the strategy's success. Facebook user algorithms easily lend themselves to define and segment populations for delivery of customized messaging to priority markets. Ad campaign findings, including ad placement and device utilized (desktop versus mobile), provide an opportunity to enhance future HIV/AIDS messaging and delivery. Using Facebook user interests to find correlations between risk behavior and/or specific social networks, should be leveraged to refine targeting high risk populations.

DP09

Abstract 1843 - Partnerships, Community, Communication, and Mobilization

Author(s): Heather Bronson, Ambrose Delpino, Fatima Elamin, Glen Pietrandoni, Ashley Samoila

Issue: The Virginia Department of Health, Division of Disease Prevention (DDP) strives to make HIV testing available in as many venues and to as many people as possible, and Walgreens is committed to offering solutions to help end AIDS. Virginia faces unique geographic challenges that require individuals to travel long distances for free HIV testing services, limiting the opportunities for HIV testing for many Virginians. Another major barrier to HIV prevention is the high level of stigma around HIV testing, especially in rural areas of the state. To increase access to HIV testing and reduce stigma, DDP entered into a partnership with Walgreens in 2013 to provide free HIV testing at select Walgreens pharmacies in Virginia.

Setting: DDP used geo-mapping tools and census data to identify areas of high minority and high poverty where HIV testing services have previously been limited. DDP and Walgreens selected 33 Walgreens stores within these priority areas in an attempt to make HIV testing available in areas that have historically been underserved. The priority areas for the selection of Walgreens stores include rural and urban localities in Virginia's five health regions, and HIV testing at Walgreens is available for anyone over the age of 18.

Project: Virginia's approach for pharmacy-based HIV testing focuses on increasing the accessibility of HIV testing and reducing stigma around HIV testing. Through a partnership with Walgreens, DDP launched a pharmacy-based HIV testing program under the Secretary's Minority AIDS Initiative Funding for Care and Prevention in the United States (CAPUS). DDP collaborated with the Virginia HIV/AIDS Resource and Consultation Centers (VHARCC) to develop a training curriculum for Walgreens pharmacists on the one-minute INSTI rapid test. The curriculum covers the HIV rapid test technology, quality assurance, delivery of results, active referral for confirmatory testing and other services, form submission, and data collection. Support is available for pharmacists 24/7 through a DDP-operated Pharmacist Hotline. HIV testing is advertised at participating Walgreens through in-store radio and print advertisements.

Results: As of April 2015, over 50 pharmacists have been trained to provide HIV testing at 13 Walgreens pharmacies throughout Virginia. A total of 1,224 individuals have been tested through the pharmacy-based program with 11 reactivities identified by Walgreens pharmacists. After a second expansion, scheduled for June 10, 2015, HIV testing will be available at a total of 33 Walgreens stores and over 130 pharmacists will be trained by VHARCC.

Lessons Learned: The availability of HIV testing alongside vaccines and other health services provided by pharmacists is helping to reduce the stigma around HIV testing. The per-test reimbursement for Walgreens represents a 76.2% reduction compared to the per-test reimbursement for traditional community HIV testing through CAPUS. The partnership with Walgreens proves to be a cost effective strategy to increase the availability of HIV testing and stigma reduction in rural and urban regions of Virginia.

DP10

Abstract 1768 - Partnerships, Community, Communication, and Mobilization

Author(s): *William Cabal II, Maura Riordan, Vignetta Charles*

Issue: The Southern region of the United States is experiencing an unprecedented burden of HIV disease. Indeed, nearly half (49%) of all new HIV diagnoses (at any state of disease) occur in the South. This is happening despite the fact that the Southern region accounts for only 37% of the total U.S. population. Many HIV-positive Southerners face an array of competing challenges in their day-to-day lives, including poverty, low education levels, persistent HIV stigma, racism, and lack of access to insurance and specialized HIV care. All of these barriers to receiving the treatment and support they need and result in poor health outcomes along the continuum of care. Not only are Southerners more likely to acquire HIV, they are dying at higher rates too.

Setting: AIDS United's Southern REACH initiative is focused on building coalitions among community-based organizations working in the HIV prevention field or another related field (such as sexual and reproductive health) that are located in the southern U.S. and includes Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia.

Project: AIDS United's Southern REACH initiative helps build stronger collaborations and coalitions in the southern U.S. through grantmaking, technical assistance, annual meetings, and webinars. Grantees work strategically together around important advocacy issues within their respective states. The combination of funding, technical assistance, and opportunities to collaborate have increased the success of those coalitions with tangible, progressive policy changes and a regional network of advocates that works to prevent harmful policies and practices from existing. The driving focus of the initiative is to ensure that Southerners living with HIV have unfettered access to care and prevention education and tools.

Results: A number of successes have occurred because of the assistance Southern REACH has provided in building networks in the South. Laws have been created or changed in both North Carolina and Louisiana as a result of Southern REACH work. A group of harm reduction organizations that are located in Georgia, Louisiana, and North Carolina came together to create an annual conference centered around harm reduction in the South. North Carolina has a very successful advocacy network that engages tens of thousands of individuals in the state each year. Multiple grantees are involved in advocacy focused on bringing comprehensive sex education into Southern schools. There are many more examples improved policies, coalition infrastructure and access to care and prevention for Southerners living with HIV.

Lessons Learned: Unique challenges exist in the South, but through this initiative the key lessons learned include:

- Southern problems must be tackled with Southern leadership to be effective and sustainable.
- An intersectional framework that takes poverty and race into account must be utilized to truly address HIV care and prevention issues effectively
- Progress can be made in the policy arena where it may seem hopeless initially due to entrenched HIV stigma.
- A regional network approach leverages resources and effectiveness in areas where there is very little support or infrastructure to make meaningful policy change.

DP11

Abstract 1299 - Partnerships, Community, Communication, and Mobilization

Author(s): Allison Friedman, Karen Schoneman, Booker Daniels, Julie Banda

Background: African Americans are disproportionately affected by HIV and other STDs. Yet to date, few efforts have focused on heterosexual men, who may play a critical role in preventing the sexual transmission of HIV. Formative research with this audience suggests that a positive, holistic approach to prevention efforts is desired. We sought to develop and test scientifically accurate, plain-language, audience-centered messages for sexually active heterosexual African-American men (ages 18-30), with potential for reaching men who have sex with men (MSM) as a secondary audience. Campaign messages were intended to support a positive sexual-health approach, with the goals of promoting (1) increased condom use, (2) healthy relationships (3) HIV/STD testing and other sexual-health services, and (4) open partner communication.

Methods: A 20-minute online survey was used to test sample Facebook messages (n=14), headlines (n=13), posters (n=2) and slogans (n=5) for appeal and effectiveness, and to assess online sexual-health information seeking behaviors and preferences. All questions were closed-ended, in multiple-choice or Likert-scale formats. Participants were recruited through a professional research firm using an online survey panel. Descriptive statistics were run for participant demographic data and message receptivity responses. Differences in message receptivity between demographic segments were analyzed using Wilcoxon rank-sum tests and Kruskal-Wallis H-tests.

Results: A total of 246 African-American men, primarily single (68%), completed the online survey. Most (90%) reported having sex only with women; 10% reported having sex with men in the last year. Most (69.1%) reported reading online articles about health, sex and relationships daily, weekly or monthly; nearly half reported completing quizzes (49.2%) or sharing related posts (45.6%) as frequently. The overall preferred tagline for a campaign was Your Health is Your Power. Most Facebook messages captured audience attention (69-90%), made participants think about the intended sexual-health objective (65-90%), and were reported to prompt sharing or click-throughs (50-70%). Sample headlines also tested well, with most respondents indicating that they would likely click to read the article (65%-85%) and share it (51%-65%). Headlines that used a "Did You Know" or "Tips/How-To" approach and those that offered insight into women's desires/thoughts seemed to be more successful in engaging audiences. Most men reported that such a sexual-health campaign was important (76.8%) and informative (57.7%); many also felt it was necessary (42.3%) and motivating (31.7%). Segmentation differences emerged by age, relationship status, region, socioeconomic status and sex of sex partners.

Conclusions/Implications: African-American men are seeking sexual-health information and resources online, providing an opportunity to reach them with desired content for behavioral prevention through online and social networking platforms. Men responded well to prevention messages using a positive, holistic approach that were light, fun, and conversational in tone and appealed to their needs and wants. Messages have been packaged into a toolkit for partner use, to enhance public health capacity for promoting sexual-health equity among young African-American men. This toolkit will be previewed during presentation.

DP12

Abstract 1601 - Partnerships, Community, Communication, and Mobilization

Author(s): *Stacey Wilking, Demetre Wilking Daskalakis, Adriana Andaluz, Patricia Abshier*

Issue: On June 29, 2014, New York State Governor Andrew Cuomo released a plan to end the epidemic in his state by 2020, supported by 3 evidence-based strategies: 1) Identifying persons with HIV who remain undiagnosed and linking them to health care; 2) Linking and retaining persons diagnosed with HIV to health care and getting them on antiretroviral therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission; and, 3) Providing access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative. The NYC Health Department has many existing and novel initiatives that support Governor Cuomo's plan. One important domain is the leveraging of community relationships and resources to align them with this plan.

Setting: The NYC Health Department has organized a series of summits with key stakeholders to reinvigorate efforts toward an AIDS-free NYC. Three separate summits were held with LGBTQ-focused agencies—the first among agencies that do not include HIV/AIDS-issues in their mission; the second with agencies that have HIV/AIDS-focused missions; and lastly, one that will include both groups and funders for LGBTQ issues.

Project: The NYC Health Department hosted three summits to re-energize the fight to end the AIDS epidemic. The first summit was conducted on January 15, 2015; the second on March 24, 2015; and the third will be held in June of 2015. The purpose of these summits is to facilitate linkages between LGBTQ-focused agencies and HIV prevention and care focused agencies, and foster active collaborations among agencies committed to ending the epidemic. The majority of attendees at the first summit were not directly engaged in HIV-related work. Participating agencies either provide ancillary services to LGBTQ community members (education opportunities, housing services, counseling, career resources, etc.) or are advocacy-focused. Facilitated discussions among attendees generated common themes. One major theme that emerged was the need to increase collaborations and the desire to form strategic alliances with HIV/AIDS service providers. This theme was echoed at the second summit among HIV/AIDS service organizations. The goal of the third summit is to foster new alliances and working relationships among agencies from the first two summits as well as inspire new funding opportunities that will allow both groups to expand their HIV-related work.

Results: Agencies committed to ending the epidemic were asked to sign the LGBTQ Be HIV Sure Coalition pledge. Over 50 agencies have signed the pledge, with more expected. Additionally, agencies will form an Executive Committee to continue this initiative, independent of the Health Department.

Lessons Learned: Creating and fostering relationships among diverse communities provides a unique opportunity for health departments. By bringing community organizations together to leverage their strengths and work collaboratively, health departments have the ability to empower both HIV/AIDS and LGBTQ-focused agencies to provide effective, culturally competent HIV/AIDS services to individuals most at risk of contracting and/or transmitting HIV. The NYC LGBTQ Health summits can be replicated by other health departments and used as a tool in their efforts to end the epidemic.

DP14

Abstract 2067 - Partnerships, Community, Communication, and Mobilization

Author(s): *Roberta Laguerre-Frederique, Clint Steib, Susan Thompson*

Background: Despite recommendations for routine HIV testing and the prevalence of acute HIV among youth, pediatric and adolescent Health Care Providers (HCP) have been slow to adopt routine HIV testing in practice. HIV Providers may serve a role in improving testing rates through peer influence.

Methods: HCP from a pediatric/adolescent HIV program provided HIV testing and linkage to care trainings to HCP serving youth in two formats: small group office staff presentations and large group “grand rounds” presentations. Outcome variables were set at delivery of curriculum to providers, satisfaction with delivery of information, improvement in knowledge with delivery and referral of new positives to the clinic (as a marker of improved HIV testing). Presentations were didactic, with case studies illustrating differentiation of testing modalities and a review of acute HIV. HCP were given a tool kit to help implement testing and provided phone consultation afterwards.

Results: Curriculum was delivered to 265 HCP, over a 12 month period. HCP satisfaction overall was 4.5 with highest grades being 5 and lowest 3 for quality of program. Pretesting showed low knowledge on routine HIV testing and providers seeking support from HIV experts, with improved HIV knowledge and willingness to seek support from HIV experts after presentation. Six new positive patients were referred to the clinic from HCP attending the sessions.

Conclusions/Implications: Significant gaps in knowledge exist among HCP and are filled with educational efforts. Presentations are well accepted and HCP indicated attitude change. Limitations include not being able to measure the behavior change by HCP and while referrals increased, this may have been changes in referral patterns rather than a net increase in testing.

DP15

Abstract 2162 - Partnerships, Community, Communication, and Mobilization

Author(s): *Julio Roman, Kyshief DeGraffenried*

Issue: Presenting Author Roman, J.C; North Jersey Community Research Initiative (NJCRI)
Co-Author, DeGraffenried, K; North Jersey Community Research Initiative

Young Men Who Have Sex With Men(YMSM)of Color faces numerous service gaps, including: a shortage of providers who can access the target population and test them for HIV; a shortage of providers who can link and retain the target population in HIV medical care and ART; a shortage of providers who provide ART and monitor viral load; and a shortage of providers who provide treatment for common co-morbidities such as mental illness and substance abuse.

Numerous factors place the target population at high risk for acquiring or transmitting HIV infection; these factors include concurrent risk transmission with other diseases (e.g., STDs, viral hepatitis, and TB), and social and environmental characteristics, as follows. The target populations are at high risk for

HIV due to low perceptions of risk, rising transmission rates of HIV, and a lack of knowledge of one's HIV/STI/HCV status. Risk factors among YMSM include:

- 1) high HIV prevalence in YMSM of color, which is exacerbated by unprotected sex—from 2008-2011, YMSM aged 13 -24 had the greater percentage increase in diagnosed infections (26%) and 93% of YMSM diagnosed HIV infections were from unprotected sex ;
- 2) the MSM “Syndemic,” a cluster of associated epidemics that increase the likelihood of HIV infection in MSM, including substance abuse, partner violence, depression, childhood abuse, severe mental illness, and homelessness;
- 3) lack of knowledge of HIV status: the vast majority of YMSM infected with HIV are unaware of their status, especially African-American YMSM; 4) Low perception of risk for HIV:

Setting: Project WOW! (Web Outreach Works), is a LGBTQ drop center and "Cyber Café" in the Northern NJ/ Tri-state area which has developed effective online outreach and education strategies through 15 years of service. Project WOW provides HIV testing, linkage to care and treatment services, individual & group level interventions like CLEAR and Mpowerment.

Project: WOW focuses on the YMSM population and their risk for HIV/STD infection, promotes testing and linkage to care and treatment while addressing stigma and the whole self. Project WOW utilizes innovative social media based approaches to improve engagement, retention and health outcomes of underserved, underinsured, and hard-to-reach youth and young adults in HIV primary care and supportive services. Specifically, Project WOW will use a range of social media and online/mobile platforms to increase access to and retention in care and viral load suppression.

Results: From July 1,2013 to June 20,2014 a total of 3,667 YMSM were outreached too, 772 accessed Prevention Services. 621 accessed Mental Health and Addiction services. 192 YMSM tested for HIV with 123 YMSM previous and newly diagnosed accessing Primary Ryan White Medical Care. 21 YMSM engaged in Prevention with Positives Intervention.

Lessons Learned: There great benefit and outcomes to creating and delivering engaging highly creative marketing materials as it pertains to prevention, care and treatment services with the YMSM of color population.

DP16

Abstract 1809 - Partnerships, Community, Communication, and Mobilization

Author(s): *Betsy Cashen, Melissa Morrison, Mia Boozer-Sharp, Josh Robbins*

Issue: According to the 2013 incidence data, 58% of new HIV diagnoses in Tennessee were among MSM and of the new diagnoses among MSM, 69% were under 34 years of age.

Setting: Thrive^615 was a collaboration of United Way of Metropolitan Nashville, the Tennessee Department of Health, local HIV organizations, and stakeholders within the HIV community.

Project: In an effort to reach out to the Lesbian, Gay, Bisexual and Transgender (LGBT) community in and around the Nashville area, the Middle Tennessee Men who have Sex with Men (MSM) Taskforce

formed a planning committee in an effort to design an event specifically tailored to this community. The overarching goal of this event was to engage with previously unreached members of the LGBT community.

A different approach was employed to extend beyond usual attendees. According to the 2014 LGBT Community Survey, 91% of LGBT millennials use Facebook for personal communication, 50% use Twitter and 90% own a smartphone. Given that the young LGBT community has a large presence on social media; a social media expert was consulted. This expert developed the website and connected the planning committee to the community through Facebook, a local LGBT news source, and Twitter with a custom hashtag (#615legit). This provided an opportunity for LGBT individuals to have open discussion about the things that really matter to them.

Planning started with an online survey directed at community stakeholders to determine what they wanted to accomplish as a result of this event. There was a large array of topics that were narrowed down to Mental and Emotional Wellness, Politics, HIV and PrEP, Fitness, Sex and HIV/STDs, and Gender/Stigma/Prejudice that included a panel of gay and transgender speakers. The World Café, which was a series of shorter segments lasting only 15 minutes each and executed in a rotating roundtable discussion format, included other identified topics of interest.

Results: The outcomes of the event surpassed the planning committee's expectations. With the help of the local LGBT news source, there were over 33,000 social media impressions of Thrive^615. In the 30 days leading up to the event, there were over 20,000 social media impressions. The registration target was to have 100 individuals; yet, 155 individuals committed to attend the event, exceeding the target by 55%. The attendance target was 60 individuals, 131 attended, more than doubling our projections.

Lessons Learned: There was an overwhelmingly positive response from the participant evaluations and all who responded indicated they would participate again. For future Thrive^615 events, targeted Facebook ads could attract LGBT individuals who do not traditionally interact with HIV prevention programs. Additionally, augmented marketing through social media may better reach this demographic than traditionally utilized media outlets. Topics for the next event will include more items of interest for young LGBT, such as increased emphasis on the transgender community, which may lead to even greater participation.

DP18

Abstract 1893 - Partnerships, Community, Communication, and Mobilization

Author(s): *Kimberly Smith, Brianne Noto, Megan Johnson, Greg Byrd, Frank Cannizzaro, Julie Miller, Katherine Sienk, Karen Somerville, Mary Younge, Byron Kennedy*

Issue: In 2013, New York State Department of Health's AIDS Institute AIDS Institute (NYSDOH) Division of STD/HIV/HCV Prevention implemented an Expanded Partner Services (ExPS) Pilot with the specific objective to re-engage people living with diagnosed HIV infection (PLWDHI) who were out-of-care for 13 to 24 months and link them to an HIV Specialty Care Medical Provider. Through Partner Service (PS) activities, Monroe County Department of Public Health (MCDPH) informs newly diagnosed patients of their HIV status and actively links them to healthcare services. Numerous obstacles within the medical

system and patient perceived, prevent linkage and retention in care. Significant barriers include delays in HIV Specialty Care Providers processing out-of-care patients for available appointments. There is a considerable lapse from the time the patient is referred to care, to the time the patient attends their first appointment. PLWDHIs out-of-care often lose motivation to attend an appointment during this extensive time lapse. Conducting PS activities outside of a structured environment result in less than optimal conditions for providing positive results and linking to care. In order to remove barriers and re-engage PLWDHIs, strategic partnerships were created to accelerate linkage.

Setting: In 2014, MCDPH was referred over 350 PLWDHIs in need of linkage and re-engagement services. MCDPH reached out to a local Federally Qualified Health Center, Anthony Jordan Health Corporation (JH). The collaboration lead to the development of the Comprehensive Access Point using Team based Approach for Individual Navigation (C.A.P.T.A.I.N.) model. The C.A.P.T.A.I.N. model allowed PLWDHIs who accepted care at JH to attend an appointment within 24 to 48 hours, and also offered MCDPH a confidential structured environment to provide results and linkage services. The C.A.P.T.A.I.N. model proved effective during the six month pilot. The C.A.P.T.A.I.N. model was then used as a template for Strong Memorial Hospital Infectious Disease Clinic. A similar model, Social Work Access Team (S.W.A.T.) was created. All referrals for re-linkage from MCDPH were navigated through S.W.A.T. By utilizing Social Work in this model, PLWDHIs had access to a full range of service connections.

Project: This model is apart of Monroe County's partnering initiative.

Results: High impact prevention (HIP) cross-sector collaborations have been successful in Monroe County. All (100%) patients referred utilizing the C.A.P.T.A.I.N model were linked to medical care or re-engaged within 24 to 48 hours of receiving the referral from MCDPH. S.W.A.T had a larger number of PLWDHI cases referred and was as equally effective. MCDPH has expanded their efforts to include an additional HIV Specialty Care Provider, two non-clinical community based organizations, and 1 substance abuse service organization.

Lessons Learned: Linkage and re-engagement is highly successful when organizations work together to create client centered processes. Collaboratively, our partnerships have created a supportive care team working on behalf of PLWDHI on linkage and retention to improve the health of our communities. The C.A.P.T.A.I.N. and S.W.A.T. models are replicable across sectors. Policies and procedures from these HIP models can be used a template for other jurisdictions engaging in this linkage work.

DP20

Abstract 1976 - Partnerships, Community, Communication, and Mobilization

Author(s): *Erin Bascom, Todd Harvey, Edwin Corbin-Gutierrez, Carlos De Leon*

Issue: State and local health departments have a core public health responsibility to foster and sustain meaningful relationships with communities impacted by HIV. Over the thirty years of addressing HIV, relationships between health departments and communities have shifted in dramatic ways. HIV community planning, a hallmark process of health department community engagement, alone, is not enough to sustain community engagement, particularly in consideration of changes in the prevention and care landscape.

Setting: Staff and members of the National Alliance of State & Territorial AIDS Directors (NASTAD) convened to develop a policy statement and disseminate best practices for meaningful community engagement in health departments.

Project: The current HIV prevention and care landscape characterized by changes in biomedical interventions, new testing technologies, and healthcare reform, requires health departments to work with communities impacted by HIV in new ways. This work includes and is not limited to advocacy for communities in larger healthcare systems, creating opportunities to listen to the lived experiences of clients and informing communities about the status of local epidemics. NASTAD, with guidance from its Executive Committee, set out to address the tension that exists in the field about the definition of community engagement for health departments versus community planning groups. Through input from health department leadership, NASTAD developed a policy statement to serve as a call to action for health departments to reevaluate and strengthen community engagement activities. Intended outcomes for NASTAD and its members were to (1) gain support for health department programs through ongoing, mutually-beneficial relationships with communities; (2) promote promising practices related to community engagement around HIV and viral hepatitis; (3) expand stakeholder relationships beyond disease silos, across health departments, academia, community advocacy groups, community based organizations and national coalitions to promote innovative community engagement; and (4) perform assessments and share evaluations that justify the investment of federal and state resources for community engagement activities.

Results: NASTAD published the community engagement policy statement in March 2015. The document defines several key elements of meaningful community engagement that are integral to achieving the goals of the National HIV/AIDS Strategy and the Action Plan for the Prevention, Care and Treatment of Viral Hepatitis. Health departments have implemented a wide spectrum of community engagement strategies including convening stakeholder villages and special workgroups. New advisory groups are being created to usher in biomedical prevention strategies. Sharing innovative health department models for community engagement promotes adoption of best practices across jurisdictions.

Lessons Learned: Rather than the prescriptive approach to community engagement through the traditional HIV planning group process, meaningful community engagement must occur continually and involve a variety of stakeholders, venues, and formats. To better address the needs of communities in the changing healthcare landscape, health departments can implement a variety of high-quality community engagement strategies that go beyond traditional planning groups.

DP21

Abstract 2090 - Partnerships, Community, Communication, and Mobilization

Author(s): *Darrin Johnson, Diana Rowan, Delton Harris, Gerald Covington*

Issue: Lesbian, gay, and bisexual are components of sexual orientation. Transgender is a gender identity. The LGBTQIA community is a place for people who mostly identify with a sexual orientation that is not heterosexual, but also a place for persons with different gender identities and expressions. However, transgender people are often marginalized within the greater society and within the LGBT community.

The Statusboiz & Statusgurlz project in North Carolina has worked extensively to develop a safe space for Black transwomen, but also provide empowerment for self-identity. Transwomen of color are often viewed as sexual beings or performance acts, and not people who are vital to the wholeness of our community. Our first step was to find a new place for Black transwomen separate from the sexual orientation paradigm, and advocate for Transgender to always be included amongst other general identities (i.e. male, female, and transgender).

Setting: As part of a CDC funded research study, community members designed a new online HIV prevention intervention named Statusboiz/Statusgurlz for young (aged 18 to 45) Black gay and bisexual men and transwomen who have sex with men in North/South Carolina and other southeastern states (USA).

Project: As part of a CDC funded research study, community members designed a new online HIV prevention intervention named Statusboiz/Statusgurlz for young (aged 18 to 45) Black gay and bisexual men and transwomen who have sex with men in North/South Carolina and other southeastern states (USA). During the development of the project, transwomen advocated to have their own identity including a logo separate from one that was male-cisgender dominating, and their own website domain (statusgurlz.com). This provided a new outlook on the community and how transgender individuals sometimes get lost in the spectrum of LGBT. The lack of visibility of this population makes it difficult to engage for HIV prevention and other health promotion. It could also be a factor that increases risk for HIV infection.

Results: Over 200 surveys were conducted online with Black gay and bisexual men and transgender women.

Upon completing this workshop, participants will be able to:

1. Acknowledge how including Transgender in a sexual orientation paradigm negates raising awareness about gender expression and sexual orientation;
2. Discuss how this could be a barrier to HIV prevention with Transwomen;
3. Discuss solutions for Transwomen and the greater LGB(T) community;
4. Identify specific examples of Transwomen empowerment from the Statusboiz & Statusgurlz cultural-specific HIV prevention intervention.

Lessons Learned: Many will argue that the "T" is important to remain as part of the LGBTQ spectrum as this population still remains outside of societal norms. This issue was raised by a group of trans people of color, and the information has been difficult to disseminate within the community. The process of soliciting and integrating guidance and feedback from the focus population is time-intensive and more complicated than culturally adapting a pre-determined set of evidence-based practices. This method requires much flexibility and humility, because it is common for what developers/researchers assume will work to not be accepted by the focus community.

DP23

Abstract 2354 - Partnerships, Community, Communication, and Mobilization

Author(s): *Terricha Phillips*

Issue: An underlying contributor that exacerbates the high incidence rate of HIV/AIDS is lack of open and honest dialogue among MSM about sexual health, especially in rural, under-served communities. My Brother's Keeper, Inc. (MBK) conducted the Ecological Study of Sexual Behavior & HIV/STI Among African-American Men Who Have Sex With Men in the Southern U.S (an ecological study of sexual behavior and HIV/STI in African American MSM). The findings revealed that only 58% of participants asked their last main male sex partner his HIV status before sex and only 55% asked their last casual sex partner his status before sex. Culturally, linguistically, and age-appropriate social media campaigns derived from Community-Based Participatory Research (CBPR) play an intricate part in not only educating the rural MSM community about the importance of sexual health, but empower individuals to initiate conversations that are key in reducing the incidence of HIV and AIDS among MSM in under-served communities throughout the United States.

Setting: What's Your Story? (WYS) is a social marketing campaign designed to reach young black MSM in under-served areas in the Jackson, MS, metro statistical area (MSA). The goal of WYS is to empower MSM to believe their lives are worth saving. When MSM disclose their status to partners before sex, it starts a dialogue and supportive services are sought for prevention.

Project: WYS begins with a needs assessment and CBPR involving focus groups and interpersonal communication. This produces data regarding actual use of social media when connecting with other MSM. Key campaign messages for the program are disseminated through: 1) outreach to the MSM community through advocates and health clinics; 2) social media marketing; 3) Traditional media advertising; 4) Electronic communications; and 5) Educational materials. Outcome evaluation examines the impact of the key messages of awareness, empowerment, and implementation of dialogue.

Results: Over a 10-year period, MBK reached over 3,000 individuals and more than 500 Community-Based Organizations nationwide using strategic social marketing based on CBPR approaches on the importance of HIV prevention, education, and awareness.

Lessons Learned: When black MSM are encouraged to disclose status before sex, it opens the door to dialogue about sexual health. A conservative environment, hyper masculinity in the black community, and intolerance from churches all complicate the process. However, WYS empowers HIV-positive and negative MSM to share personal stories about prevention and early detection. Outreach workers rely on social media to engage and mobilize MSM communities. Interpersonal contact may take place in health clinics, social and supportive services, and include providers for sexual skill-building interventions.

DP24

Abstract 1370 - Partnerships, Community, Communication, and Mobilization

Author(s): *Florida Kweekeh, Yen Nong, Ray Watts, Marlene McNeese, Camden Hallmark*

Issue: Since 1989, the Bureau of HIV/STD and Viral Hepatitis Prevention (the Bureau) has awarded HIV prevention sub-contracts. There have been challenges in the implementation of best practices and overall performance by the Community Based Organizations (CBOs) with regard to testing and positivity

rate. Problematic issues include timely reporting, specimens not meeting lab requirements, poor budgeting and spending, and general lack of communication about program implementation.

Setting: Houston is the fourth largest city in the US with a population of approximately 2.2 million people. According to the Centers for Disease Control and Prevention (CDC), the Houston Metropolitan Area has the thirteenth highest rate of new HIV diagnoses in the country. The Bureau operates within the Houston Department of Health and Human Services (HDHHS) and subcontracts with local CBOs to implement HIV prevention interventions focused on counseling, testing and referral (CTR) and health education and risk reduction (HERR).

Project: In 2006, the prevention program was re-organized to ensure that CBOs receive assistance to improve performance by assigning Program Liaisons to monitor contract compliance, provide technical assistance and liaise between the CBOs and the Bureau. Electronic Client-Level Integrated Prevention System (ECLIPS), a web-based HIV prevention data collection system, was introduced in 2012 to assist Liaisons in monitoring CBOs with accurate, timely, paperless reporting. ECLIPS generates data on HIV and syphilis test results, reports positivity rates, tracks client referrals to care, calculates the percentage of annual goals achieved each month, and houses monthly invoices.

Results: For the five agencies included in this evaluation, comparing the time periods pre-ECLIPS (2010-2011) and post-ECLIPS (2013-2014) showed: 1) the number of tests conducted increased from 5,422 to 7,801 and the positivity rate of new HIV diagnoses increased from 2.29% to 2.4%, 2) improvement in key indicators was observed in a 33.3% reduction in lab errors, 64.3% reduction in tardy invoices, and 38.3% reduction in the percent of awards with unspent funds, 3) sanctions increased (20%), possibly as a result of Program Liaisons intensifying CBO monitoring and programmatic management during site visits and monitoring through ECLIPS, and 4) of the 17 variables with either missing or invalid data in Phase I, data quality improved for 14 variables with an overall 93.9% decrease in missing values and 100% decrease in invalid values.

Lessons Learned: ECLIPS, a locally developed electronic system, has provided a beneficial tool for Program Liaisons to assist CBOs with more timely and accurate reporting for CTR, HERR and fiscal activities. The capacity to enter data on a daily basis, and proof read data entered to ensure accuracy, allow ECLIPS users to monitor program progress in real-time, calculate up-to-date percentages of goals met, and generate reports on each CBO for programmatic review. It also potentially allows for more efficient use of CBO staff time as they no longer have to travel to HDHHS to drop off monthly reports, scan testing data, and submit invoices/reports. Overall, HDHHS has found that combining Program Liaison efforts and an electronic reporting tool has helped the CBOs improve their performance and reach program goals.

DP25

Abstract 1979 - Partnerships, Community, Communication, and Mobilization

Author(s): *Miguel Gomez, Jodi Sperber*

Issue: The Pew Research Center's 2014 Social Media Update reports that 81% of all American adults ages 18+ are Internet users, of which 52% of online adults use two or more social media sites. Twitter,

Instagram, Facebook, Instagram and Pinterest saw significant growth between 2013 and 2014. Among those who use Facebook, 67% are Black, Non-Hispanic and 73% are Hispanic. CDC data notes that 9 in 10 new U.S. HIV infections come from people not receiving HIV care, underscoring the importance of HIV prevention. These data emphasize the need to leverage social media tools to advance targeted HIV prevention messages.

Social media presents a vital opportunity for organizations to share health information. But this know-how is not always easily understood by personnel within HIV programs with limited resources including training capacity. AIDS.gov is a federal program that provides HIV information through online communication tools and a key program goal is to demonstrate and provide technical assistance to promote the use of social media in response to HIV.

To meet this need, AIDS.gov has launched “Virtual Office Hours” (VOH): bi-weekly phone sessions with social media experts to offer free technical assistance to staff and volunteers within HIV programs and other stakeholders.

Setting: Virtual technical assistance. Federal and community based program staff from HIV programs all over the country can register online and then receive phone and web-based assistance.

Project: Virtual Office Hours is a phone and web-based social media training service open to all federal and community-based HIV programs to improve their personnel’s capacities to implement digital communication. The process allows participants to register online for an individual training session during stipulated bi-weekly training hours, receive a one-on-one phone-based session focused around their individual social media queries, and then return to receive more assistance. Training topics span basic social media introductions to more advanced issues such as metrics, privacy, and accessibility. The ongoing nature of the service allows program staff continuous support as they develop and implement their social media strategy.

Results: Through VOH, AIDS.gov identified and responded to a high demand for free, social media assistance and the opportunity to sustainably fill that need. Since launching in December 2014, VOH has received positive feedback and high participation rates from over 70 HIV program staff from all over the country.

Lessons Learned: AIDS.gov has identified four lessons learned: (1) Based on intake for VOH, there is a nation-wide demand for free communications planning technical assistance to help HIV programs improve their prevention outreach. (2) There is a need for comprehensive prevention messaging but also the need to understand how to dovetail tailored prevention approaches into larger messages using a matrix of social media tools. (3) The VOH service model of scheduled training sessions available on a rolling basis provides much-needed support to HIV prevention programs that do not have adequate communications planning resources. (4) Learning digital outreach strategies for HIV prevention increases the capacity of staff to use digital media in order to extend the reach of prevention messages.

DP28

Abstract 1537 - Partnerships, Community, Communication, and Mobilization

Author(s): *Lydia Guy Ortiz, David Kern*

Issue: Effective community planning requires collaboration and input from a variety of different sources. HIV planning typically relies heavily on a single planning group to gather information and make decisions. Traditional efforts tend to limit participation to a select set of individuals and organizations, and, as such, limit perspectives, skills and levels of professional expertise. To remedy, WA DOH created an innovative planning “system” to expand its ability to provide and receive critical input into its decision-making processes.

Setting: Statewide HIV planning

Project: In April 2014, WA DOH integrated its HIV care and prevention planning groups to create a new HIV planning “system.” The primary goal of the system is to create multiple mechanisms to give and receive information. The system, which replaced the previous planning bodies, includes three components.

The HIV Planning Steering Group (HPSG) is a 21-member, formal, standing advisory committee that works collaboratively with DOH in the development of the State Plan. The HPSG meets every other month. Its function is to provide “big picture” analysis. The HPSG most closely resembles a traditional planning group.

The HIV Stakeholder Village (Village) serves the dual purpose of educating a broad range of stakeholders on current and future HIV activities and eliciting input from stakeholders to enhance HIV service delivery. Information presented at Villages mirrors HPSG meeting agendas, so Village conversations can actively influence HPSG discussions. The Village meets every other month -in person and / or via web in town hall style meetings. The Village has no formal membership and can include -anyone interested in learning and sharing. When possible, in-person Village events are coordinated with local service providers.

HIV Special Emphasis Workgroups (SEW) are formal, ad-hoc advisory bodies - convened by DOH and / or the HPSG. SEWs are charged with creating effective implementation strategies for specific prevention, care and treatment services. SEW membership is chosen by DOH based on the topic; relevant subject matter experts are always included. At the completion of its work, a SEW presents recommendations to WA DOH and the HPSG for consideration.

Results: The first deliverable of our new system was a systematic review of HIV-health disparities in WA State. Following initial discussions at the HPSG, a Health Disparities SEW was created to review data and develop recommendations. The SEW report was presented to and adopted by the HPSG and WA DOH. Findings from the report were then presented to stakeholders via a Village webinar. This process allowed WA DOH to hear from a broad range of stakeholders and to benefit from all three levels of insight.

Lessons Learned: All components of our planning “system” have been convened and meet regularly. Our new system has demonstrated much broader participation of interested stakeholders. Because topics are often discussed at all three levels of the system, the value and quality of the information we receive is much deeper and useful. Implementing this system has provided us with an opportunity to

clarify the goals and vision of our planning process, which is creating a more dynamic and responsive approach to planning.

DP29

Abstract 1589 - Partnerships, Community, Communication, and Mobilization

Author(s): *Julie Fitch, DeAnn Gruber, Jacky Bickham, Samuel Burgess*

Issue: HIV disparities based on race, sexual orientation, and gender identity persist in Louisiana. In 2011, the HIV rate for African Americans in Louisiana was over seven times higher than among Whites, and the percentage of adult HIV diagnoses attributed to MSM peaked at 53% from a low of 40% in 2002. Transgender women that were tested for HIV in 2011 were 4 times more likely to have a positive result than males that were tested. By focusing on institutional racism, homophobia, and transphobia, the health department and partners are addressing these inequities and working towards building anti-racist and anti-heterosexist institutions. The Louisiana Office of Public Health-STD/HIV Program (SHP), with three community partners, have worked on a capacity building strategy to address these disparities for three years as a part of the CAPUS grant.

Setting: Staff from SHP and three CBOs in New Orleans and Baton Rouge participated in a process of workshops and strategic planning in an effort to reduce HIV inequities related to race, sexual orientation, and gender identity.

Project: SHP sponsored two series of workshops. 1) Undoing Racism provided by the People's Institute of Survival and Beyond focused on institutional racism and provided insight as to how institutional racism serves as a barrier to effective HIV prevention, treatment and care. 2) Deconstructing Homophobia and Transphobia: A Way Forward provided by the California STD/HIV Prevention Training Center and the Center of Excellence for Transgender Health, focused on how heterosexism, homophobia, and transphobia create barriers to care and HIV prevention. Heterosexual privilege was closely examined as well as a historical perspective of LGBT based oppression in the United States. After the two workshops, agencies engaged in a strategic planning effort with the assistance of the Interaction Institute for Social Change to further clarify understanding of these oppressions and begin to prioritize steps to create positive change.

Results: From June 2013-September 2014, 200 people have attended 12 workshops related to structural racism, homophobia, and transphobia. Individual participant responses to pre and post workshop surveys from all Undoing Racism and Deconstructing Homophobia and Transphobia workshops yielded significant increase in the following areas: knowledge of institutional racism, homophobia, and transphobia, self-efficacy to engage in improving institutional racism, homophobia, and transphobia, self-efficacy to explain racial and heterosexual privilege, and intentions to address bias related to racism, homophobia, and transphobia.

Lessons Learned: Leadership involvement and buy-in from organizations are crucial to the success of this type of process, and there were several instances which required leadership to assist staff in digesting the content from the workshops. Understanding privilege was also key to moving conversations forward. Working toward equity is a serious time commitment, and requires a slow,

deliberate pace so that all staff understand the framework of structural oppression. In addition to focusing prevention efforts on individual behavior change and biomedical interventions, we learned that these HIV prevention strategies must be coupled with an understanding of the systemic racism and heterosexism impacting clients' lives.

EP02

Abstract 1533 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Kendra Cuffe, Jami Leichter, Thomas Gift*

Background: US STD programs at the federal, state, and local levels have experienced budget cuts, reduction in staffing and program capacity, and clinic closures. Program cuts may negatively impact disease intervention services, which are essential in interrupting the chain of transmission for STD/HIV. Therefore, it is important to assess the current infrastructure for publically funded agencies that provide STD services. From December 2013 to January 2014, CDC and the National Association of County and City Health Officials (NACCHO) conducted a national survey analyzing services provided by local (LHD) and state (SHD) health departments.

Methods: A sample of LHDs (n=311) was drawn from the 2012 National Profile of Local Health Department survey and included respondents that indicated they offered STD screening or treatment. All SHDs were invited to participate. 47.6% of LHDs and 58.6% SHDs responded to the survey. LHD survey responses were weighted based on U.S. Census region, jurisdiction population size, and non-response. Program characteristics were analyzed by US region and population size.

Results: During the 2012 fiscal year, most STD programs in LHDs and SHDs provided partner services (80.9%, 84.6%, respectively). Among LHDs offering partner services, the main providers were disease investigation specialists (DIS) or community disease investigators (CDI) (42.2%) and public health nurses (50.8%). Among SHDs 90.9% were DISs or CDIs and 9.1% were public health workers. In LHDs with a jurisdiction size of $\geq 50,000$, almost half (54.2%) reported that DISs and CDIs were the main providers of partner services. Conversely, in LHDs with a jurisdiction size of less than 50,000 residents, 68.2% reported that public health nurses were the main providers of partner services. 47.6% of LHDs and 57.1% of SHDs reported a decrease in DIS FTEs: the average number of DIS lost during the 2012 fiscal year in LHDs was 2.0 (95% CI: 1.5, 2.5) and 2.6 (95% CI: 1.2, 4.0) in SHDs. Of these LHDs, 80.4% reported offering fewer partner services for chlamydia, gonorrhea, and other STD cases due to program cuts. 36.1% of LHDs reported that FTEs were detailed or pulled for non-STD related activities such as public health emergencies during the 2012 fiscal year. Among LHDs that have had staff detailed or pulled, 56.8% reported this had a minor impact on STD on programmatic activities and 22.4% reported having a major impact. Among SHDs, 29.6% reported having staff pulled or detailed. 77.8% reported this as having a minor impact and 11.1% having a major impact on programmatic activities.

Conclusions/Implications: There was a reduction in DIS in some local and state health departments, which may undermine efforts to prevent the transmission of STDs and HIV through partner services. Also, DIS in STD programs often aid in other public health emergencies; therefore, it is important to maintain DIS staff in LHDs and SHDs for STD/HIV prevention and public health infrastructure.

EP03

Abstract 1861 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Ryan Guinness, Stephanie Cohen, Andy Scheer, Edwin Charlebois, Steve Morin, Wayne Steward*

Background: Implementation of the Patient Protection and Affordable Care Act (ACA) expanded healthcare access for millions of uninsured, including those living with HIV who previously only had coverage for HIV-related care through the Ryan White HIV/AIDS Program. However, the move to private insurance or expanded Medicaid plans also introduced the risk that people would fall out of HIV care or temporarily lose access to services as they were shifted from one payer source to another. To describe the barriers encountered during ACA-related transitions in healthcare coverage and to identify resources for overcoming such barriers, we examined the experiences of patients in San Francisco who were moved to new healthcare payer sources during ACA rollout, as well as the perspectives of those who were providing services to this population during their change in coverage.

Methods: We conducted interviews with 5 key informants and 11 patients. Key informants were asked to describe the kinds of challenges they had observed among clients moving to new payer sources, and to discuss strategies employed to help such individuals. Patients were asked to talk about their own coverage transition experiences. All interviews were transcribed and coded for recurring themes.

Results: Although patients enrolling in ACA-related coverage appreciated enhanced access to comprehensive health services, both they and key informants described problems with the transition. These included delays in application processing for Covered California (the state exchange) and Medi-Cal (the state Medicaid program), lack of information about the best plan options for patients living with HIV, and undesired changes in access to providers due to network restrictions imposed by the new plans. In many cases, patients were able to continue to receive care during their coverage transition because they had access to Ryan White-funded clinics, which acted as a safety-net, particularly for those who encountered delays or uncertainty with their new plan (e.g., missing insurance cards, delayed crediting of premium payments).

Conclusions/Implications: Effective engagement in HIV care and services is essential for meeting the objectives of the National HIV/AIDS Strategy. New ACA plan options can help ensure access to care once patients are successfully enrolled. But vulnerabilities exist while transitioning to these new coverage sources. The challenges can be reduced by increasing navigation support, improving communication, particularly about appropriate plan options for patients with HIV; and ensuring that HIV providers are connected with many plan options (to reduce the likelihood that a patient would need to change providers as a result of a change in healthcare coverage). Most importantly, safety-net coverage options like the Ryan White Program are essential for ensuring that HIV patients do not lose access to care should they encounter coverage gaps while attempting to transition to new insurance and Medicaid plans.

EP05

Abstract 2001 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Darrin Maxwell, Summer Stephanos, Pedro Carneiro*

Issue: Approximately 4 million Americans are infected with chronic HCV, compared an estimated 1.2 million people who are infected with HIV. Mirroring this, there is an estimated 146,000 New York City residents affected by this virus compared to 120,000 people living with HIV. Prior to the Hepatitis Rapid Testing program, HCV testing was done for “high-risk” patients with insurance; if a patient was uninsured they would incur the extra lab costs for HCV testing. Although HCV is both more prevalent and virulent than HIV – in a 10 year period (1999-2011), HCV related deaths increased by 46% while HIV-related deaths have decreased by 60% - routinized testing for this disease had not been established at our clinic prior to our Hepatitis C Testing Program, whereas HIV testing was well integrated into the workflow of staff.

Setting: Community Health Center

Project: Given the success of HIV testing, our Hepatitis C Testing Program sought to replicate the process by offering rapid HCV testing alongside HIV testing. The service functions as an “opt-out” model for HCV testing for any patient receiving a HIV test during a primary care visit, as well as during HIV counseling and testing visits. The uptake of this system was easily implemented by HIV testing counselors; however, medical and nursing departments proved to be more resistant to the program. The Hepatitis C Testing coordinator responded by providing additional support in form of weekly feedback about testing rates and incentives for those who conducted the most tests. In tandem with these efforts, the coordinator increased clinic-wide knowledge of HCV risks and treatment with education courses and information sessions

Results: Given its high prevalence virulence, HCV is an important disease to be screening patients for. However, implementation of a Hepatitis C Testing Program presents nuanced challenges for a community health center. Tailored approaches to departments produce long-lasting adoption of screening practices, and this ultimately contributes to a more comprehensive health screen for patients. Integrating HCV testing into established HIV testing programs are feasible, cost effective and efficient in identifying people affected by this disease.

Lessons Learned: Prior to its implementation, we hypothesized that the Hepatitis C testing program would be seamlessly absorbed into the clinic, given our successful HIV testing program. Our hypothesis did not prove to be true. Having a coordinator dedicated to the program was key to maintaining visibility and relevance about both the program and HCV in general. Educating the staff on strategies of prevention for hepatitis C as well as preparing them to discuss risk-reduction plans tailored to preventing this disease proved to be key factors influencing buy-in across all clinic departments.

EP07

Abstract 2512 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Tommi Gaines, Julia Caldwell, Chandra Ford, Mesfin Mulatu, Dionne Godette*

Background: The CDC’s Expanded Testing Initiative (ETI) aims to bolster HIV testing among populations disproportionately affected by the epidemic by providing additional funding to health departments serving these communities. Given that ETI prioritizes testing in clinical settings, we examined the

relationship between state-level ETI participation and past-year HIV testing among a racially/ethnically diverse sample of adults who accessed medical services in the 12 months prior to being surveyed.

Methods: The study used data from the 2012 Behavioral Risk Factor Surveillance System and two-level random intercept logistic regression, with individuals (level 1) nested within states (level 2), to analyze the relationship between state-level ETI participation and an individual's likelihood to report a past-year HIV test. State-level variables included the number of CDC funded HIV testing events, population size, proportion of population age 25-34 years, and HIV prevalence rate. Individual-level characteristics included race/ethnicity, age, gender, marital status, education, income, insurance coverage, health care costs, and HIV risk-related behaviors. An interaction between state-level ETI participation and individual-level race/ethnicity was included in the final model to explore potential racial/ethnic disparities.

Results: The weighted proportion of adults reporting a past-year HIV test was 13.3%, with considerable state variation ranging from 6.1% in Utah to 18.8% in Georgia. With the exception of American Indians and Alaska Natives (AIAN), every racial/ethnic group had a higher percentage of past-year testing if they resided in an ETI than non-ETI participating state. Controlling for state-level characteristics, ETI participation was independently and positively associated with past-year testing (AOR, adjusted odds ratio: 1.25, 95% CI: 1.09, 1.43) but this association varied by race/ethnicity when adjusting for individual characteristics in the multilevel regression. Latinos had higher odds (AOR: 1.49, 95% CI: 1.11-2.02) and AIAN had lower odds (AOR: 0.66, 95% CI: 0.43-0.99) of testing if they resided in states with (versus without) ETI participation. State-level ETI participation did not significantly associate with past-year testing among whites (AOR: 0.98, 95% CI: 0.84-1.14), African Americans (AOR: 0.98, 95% CI: 0.78-1.21), Asian/Native Hawaiians or other Pacific Islanders AOR: 0.83, 95% CI: 0.52-1.32), and other racial ethnic groups (AOR: 1.02, 95% CI: 0.64-1.61).

Conclusions/Implications: In the United States, the HIV epidemic continues to be geographically concentrated and disproportionately affect certain racial/ethnic groups. Prioritizing public health resources in states most affected by HIV can improve testing patterns, but other mechanisms likely influence which racial/ethnic groups undergo testing.

EP08

Abstract 1555 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Ram Shrestha, Stephanie Sansom*

Background: An estimated 1.2 million people are living with HIV in the United States, and 54% of them are men who have sex with men (MSM). Among men living with HIV, more than 70% of infections are attributable to male-to-male sexual contacts. MSM at risk for HIV can use various prevention interventions to reduce their risk. Their choice of interventions or combinations of interventions can be informed by understanding interventions' prevention effectiveness over short and longer terms.

Methods: We used a Bernoulli process model to estimate the cumulative HIV acquisition risk among MSM over 1 and 10 years with and without prevention interventions. In the base case, we assumed 6 sex acts (3 receptive, 3 insertive) per month, and a 19% HIV prevalence among sex partners.

We examined interventions that do not depend on adherence (circumcision and the practice of receptive anal sex), and those that do (condoms and preexposure prophylaxis (PrEP). Efficacy in preventing HIV associated with circumcision was 73% for insertive anal sex. We associated 100% condom use with an efficacy of 70%, and less than 100% adherence with no efficacy. We assumed 3 levels of adherence to PrEP: average, as reported in an intent-to-treat analysis, high, based on pill count, and very high, based on drug detection in blood samples. The corresponding efficacies were 44%, 73%, and 92%, respectively.

Results: In the base case with no prevention interventions, the 1- and 10-year risk of HIV acquisition among MSM was 13% and 75%. Combining interventions whose efficacy does not depend on adherence, circumcision and no receptive anal sex, the 1- and 10-year risk was 2% and 21%. Combining the interventions whose efficacy depends on adherence, condoms and PrEP, the 1-year risk associated with average, high, and very high PrEP adherence was 2%, 1%, and 0.3%, and the 10-year risk was 21%, 11%, and 3%.

Conclusions/Implications: The cumulative risk of HIV acquisition is high among MSM when no prevention strategies are employed. Use of interventions that do not require adherence can reduce risk substantially. Use of interventions that depend on adherence can reduce risk to a much larger degree when adherence is very high. Understanding the effects of combinations of prevention interventions, and the role of adherence, can help men determine which strategies to use to reduce their risk of acquiring HIV.

EP09

Abstract 1451 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Ya-lin Huang, Angela Hutchinson, Ram Shrestha*

Background: Although the majority of HIV-infected persons in the United States are of prime working age, estimates of lost productivity associated with HIV have been lacking in the current treatment era. The goal of this study is to assess the employer costs of lost productivity associated with work absence days and short-term disability days in a population of commercially insured workers with HIV in the United States.

Methods: We conducted a retrospective, observational study using data from the Truven Health MarketScan® Commercial Claims Database and Health and Productivity Management Database. We identified a cohort of HIV-infected workers aged 18-64, who had at least one HIV diagnosis or antiretroviral drug prescription claim between January 1 and December 31, 2008 (n=45,357). The date of each worker's first claim defined their index date. We limited our study sample to those with productivity data available and who had continuous enrollment in their health plan during the analysis timeframe. We created a comparison group of workers without HIV infection, matching 3:1 for demographic characteristics. Both HIV-infected (n=2,111) and HIV-uninfected (n=6,333) groups were followed for one year from the index date during which work absence and short-term disability days were compared. We used 2008 age- and gender-specific wage and benefits data from the Bureau of Labor Statistics to estimate the costs of lost productivity associated with absence and short-term

disability days. We conducted multivariate analyses to estimate the differences in these annual costs between HIV-infected and uninfected workers after adjusting for demographics, employment (full-time versus part-time; salaried versus hourly) and comorbidities. We calculated the Charlson Comorbidity Index for comorbidity severity and also included variables measuring the presence of HIV-related comorbidities, including hepatitis B, hepatitis C, depression, and alcohol or drug use disorder within the 6 months prior to the index date.

Results: During the follow-up year, 6.3% of HIV-infected workers took short-term disability leave versus 3.5% of the HIV-uninfected workers ($p < 0.001$). Among the subgroup of HIV-infected workers with comorbidities, 10.8% took short-term disability leave. HIV-infected workers took average 27 work absence days per year versus 24 days among the uninfected workers ($p = 0.007$). After controlling for confounding factors, HIV-infected workers had excess productivity costs of \$1,131 per person over one year, consisting of \$507 higher annual absence costs ($p = 0.006$) and \$624 higher short-term disability costs ($p < 0.001$), compared to HIV-uninfected workers. HIV-infected workers with comorbidities had \$4,054 higher productivity costs per person [\$2,610 higher absence costs ($p = 0.006$) and \$1,444 higher short-term disability costs ($p = 0.002$)] compared to HIV-uninfected workers.

Conclusions/Implications: We estimated that annual excess lost productivity costs in 2008 were approximately \$1,100 per HIV-infected worker and \$4,000 per HIV-infected worker with comorbidities compared to the uninfected population. The presence of HIV-related comorbidities substantially increased productivity losses. These estimates are conservative as they do not include lost household productivity. To our knowledge, this is the first estimate of morbidity-related HIV productivity losses in the current treatment era in the US. Our results apply only to the commercially insured population with access to care and are not generalizable to other HIV-infected populations.

EP10

Abstract 1674 - HIV-Related Policy, Economics, and Program Integration

Author(s): Kendra Cuffe, Jami Leichter, Tom Gift

Background: People diagnosed with STDs are at an increased risk for HIV infection; thus, many publicly funded STD programs also provide some HIV services in their jurisdiction. Although the linkage between STD and HIV is important, STD programs that provide HIV services have experienced budget cuts, reductions in staff and program capacity, and clinic closures. Program cuts can negatively impact program services including HIV field testing and linkage of STD surveillance data with HIV data. Therefore, it is important to assess the current infrastructure for publically funded agencies that provide STD services. To characterize these cuts and impacts, CDC and the National Association of County and City Health Officials (NACCHO) conducted a national survey analyzing services provided by local (LHD) and state (SHD) health departments from December 2013 to January 2014.

Methods: The sampling frame consisted of LHDs ($n = 311$) drawn from the 2012 National Profile of Local Health Departments survey and respondents that offered STD screening or treatment. Survey responses from LHDs were weighted based on US Census region, jurisdiction population size, and non-response. SHDs were also included in the sample but were not weighted and were analyzed separately. 47.6% of

LHDs and 58.6% SHDs responded to the survey. Program characteristics were analyzed by US region and population size.

Results: During the 2012 fiscal year, 70.5% of LHDs and 57.1% of SHDs provided STD screening in non-clinical settings. Of those, 25.0% of LHDs and 38.2% of SHDs provided HIV field testing for STD contacts. LHDs in Southern region reported the highest percentage of HIV field testing (30.4%), and those in Northeast region reported the lowest percentage of HIV field testing of STD contacts (6.7%). 65.4% of LHDs and 92.3% of SHDs directly linked persons found HIV-positive during partner services field testing to care. 34.6% of LHDs linked those found HIV positive to care by referral. LHDs reported that about half of staff responsible for linking newly diagnosed HIV patients to care were disease investigation specialist (DIS) and community disease specialist (CDI) (52.3%). In SHDs, DIS and CDI were largely responsible for linking newly diagnosed HIV patients to care (83.3%). Overall, 46.7% of LHDs and 84.2% of SHDs conducted provider visitation with HIV care. In jurisdictions with a population size of less than 50,000, 55.0% of LHDs reported linking STD case report data to HIV data. Only 16.3% of those with a jurisdiction size of greater than or equal to 500,000 performed this data linkage. 34.2% of LHDs reported experiencing a decrease in staffing levels from fiscal years 2006 to 2011 with a mean decrease of 3.0 (95% CI: 4.8, 1.2).

Conclusions/Implications: Reductions of DIS staff may hamper efforts to link newly diagnosed HIV patients found during field testing of STD contacts to care since 52.3% of local and 83.3% of state health departments reported that DIS/CDI's were the primary staff members in charge of performing the linkage to care. Additionally, LHDs and SHDs often shoulder the burden of visitation to HIV care providers and linking STD and HIV surveillance data.

EP11

Abstract 1417 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Jessica Frasure-Williams, Lauren Nelson, Nicole Burghardt, Rilene Ng, Heidi Bauer*

Background: The Centers for Disease Control and Prevention recommend HIV testing for patients with incident sexually transmitted disease (STD) infection. We used existing data from 2011-2013 to assess rates of HIV testing among California STD cases by gender, sexual orientation, and provider type.

Methods: Early syphilis (ES) cases and a sample of gonorrhea (GC) cases were interviewed by local or state health department staff. Interview documentation includes self-reported HIV status and month/year of current HIV test.

Frequencies of HIV testing among HIV-negative ES and GC cases were stratified by gender, sexual orientation, and STD reporting provider type for all cases not diagnosed in HIV care or who self-reported as HIV-infected. ES data excluded San Francisco and Los Angeles. GC proportions were weighted to account for sampling.

Positive chlamydia (CT) tests from a large laboratory dataset were matched to insurance claims data for Family Planning, Access, Care and Treatment (Family PACT), a public medical insurance provider for reproductive health. Frequencies of current HIV tests were stratified by gender and CT testing provider

type. Sexual orientation and HIV status were unavailable but previous analyses indicate low HIV prevalence among clients in Family PACT.

Current HIV test was defined as an HIV test received in the same, previous, or following month as the month and year of the positive STD test.

Results: The overall proportions of cases with current HIV tests included 57% of ES cases, 51% of GC cases, and 53% of CT cases.

Of the 7,181 ES cases with complete data for required variables from 2011-2013, HIV status differed by gender/sexual orientation, with 43.6% of men who have sex with men (MSM), 24.4% of non-MSM males, and 1.5% of females reporting HIV positivity at the time of the ES test. Frequency of current HIV testing among HIV-negative ES cases did not differ by gender (males 54%, females 58%), but differed between MSM (64%) and non-MSM male (7%) cases. STD (67%) and family planning clinics (70%) tested the highest proportion of HIV-negative ES cases. Emergency departments/urgent care (ED) settings tested the lowest proportion of HIV-negative ES cases at 44% of 485 cases.

Of the 8,065 GC cases that were sampled and interviewed with complete data, 20.3% of MSM cases and <1% of female and non-MSM male cases reported HIV-positivity at the time of STD test. Among HIV-negative patients, 48% of females, 52% of non-MSM males, and 64% of MSM had a current HIV test. The proportion of GC cases tested was highest in STD (62%) and family planning (55%) clinics, and lowest in ED settings (35%).

Among the 19,431 positive CT tests documented in Family PACT, 70% were among females. Differences in current HIV tests were observed by gender (females 47%, males 66%), but not by provider type (private 43%, public 48%).

Conclusions/Implications: Public health efforts should focus on HIV testing of HIV-negative persons with an incident STD, regardless of sexual orientation. ED and STD clinic settings should be targeted for quality improvement related to HIV testing among STD cases in California.

EP13

Abstract 2104 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Alexia Eslan, John Guidry, Yumiko Fukuda, Ding Pajaron, Therese Rodriguez*

Issue: Over the last decade, HIV/AIDS science and policy have come together to produce a promising environment for improving both HIV prevention and health outcomes for persons living with HIV (PLWH). Key events and policies have included the demonstrated efficacy of antiretroviral treatments (ARVs) for both prevention and wellness, the establishment of the National HIV/AIDS Strategy (NHAS), and the HIV Care Continuum Initiative—but the key to realizing the full potential of these developments to end the epidemic is the expansion of access to quality preventive, primary and medical care through the Affordable Care Act (ACA).

Setting: During this time, community-based organizations (CBOs) dedicated to addressing the impact of the HIV/AIDS epidemic faced choices in how to adapt to the changing environment. Support from the Health Resources and Services Administration (HRSA) for the development of HIV primary care and treatment assistance provided opportunities to serve persons affected by HIV through the provision of health care services. At the same time, federal funding for behavioral prevention was decreasing and became more closely tied to testing and treatment programs.

New York City's APICHA Community Health Center is one example of an organization that adapted to the changing environment by expanding its services and becoming a federally qualified health center (FQHC) Look-Alike while remaining true to its mission.

Project: This presentation describes APICHA's journey, including lessons learned and successes. Its journey began in the 1980s as a CBO dedicated to providing HIV education and behavioral prevention interventions to Asians and Pacific Islanders (API). By 2000, APICHA's leadership made a strategic decision to grow the organization and expand their services and client populations to better serve the needs of their community. However, once the organization began to provide HIV primary care, they faced choices on how to sustain their fundamental commitments. The challenge was to continue serving its "legacy" population of HIV-positive API while expanding health care services that align with available federal resources.

Results: From 2005 to 2013, as APICHA progressively developed its medical care facilities, from HIV primary care to general primary care, and ultimately FQHC Look-Alike status in 2013, the client base increased from around 100 individuals to over 1,000. While API and HIV-positive clients are no longer the majority of those served, they increased from 43 API patients in 2005 to 357 in 2013, and from 76 HIV-positive patients in 2005 to 440 in 2013. In 2014 the organization, secured a state grant to develop the infrastructure necessary to complete the FQHC certification process.

Lessons Learned: APICHA has emerged in 2015 well-poised to utilize the benefits of health care reform under the ACA to ensure access to HIV preventive care and treatment for both its legacy populations and other communities struggling with economic hardship and issues with access to care, including lesbian, gay, bisexual and transgender (LGBT) individuals and racial and ethnic minority populations in their catchment area.

EP14

Abstract 1587 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Molly Wlodarczyk, Eric Press*

Issue: Despite progress in combating HIV, data released in the White House Office of National AIDS Policy Report titled, "National HIV/AIDS Strategy - Improving Outcomes: Accelerating Progress Along the HIV Care Continuum," show that there are significant gaps along the HIV care continuum -- the sequential stages of care from being diagnosed to receiving optimal treatment. The HIV Care Continuum Initiative was developed to further strengthen the capacity of the Federal Government to effectively respond to the ongoing domestic HIV epidemic by accelerating efforts to increase HIV testing, services, and treatment along the continuum.

Vulnerable populations, including certain racial and ethnic groups and limited English proficient persons are disproportionately affected by barriers which prevent or decrease access to healthcare services. In addition, there are measurable differences in the use of healthcare services and the quality of healthcare services received among various population groups. This presentation will highlight the role of the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) in addressing health disparities and its newly created initiative that seeks to inform the public of its right to receive services in a non-discriminatory manner and their right to have health information protected so that they are more likely to get tested and be actively involved in their health care.

Setting: President Obama issued an Executive Order creating the HIV Care Continuum Initiative. To meet the goals of the initiative, OCR rolled out the “12 cities project” which refers to the 12 cities in the country most affected by HIV/AIDS and which represent 44% of the HIV/AIDS cases in the United States.

Project: First, we will provide an overview of the White House Office of National AIDS Policy, HIV/AIDS Strategy. This overview will highlight the three outcome goals of reducing new HIV infections, increasing access to care, and reducing HIV-related health disparities.

Second, we will provide a brief overview of OCR’s role with respect to the “12 cities project.” We will provide a discussion of the project and identify “best practices” for providing services to persons living with HIV/AIDS in a culturally sensitive and linguistically appropriate manner.

Third, we will provide a quick overview of OCR’s role in ensuring that people have equal access to and opportunity to participate in health care and human services programs without facing unlawful discrimination. We will also discuss the HIPAA Privacy Rule and Security Rule, which set national standards for the privacy and security of electronic protected health information.

Results: We will provide an overview of how the National HIV/AIDS Strategy resulted in better identification of and response to service gaps and unmet needs, scaled-up activities that will have a greater “payoff” in terms of achieving the goals of the National HIV/AIDS Strategy, enhanced integration of local service delivery, and – where appropriate – realigned resources from lower priority to higher priority activities.

Lessons Learned: OCR will present its findings from the “12 cities project” and provide participants with specific recommendations of effective programs and practices for addressing HIV related health disparities.

EP15

Abstract 1643 - HIV-Related Policy, Economics, and Program Integration

Author(s): *Jennifer White, Krystal Phillips*

Issue: In the United States, two-thirds of the population living with Human Immunodeficiency Virus (HIV) are currently uninsured relying on publicly funded coverage, including Medicaid and Medicare. In Mississippi, 9,907 are of known diagnosis of HIV. Out of the 9,907 HIV positive patients, 5,590 HIV positive patients are currently uninsured.

Setting: The Community REACH Initiative (ACA) Outreach project began in October 2014 in order to expand the knowledge of affordable health insurance, Medicaid, and other insurance coverage options. By conducting education sessions, the goal was to increase the knowledge of Affordable Health Insurance by 80% above the baseline. The designated area for the ACA Project is in Jackson, MS, MSA and other underserved counties.

Project: The Community REACH Initiative focuses on partnership agreements in order to better reach patients who are uninsured or are underinsured. Along with establishing strategic partnership agreements, the Community REACH Initiative will train community health workers and Certified Application Councilors (CACs) on conducting education and enrollment sessions for those living with HIV and currently uninsured or under insured. Open Arms Health Care Clinic is one of the partnerships that was established due to the amount of HIV positive patients who are seeking medical attention from the clinic. Insurance companies are other partnerships that are established due to their better knowledge for what HIV positive patients need as far as the correct coverage.. Our target areas are geared not only to just those uninsured, but towards HIV positive patients who are uninsured.

Results: From October 2014 to February 2015, 25 partnership agreements were established and 50 CACs were trained in order to assist with enrollment which increased the knowledge of affordable health insurance. The strategic partnerships established were with Open Arms Health Care Clinic, insurance brokers, Barbershopshair salons, faith-based organizations, community based organizations, and local bars and night clubs.

Lessons Learned: By establishing partnerships with organizations in the designated areas, many people were informed on being insured and the importance of being insured. Community REACH Initiative results of establishing the partnerships indicate that many more partnerships will be established in order to increase the awareness of the affordable care act and other methods of affordable insurance. The projects goals were an excellent way to create awareness in the community on the importance of being insured.

Track A

Session A09 - Trends in HIV among Persons Who Inject Drugs (PWID): The Intersection of Injection and Sexual Practices, Syringe Exchange Program Availability and HIV and Viral Hepatitis Seroprevalence

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1520 - Low HIV Testing Prevalence among Persons Who Inject Drugs—National HIV Behavioral Surveillance, 20 U.S. Cities, 2012

Author(s): *Laura Cooley, Cyprian Wejnert, Michael Spiller, Dita Broz, Gabriela Paz-Bailey*

Background: Despite declines in HIV diagnoses among persons who inject drugs (PWID), 16% of infections among those living with diagnosed HIV infection in the United States are attributed to injection drug use. HIV testing—recommended by CDC at least annually for PWID—is key to reducing HIV transmission by increasing awareness of HIV status, which precipitates linkage to care and treatment and behavior modification. We examined the association between recent HIV testing and recent use of health services and HIV risk behaviors among PWID.

Methods: We analyzed National HIV Behavioral Surveillance (NHBS) data from PWID > 18 years old recruited via respondent-driven sampling in 20 cities in 2012. Recent HIV testing was defined as testing in the 12 months before interview. Those who reported a positive HIV test result > 12 months before interview were excluded. We examined factors associated with recent HIV testing using a Poisson model with robust standard error clustered on city to calculate adjusted prevalence ratios (aPRs) and 95% confidence intervals (CIs); demographic characteristics and variables related to recent use of health and prevention services and HIV risk behaviors were included in the model.

Results: Of 9,570 PWID, 72% were male; 44% were black or African American, 24% were Hispanic or Latino, and 27% were white. Median age was 47. Overall, 53% had recently tested for HIV. In multivariable analysis, recent HIV testing was more prevalent among participants who recently visited a health care provider (aPR 1.51, $P < 0.001$), underwent alcohol or drug treatment (aPR 1.21, $P < 0.001$), or received an HIV prevention intervention (aPR 1.26, $P < 0.001$). Recent HIV testing was also more prevalent among participants who recently received free sterile syringes from a source other than a friend, relative, or sex partner, typically a healthcare or outreach organization (aPR 1.15, $P < 0.001$). Recent HIV testing was less prevalent among participants reporting receptive syringe sharing with 1 (aPR 0.88, $P < 0.001$) or more than 1 (aPR 0.88, $P = 0.001$) partners than for those with none.

Conclusions/Implications: Only half of the PWID participating in NHBS in 2012 reported recent HIV testing. Recent HIV testing was more prevalent among participants who accessed health and HIV prevention services and less prevalent among participants with syringe-sharing partners. Efforts to

increase use of health and HIV prevention services, including those targeting safer injection practices, may improve HIV testing rates among PWID, which might reduce HIV transmission overall.

Abstract 1675 - HIV Risk Behaviors and Prevention Services among Persons who Inject Drugs in 20 cities with and without Large-Scale Syringe Exchange Programs in the United States

Author(s): *Dita Broz, Michael Spiller, Cyprian Wejnert, Brooke Hoots, Gabriela Paz-Bailey*

Background: Syringe exchange programs (SEPs) have been shown to prevent the spread of HIV infection among persons who inject drugs (PWID), yet coverage remains limited in the United States. To assess the varying impact of the presence of SEPs across geographically diverse cities in the United States, we compare HIV risk behaviors among PWID recruited from 20 cities with and without large-scale SEPs.

Methods: PWID aged ≥ 18 years were recruited for the 2012 National HIV Behavioral Surveillance system using respondent-driven sampling. Information on presence and characteristics of SEPs in each city was collected using formative research methods; SEPs reporting $>55,000$ syringes distributed annually were classified as large-scale programs. Multi-level models with a city-level random intercept were used to assess the association between the presence of large-scale SEPs and participant risk behaviors in the past 12 months. Multivariable models adjust for age, gender, race/ethnicity, self-reported HIV status, and HIV prevalence among PWID in each city.

Results: Of 10,002 PWID, 7,201 (72%) were recruited from cities with large-scale SEPs ($n=14$ cities). Most (66%) PWID from cities with large-scale SEPs obtained sterile syringes from SEPs compared to 17% of PWID from cities without large-scale SEPs. In multivariable analyses, PWID from cities with large-scale SEPs were less likely to receptively share syringes (adjusted Prevalence Ratio [aPR] = 0.68, 95% Confidence Interval [CI] 0.52-0.91), and to receptively share syringes with ≥ 2 people (aPR=0.61, 95%CI 0.41-0.92), and more likely to receive free condoms (aPR=1.40, 95%CI 1.07-1.84).

Conclusions/Implications: PWID from cities with large-scale SEPs are less likely to engage in high-risk injection behaviors. Together with past and current research on effectiveness of SEPs in reducing injection-related HIV transmission, these findings support the utility of SEPs as important HIV prevention tools in large urban centers in the United States.

Abstract 1805 - Trends in Injection and Sexual HIV Risk among People who Inject Drugs in New York City, 2005-2012

Author(s): *Alan Neaigus, Kathleen Reilly, Samuel Jenness, Holly Hagan, Travis Wendel, David Marshall, Camila Gelpi-Acosta*

Background: Although new HIV diagnoses among people who inject drugs (PWID) have fallen in the US and in New York City (NYC), PWID remain at risk of infection through parenteral and sexual transmission. Monitoring injection and sexual HIV risk among PWID over time can help to assess the efficacy of HIV prevention programs that target PWID and can provide sentinel indicators of potential HIV epidemics in this population.

Methods: PWID were recruited in NYC in 2005, 2009, and 2012 for the CDC-sponsored National HIV Behavioral Surveillance study using respondent driven sampling. Eligible participants (age ≥ 18 years, injected drugs in the past 12 months, able to be interviewed in English or Spanish, and lived in NYC) who consented were interviewed about their HIV risk/prevention behaviors and tested for HIV. Logistic regression was used to test for linear trends between time and sample characteristics, and between time and HIV risk/prevention behaviors, and to estimate odds ratios (OR) and 95% confidence intervals (95%CI). Multivariate models of HIV risk/prevention behaviors included time and sample characteristics significantly associated with time. Statistical significance is $p < 0.05$.

Results: The total sample size was 1,539 (500 in 2005, 514 in 2009, and 525 in 2012). Over time, there was a significant increase in median age (in years) (42.5 [IQR:35.0,48.5]; 40.5 [IQR:33.0,46.0]; 45.0 [IQR:37.0,51.0]; Spearman's $\rho = 0.10$) and in reporting an annual income of $< \$10,000$ (64.5%, 60.3%, 72.7%), and significant declines in injecting > 1 time/day (55.8%, 76.1%, 45.9%), self-reported HIV-positive status (20%, 7.0%, 8.2%), and testing HIV positive in the study (18%/249 tested, 12.5%/511 tested, 12.2%/502 tested). Time trends for gender, race/ethnicity, and sexual identity were not significant. Among HIV risk/prevention behaviors, obtaining all syringes from a syringe exchange or pharmacy increased significantly (35.4%, 67.5%, 50.1%; OR=1.34, 95%CI=1.18,1.51). Always injecting with a sterile needle (52.6%, 40.3%, 47.8%), receptive syringe sharing (21.4%, 27.0%, 25.1%), and sharing other injecting equipment (45.0%, 43.4%, 46.7%) were not significant. There was a significant increase in unprotected vaginal or anal sex (53.6%, 71.2%, 70.3%, OR=1.45, 95%CI=1.27,1.65) and a marginally significant increase in exchange sex (26.2%, 13.2%, 30.7%, OR=1.14, 95%CI=0.99,1.32). The median number of sex partners was not significant (2 [IQR:1,4]; 1 [IQR:1,3]; 2 [IQR:1,4]; Spearman's $\rho = 0.01$). In multivariate analysis of HIV risk/prevention behaviors and time, controlling for age, income, injecting > 1 time/day, self-reported HIV-positive status, and PWID social network size, significant time trends remained significant and exchange sex achieved significance (adjusted OR=1.17, 95%CI=1.01,1.37).

Conclusions/Implications: During 2005 to 2012, PWID in NYC increasingly obtained all their syringes from safe sources. However, injecting risk behaviors in this period were considerable with approximately a quarter engaging in receptive syringe sharing and close to half sharing other injecting equipment. Sexual risk was high, with increases in unprotected sex and exchange sex. Although HIV infection among PWID in NYC has declined continued injecting and sexual risk behaviors are of concern. Ongoing surveillance and maintaining prevention programs that target both injection and sexual risk among PWID are needed in order to reduce and eventually eliminate new HIV infections in this population.

Abstract 2032 - Influence of Injection Venue on HIV/Hepatitis Prevention Knowledge, Injection-Associated Risk Behaviors, and Seroprevalence among Nonurban Injectors in Southwest Connecticut

Author(s): *Lauretta Grau*

Background: Little is known about injection-associated risk behaviors, knowledge, and seroprevalence of viral infections among people who inject drugs (PWID) in nonurban locales in the U.S. Baseline data from a longitudinal study of active, nonurban injectors residing in Southwestern Connecticut were used to assess if injecting in locations that offer harm reduction services was associated with greater

knowledge, lower levels of injection-associated risk behaviors, or lower prevalence of HIV or hepatitis B or C infection.

Methods: We described the sample and performed bivariate and multivariate analyses on self-reported and serological data to identify differences between individuals who injected primarily in nonurban locales and those who did not.

Results: Those injecting most often in nonurban areas were more likely to have health insurance (80.7% vs 64.7%; $p < 0.001$) and be older (37.2 vs 31.4 years; $p < 0.0001$), with longer injection careers (12.1 vs 9.3 years; $p < 0.01$). Regardless of location, most had been in substance abuse treatment at least once and had a criminal record. Harm reduction knowledge and access to harm reduction services were poor in both groups. Those injecting most often in urban settings were 1.88 times more likely to engage in at least one injection-associated risk behavior than their nonurban counterpart ($p = 0.007$). Knowledge was positively and independently associated with larger injection networks. Seroprevalence rates (23.6% for HBV, 39.2% for HCV, and 1.1% for HIV) were no different between the two groups.

Conclusions/Implications: There was little evidence that the benefits of urban harm reduction programs—syringe exchange, safer injection practices, or HIV, hepatitis and overdose education—have penetrated into this nonurban population, even among those who injected drugs in urban locales where these programs are situated. HCV infection was positively associated with the length of injection career and underscores the continued and urgent need to intervene as soon as possible with new injectors in order to provide them with harm reduction information and services. Innovative harm reduction interventions for nonurban communities are needed to reduce HBV and HCV transmission and prevent the spread of HIV should it enter this population of PWID. Future directions in research will be discussed as well as recommendations for changes in policy and potential interventions.

Session A11 - Testing, Testing, Testing: The First Entry Step Into The HIV Care Continuum

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1268 - Predictors of Acute HIV Cases Missed by Fourth Generation Assays

Author(s): Sarah Lewis, Stephanie E Cohen, Susan S Philip, Cindy Gay, Lisa Hightow-Weidman, Emily Westheimer, Jie Fu, Laura Hall, Philip J Peters,

Background: Acute HIV infection (AHI) occurs during the period between HIV infection and seroconversion, when anti-HIV antibodies become detectable in the blood. Due to increased infectivity during this period, the diagnosis of AHI is important for interrupting cycles of transmission. Because traditional antibody tests cannot detect AHI, it must be diagnosed by a viral nucleic acid test (NAT), which can be slow and relatively expensive, or by 4th generation HIV antigen-antibody (Ag/Ab) tests, which are less expensive than NAT but also less sensitive. Identifying correlates of 4th generation HIV Ag/Ab-negative acute HIV, may provide information about which populations should be offered NAT testing for AHI screening.

Methods: The Screening Targeted Populations to Interrupt On-going Chains of HIV Transmission with Enhanced Partner Notification (STOP) study is a CDC-funded study conducted from 2011 to 2013 at

multiple testing sites in New York, San Francisco, and North Carolina in which subjects were tested with a rapid point of care HIV antibody test. Rapid antibody negative specimens were tested with a 4th generation Ag/Ab test (Abbott ARCHITECT, Abbott Park, IL) and were pooled in batches of 10-80 for HIV nucleic acid testing (NAT). Univariable subanalysis was used to compare the subjects with AHI and a positive 4th generation test to those with AHI and a negative 4th generation test and diagnosed only by pooled NAT.

Results: Of the 86,840 tested, 168 subjects had test results consistent with AHI. Of these 168 cases, 130 were positive by both 4th generation test and pooled NAT, 4 were positive only by 4th generation test, and 34 were positive only by pooled NAT. Univariable analysis revealed reporting an HIV-infected partner increased the odds of 4th generation-negative AHI with OR 2.4 (95% CI 0.95-5.86; $p=0.06$) across all sites combined and with OR of 4.5 (95% CI 1.3-16.8; $p=0.01$) among those cases diagnosed at the San Francisco sites. Reporting sex while intoxicated decreased odds of 4th generation negative AHI, with OR 0.4 (95% CI 0.01 – 1.1; $p=0.04$).

Conclusions/Implications: Fourth generation HIV Ag/Ab tests missed 18% of AHI cases detected during the STOP study. Demographic and risk behavior data available at the time of testing were not predictive of 4th generation-negative AHI except among San Francisco sites, in which reporting an HIV-infected partner was positively associated with 4th generation-negative AHI. Other factors, for instance HIV prevalence and incidence in the population accessing testing and time since last HIV test, should be used to determine whether 4th generation HIV Ag/Ab test or NAT should be used to screen for AHI.

Abstract 1479 - CDC-Funded HIV Testing and HIV Service Delivery to Persons Attending STD clinics in the United States

Author(s): *Matthew Hogben, Puja Seth, Guoshen Wang, Erin Sizemore, Lisa Belcher*

Background: Over 1.2 million people are living with HIV in the US. STD clinics often serve minority populations, persons who may be economically disadvantaged and have limited access to health care, and persons who are at high risk for HIV infection and seeking confidential HIV/STD services. Therefore, the purpose of these analyses were to examine CDC-funded HIV testing and HIV service delivery in STD clinics.

Methods: Data were submitted by 61 health department jurisdictions in 2013. CDC-funded HIV testing, HIV positivity, and linkage to HIV medical care were described by client characteristics. Data to identify gay, bisexual, and other men who have sex with men (collectively referred to as MSM) and transgender persons are required for testing events in non-healthcare settings but are required only for HIV-positive persons from healthcare settings. Additionally, trends on HIV testing, HIV positivity, and linkage to HIV medical care from 2011-2013 were examined. Data from 2014 will be included in the presentation.

Results: In 2013, 18.6% (621,010) of all CDC-funded HIV testing events were conducted in STD clinics. The majority of HIV tests in STD clinics were among males (52.2%), African Americans (50.1%), and persons aged 20-29 years (49.7%). The overall HIV positivity of newly identified positives in STD clinics was 0.8%. Of all new positives identified by CDC-funded testing in 2013, 27.3% were identified in STD clinics, and 30.1% of all newly identified HIV-positive MSM were identified in STD clinics. The highest

percentage of newly identified HIV-positive persons was identified among African American MSM (10.5%), Hispanic/Latino MSM (5.6%) all MSM (5.6%), and transgender persons (1.7%). Linkage within any timeframe was 63.8%-78.0%, and linkage within 90 days was 55.3%-85.3%. Because of incomplete data, ranges are presented to show the minimum and maximum percentages achieved on linkage. From 2011 to 2013, there was an overall increase in the number of CDC-funded HIV testing events conducted in STD clinics: a large increase from 2011 (467,676) to 2012 (635,410), but a slight decrease from 2012 to 2013 (621,010). Chi-square analyses revealed that the percentage of first-time HIV testers in STD clinics significantly decreased each year, $p < .01$. However, the percentage of newly identified HIV-positive persons significantly increased each year from 0.6% in 2011 to 0.8% in 2013, $p < .01$. Finally, percentages for linkage to HIV medical care within any timeframe and linkage within 90 days significantly increased each year, $p < .01$.

Conclusions/Implications: STD clinics found a meaningful proportion of newly identified HIV-positive persons, and they are settings to target persons who might otherwise not seek HIV testing or medical evaluation. The success of linkage to HIV medical care varies within and across jurisdictions and populations, with implementation research being the putative route to understand the barriers of linkage efforts so that improvements can be made. HIV testing in STD clinics has added value if the testing can be sustained through CDC funding or through other sources, such as reimbursement from insurance.

Abstract 1854 - Recruiting Labs into Public Health Reporting to Implement the HIV Diagnostic Testing Algorithm

Author(s): *Deepa Rajulu, Joanne Gerber, Kathleen Hukey, Brenda Moncur, Jessica Simpson, Senait Woldaj, Stephanie Shulman, Monica Parker, Bridget Anderson,*

Background: The Centers for Disease Control and Prevention (CDC) and the Association of Public Health Laboratories (APHL) issued updated recommendations in June 2014 for HIV diagnostic laboratory testing. The HIV Diagnostic Testing Algorithm (DTA) was proposed in 2010, the first substantive change since the 1980's. The DTA does not rely on the HIV Western blot (WB). A key test required a change to the Food and Drug Administration (FDA) permitted use statement. Approval was granted March 2013 enabling laboratories to adopt the DTA. In May 2013, New York State Department of Health (NYSDOH) released interim guidance regarding public health reporting of DTA results in anticipation of official CDC/APHL recommendations. The NYSDOH Clinical Laboratory Evaluation Program (CLEP) has regulatory oversight of clinical laboratories performing testing on NYS residents.

Methods: Internal processes were reevaluated and a laboratory recruitment protocol was developed to facilitate and standardize reporting related to DTA. It was anticipated that alternate testing sequences or algorithms would be acceptable, so procedures were flexible to each laboratory's nuanced DTA implementation. A CLEP survey was administered to laboratories permitted by NYS to conduct HIV testing to assess their intention to adopt the DTA; 100% responded. Using survey results, non-reporting laboratories were identified and targeted for recruitment into public health reporting. Simultaneous to DTA implementation, laboratories that continued HIV WB testing were asked to report both positive and indeterminate results of WB because of its' lower sensitivity compared to other testing methodologies.

Results: The CLEP survey identified and prioritized laboratories to be recruited into public health reporting. Thirty-seven laboratories currently report results of the DTA; 14 labs are new reporters. Twenty-two labs are undergoing NYSDOH certification. In 2014, 1.1 million HIV-related test results were reported, with 7,852 reports of either 4th or 3rd generation (Step 1) test results, 10,908 HIV1/HIV2 antibody differentiation assay (Step 2) results and 1,676 qualitative RNA (Step 3) results. A total of 4,753 incomplete sets of results and, ultimately, unresolved HIV-infection status, reports have been received. From May 2013-December 2014, 1,004 indeterminate WB reports were received from 29 laboratories; 463 are without additional testing and have unresolved infection status.

Conclusions/Implications: Incomplete reporting of the algorithm is common. Alternate algorithms and laboratory specific reporting nuances complicate interpreting and processing some test results. While it is challenging to pioneer public health reporting in the absence of official recommendations, the lessons learned in NYS are relevant for jurisdictions in all stages of implementation.

Abstract 2259 - Is self-reported HIV status a reliable measure of true HIV burden?

Author(s): *Hilda Ndirangu, Sophie Sembajwe Sembajwe, Ravikiran Muvva, Carolyn Nganga-Good, Tanya Myers*

Issue: Many jurisdictions rely on self-reported HIV status to determine the next steps for action in the field. Over time, we have questioned its validity and thus sought to compare self-reported HIV status with HIV status verified by surveillance.

Setting: Prior to 2009, our jurisdiction classified HIV-positive encounters as new or previous positives, based on self-reported HIV status obtained during the testing encounter. Currently, our Health Department has an agreement with the State Health Department, giving us access to the State's eHARS system to determine if a positive encounter was truly new or had been previously reported to surveillance. In addition, we also check if there are encounters in the local HIV/STD databases.

Project: Although we have the ability to check multiple databases to determine if HIV positive people we encounter are truly new, many other jurisdictions do not have this capacity. Moreover, our funders continue to aggregate testing data for feedback reports by self-reported HIV status in the absence of these verification-by-surveillance mechanisms. Our program staff record-search in the State's surveillance database, the city HIV/STD prevention database, Ryan White provider databases and STD Clinics' medical records to check if these patients have been previously diagnosed or are in care. A reactive result is considered new by surveillance if not found in any of the above databases. We sought to assess if there is concordance in self-reported positivity versus positive status verified through surveillance. We analyzed data from 517 positive patient encounters from 2013.

Results: Of the 517 positive encounters, only 472 had both self-reported and surveillance-verified measures and were thus included in the analyses. When comparing self-reported HIV status to status verified by surveillance, self-reported new HIV status showed good concordance with new positives verified by surveillance primarily among new positives (162/169, 95.6%), but not previous positives (62/303, 20.5%; $p=0.00$). Self-reported HIV status was not a reliable measure of HIV positivity for previous positives, as most people tested were not willing to disclose previous positive results.

Lessons Learned: On record searching and verifying positives by surveillance, we immediately noticed a drop in the number of new HIV cases reported in our jurisdiction, which makes it harder to meet pre-determined outcome measures from the funders. Doing this however, helped us to identify the real burden of disease and to better allocate our financial and staff resources. We generally interview all new positives, and only interview previous positives if they concurrently test reactive for a bacterial STI. There is utility for self-report particularly when better quality data is not easily available. However, we recommend limiting the use of self-reported status when more valid surveillance data are available as patients generally deny being previous positives likely due to incentives offered during testing and social desirability bias. There is a need for better data-sharing and decentralization of surveillance by jurisdictions to allow more reliable and timely determination of HIV positive status, in order to reduce misclassification of previous positives in the field and to administer appropriate follow-up of cases.

Session A17 - The HIV Care Continuum and the Affordable Care Act

Room: A703 (Atlanta Marriott Marquis)

Abstract 5020 - Insurance Status Following the Implementation of the Affordable Care Act among Adults in HIV Care in Six US Jurisdictions.

Author(s): *Julia Hood, Alexandra Gagner, Jennifer Kienzle, David Maggio, Katie Markey, Jennifer Reuer, Michael Wu, Bridget Anderson, Susan Buskin*

Background: The Affordable Care Act (ACA) was anticipated to impact health care coverage for people living with HIV (PLWH), with notable differences between states with and without Medicaid expansion. We compared indicators of ACA's impact on adults in HIV care, aged 18-64, in three jurisdictions with Medicaid expansion [Chicago, New York State (excl. NYC), Washington] and three jurisdictions without Medicaid expansion [Georgia, Texas (excl. Houston), Virginia].

Methods: Medical Monitoring Project (MMP) interview data were analyzed separately in each of the six jurisdictions. MMP is designed to sample PLWH representative of the underlying population of adults in HIV-care. We assessed cross-jurisdictional differences in the implementation of ACA; demographics of MMP sample; insurance status and type that was reported pre-ACA implementation (Aug. 2012-Apr. 2013, "MMP 2012") and post-ACA implementation (Aug. 2014-Apr. 2015, "MMP-2014"); and self-report of ACA impact on HIV care among respondents <65 years of age. We used multivariate Poisson regression models to estimate the relative risk of two outcomes, possession of health insurance and possession of Medicaid specifically. Models were adjusted for age, race, sex, education level, nativity, and income. Since weights are currently unavailable for MMP 2014, all analyses are unweighted.

Results: From the 2012/2014 MMP cycles, respectively, we analyzed interview records from 1236/1251 PLWH who were sampled from 131/126 facilities across the six jurisdictions. The percent of MMP respondents who were uninsured and likely solely reliant on Ryan White decreased from 34% to 8% in Chicago, 27% to 10% in Georgia, 3.1% to 2.7% in New York State, 29% to 8% in Texas, 37% to 21% in Virginia, 15% to 4% in Washington. With the exception of New York State which already had a low percent uninsured in MMP-2012, the likelihood of having insurance was significantly greater post-ACA compared to pre-ACA implementation in all 5 remaining jurisdictions [Chicago: aRR=1.39 (95% CI= 1.26,

1.54); Georgia: aRR=1.25 (95% CI= 1.13, 1.38); Texas: aRR=1.33 (95% CI= 1.20, 1.46); Virginia: aRR=1.20 (95% CI= 1.1, 1.4); Washington: aRR=1.12 (95% CI= 1.06, 1.20)]. In two of six jurisdictions, the likelihood of having Medicaid was greater post-ACA compared to pre-ACA implementation: [Chicago: aRR=1.28 (95% CI= 1.05, 1.56); Washington: aRR=1.71 (95% CI= 1.34, 2.18)]. Post-ACA implementation, 23-41% of respondents (representing the range across jurisdictions) indicated having difficulty paying for medical care and 15-35% reported a change in health insurance in the prior 12 months. Among respondents indicating a change in health insurance, 6-22% indicated a recent change in HIV care provider; 29-77% indicated a change in the amount spent on medical care; and 15-33% indicated a change in quality of HIV care.

Conclusions/Implications: MMP data from these six jurisdictions suggest that more HIV care patients were insured following the implementation of ACA. An increase in the likelihood of being Medicaid-insured was observed in two jurisdictions with Medicaid expansion. Many MMP participants reported a recent change in insurance coverage, HIV care provider, and HIV care quality and cost. Our analysis illustrates the considerable heterogeneity across the United States in terms of structural and individual-level factors that affect population-level HIV care indicators.

Abstract 5057 - Timing of Linkage to Care After HIV diagnosis and Time to Viral Suppression

Author(s): *H Irene Hall, Tian Tang, Anna Satcher Johnson, Lorena Espinoza, Norma Harris, Eugene McCray*

Background: Prompt linkage to care after HIV diagnosis allows early initiation of HIV treatment, which is associated with reduced morbidity, mortality and transmission of the virus. We compared outcomes for two indicators of linkage to care: linkage within 3 months after HIV diagnosis vs. linkage within 1 month after diagnosis.

Methods: Using data from the National HIV Surveillance System from 14 jurisdictions with complete reporting of HIV-related laboratory test results during 2010-2014, we assessed the relation of linkage to care within 1 month vs. 3 months with time to viral suppression among persons who received a diagnosis of HIV infection during 2010-2011. Linkage to care was defined as ≥ 1 CD4 or viral load test result in the specified time period. Kaplan-Meier survival analyses were conducted to determine time to viral suppression (first viral load < 200 copies/mL) and percentage with a suppressed viral load at 12 and 24 months after HIV diagnosis.

Results: Among 26,026 persons who received a diagnosis of HIV infection during 2010-2011, 20,572 (79.0%) were linked to care within 3 months after diagnosis. Among these, 81.7% were linked to care within 1 month. Among persons linked to care within 3 months after diagnosis (including those linked within 1 month), the mean time to viral suppression was 15.9 months, with 63.6% achieving viral suppression within 12 months after diagnosis and 75.5% achieving viral suppression within 24 months. Among those linked to care within 1 month after diagnosis, the mean time to viral suppression was 15.4 months, with 64.9% and 76.1% achieving viral suppression within 12 months and 24 months, respectively. Among those linked to care within 2-3 months after HIV diagnosis, 58.2% and 72.7% achieved viral suppression within 12 months and 24 months, respectively, which was significantly lower than the percentage with viral suppression among persons linked to care within 1 month. Among those

not linked to care within 3 months after diagnosis, 17.0% had a suppressed viral load within 12 months and 32.7% within 24 months after diagnosis.

Conclusions/Implications: Prompt linkage to care (≤3 months after HIV diagnosis) facilitates treatment and reduces time to viral suppression. Overall, the difference in time to viral suppression between the two indicators of linkage to care within 1 month vs. within 3 months after HIV diagnosis is small because the majority are linked within 1 month. However, results indicate that linkage within 1 month improves outcomes compared to linkage within 2-3 months and may accelerate mitigation of onward HIV transmission.

Abstract 5090 - HIV Staging Outcomes of Newly Diagnosed Cases Over a 5-year Period in Washington, D.C.

Author(s): *Garret Lum, Maryam Iqbal, Saba Qasmieh, Kerri Dorsey, Amanda Castel*

Background: Staging of HIV infection serves as an indicator of the effectiveness of risk reduction interventions, HIV screening, late testing, and the potential for onward transmission. Given the advent of technologies to detect HIV earlier, changes in routine testing guidelines, and support for early treatment initiation, coupled with the new CDC revised surveillance staging guidelines, the objectives of this analysis were to determine if HIV diagnoses were occurring at earlier stages of infection, and whether improvements in clinical staging were observed over time.

Methods: Cases 13 years of age and older who were newly diagnosed with HIV/AIDS and had at least one CD4 count within a year of diagnosis were extracted from the District of Columbia HIV/AIDS Surveillance System. Cases were classified using the new CDC surveillance case definitions for staging of HIV infection (stage 1: CD4 \geq 500 cells/ μ L; stage 2: CD4 200-499 cells/ μ L; or stage 3 (AIDS): CD4 <200 cells/ μ L. Cases were staged at diagnosis and for the subsequent 5-year period; deaths and viral load (VL) results were also measured. Chi-square tests and Wilcoxon-Mann-Whitney tests for trend were calculated to assess changes over time.

Results: Between 2009 and 2013, the percentage of persons diagnosed at Stage 1 increased significantly from 32.7% to 42.7% ($p < 0.001$). Among 881 newly diagnosed HIV/AIDS cases in 2009, 761 (86%) had CD4 cell counts reported within the first year of diagnosis. At diagnosis, 249 cases (32.7%) were classified as Stage 1, 292 (38.4%) as Stage 2, and 220 (28.9%) as Stage 3. Among cases initially diagnosed in Stage 1, over the 5-year period, 48.2% remained in Stage 1 and median VL decreased from 2,786 to 20 copies/mL (p -value < 0.001). Among Stage 2 cases, 20.5% remained in Stage 2, 38.7% moved to Stage 1, and median VL decreased from 12,821 to 27 copies/ml ($p < 0.001$ for trend). Among Stage 3 cases, 9.5% of cases remained in Stage 3, 32% moved to Stage 2, and 19.1% moved to Stage 1. Median VL among Stage 3 cases declined significantly from 61,071 to 20 copies/mL ($p < 0.001$). By the end of the 5-year period, deaths occurred among 1.6%, 4.5%, and 12.2% of cases in Stage 1, 2, and 3, respectively. CD4 data were unavailable for 42.2%, 37.7%, and 39.1% of persons in Stages 1, 2, and 3, respectively, at the end of the observation period suggesting a lack of care receipt, testing, underreporting, or possible migration out of the District.

Conclusions/Implications: Using the new CDC staging definitions, the data showed that people were diagnosed earlier in the stage of their infection and observed improvements in immune function and viral suppression over time, regardless of initial stage at diagnosis. However, persons diagnosed in Stage 3 (AIDS), continue to have poorer outcomes and large proportions of cases had evidence of marginal care engagement. Analysis of CD4 staging over time provides an alternative perspective on the impact of technological and programmatic advances in HIV diagnosis, care, and treatment and underscores how these efforts can result in improved health outcomes among HIV-infected persons.

Abstract 5111 - Assessing the HIV Care Continuum in Persons Co-Infected with Hepatitis B or C, in Georgia, 2012

Author(s): *Andrenita West, Delmar Little*

Background: HIV and Hepatitis B Virus (HBV) are blood-borne viruses that have common modes of transmission, and persons who are co-infected with HIV and HBV are at risk for developing chronic HB. As with HBV, a Hepatitis C Virus (HCV) co-infection with HIV can result in health complications such as increased progression of liver deterioration, a higher rate of HIV viral persistence, and even death. In addition, HCV can also impact the course and management of HIV. Georgia has never assessed the continuum of HIV Care among individuals co-infected with HIV and either HBV or HCV.

Methods: Notifiable disease reports received by the Georgia Department of Public Health (DPH) for individuals diagnosed with HBV and/or HCV by December 31, 2012 were abstracted from the State Electronic Notifiable Disease Surveillance System (SENDSS). These data were then matched to prevalent HIV cases in the state Electronic HIV/AIDS Report System (eHARS) diagnosed by September 2011 and alive as of December 31, 2012. The final dataset contained n=1,642 cases > 13 years of age individuals co-infected with hepatitis B or C and HIV. Engagement in care (at least 1 CD4 or VL), retention in care (> 2 CD4 or VL at least 3 months apart after diagnosis), and VS (most recent VL <200 copies/mL) were assessed for the matched cases and for all 48,544 persons living with HIV in Georgia as of the same date.

Results: Among the 1,642 matched co-infected cases, 77.28% were engaged in care, 58.4% retained in care, and 47.2% were virally suppressed. Comparatively among persons living with HIV in Georgia; 58% were engaged in care, 45% were retained in care, and 38% were virally suppressed.

Conclusions/Implications: This analysis establishes baseline data regarding the differences in care among individuals co-infected with HIV and HBV/HCV. It shows, in all measures of the care continuum, that the co-infected individuals were found to have better outcomes than those who were mono-infected with HIV. The outcome differences identifies where co-infected individuals are doing better, thus pinpointing areas of further investigation and research. Further analysis is needed to investigate reasons why co-infected individuals appear to have better continua outcomes than those not co-infected.

Track B

Session B07 - Bringing Them Back: Innovative Strategies for Locating and Re-Linking PLWH Not-In-Care

Abstract 1429 - Virginia's Care Marker Database: Using Multiple Data Sources for HIV Care Linkage and Re-Engagement

Author(s): *Anne Rhodes, Lauren Yerkes, Jean Cadet, Elaine Martin*

Issue: The use of HIV surveillance data to increase linkage to and retention in medical care is the focus of many initiatives responding to the issues of the HIV Continuum of Care (HCC). Surveillance data alone may lack information contained in other data systems that track persons living with HIV (PLWH).

Setting: In Virginia, with funding from the CAPUS grant, VDH developed the Care Markers Database (CMDB) to merge multiple data systems that contain data on PLWH.

Project: A group of analysts and data managers from different HIV programs worked together to develop a series of data extracts that could be produced on a monthly basis to populate the CMDB, a secured SQL-server database. These databases included the enhanced HIV/AIDS Reporting System (eHARS), the AIDS Drug Assistance Program (ADAP) data, Ryan White services data, HIV testing data, data from the Medical Monitoring Project and Medicaid data. Demographic information, including race/ethnicity, gender, age, risk, current residence, and date of HIV diagnosis are included, along with all care markers. A care marker is defined as evidence of a CD4 count, a viral load, antiretroviral therapy, or an HIV medical visit. The data are utilized to generate lists of persons lost to care, defined as not having a care marker in the past 12 months but have a care marker in the past 24 months. Piloting of these lists was done by Disease Intervention Specialists (DIS) to determine if persons could be re-engaged in care.

Results: The utilization of data from sources other than eHARS for determining the HCC measures led to increases of over 5% statewide in linkage and viral suppression rates and over 8% in retention rates. The lost to care lists for 2014 generated from the CMDB had 1,852 persons who had a care marker in 2013 but not in 2014. Initial investigations by DIS at two health districts indicated that of 18 cases investigated, 28% (n=5) were in care, 16.7% (n=3) had moved out of state, 28% could not be located, and 16.7% were re-engaged in care. VDH is currently working to generate lost to care lists for medical sites, using the CMDB.

Lessons Learned: The utilization of multiple data sources to generate the HCC and lost to care lists has assisted VDH in assessing linkage, retention and viral suppression rates for different target populations. Regional differences have generated discussions about reporting issues in areas of the state where persons may be crossing borders to get care and have assisted in developing inter-jurisdictional data sharing agreements.

The lost to care lists have provided DIS and medical sites with outreach populations and assisted in improving data systems, as feedback is received at VDH on persons who are in care. Further refinements of the lists are currently underway, including electronic distribution of lists through a secured web-based system and the ability for providers and DIS to track a client's appointments and update their care status through the system.

Abstract 1645 - Project Engage: An Innovative Technique for Finding and Linking Marginalized Out of Care HIV-Infected Persons in Los Angeles County

Author(s): *Rhodri Dierst-Davies, Natasha Ludwig-Barron, Amy Wohl*

Issue: National estimates indicate that 37-55% of HIV-positive individuals received regular clinical care between 1995 and 2010. Innovative methods are needed to identify and link marginalized (e.g., homeless, highly-mobile, substance-using, recently incarcerated) HIV-infected persons who have fallen out of care (OOC).

Setting: Los Angeles County (LAC) has one of the largest populations of HIV- infected persons in the United States. It is estimated that only 47% of persons living with HIV (PLWH) in LAC were retained in HIV care in 2011.

Project: Project Engage (PE) was designed to find hard-to-reach OOC HIV-positive persons and link them to HIV care. Recruitment strategies included a combination of snowball sampling using trained recruiters from local HIV clinics and direct recruitment through the use of outreach workers and flyers. OOC was defined as an HIV-positive individual with either: 1) no HIV care visits in >12 months; 2) no HIV care for 7-12 months and most recent VL>200 copies/ml; 3) newly-diagnosed and not linked to care within 3 months; or 4) recently released from jail with no identified primary HIV provider. Participants were incentivized \$40 for completing a baseline survey. Recruiters and OOC persons received \$40 when a referred OOC person linked to care. OOC status was verified using HIV surveillance data. Staff advocated for linkage to care and helped negotiate barriers.

Results: To date, 140 participants have enrolled, including 61 recruiters and 79 OOC PLWH. Among OOC persons, 28 (35%) were enrolled through direct recruitment and 51 (65%) through snowball sampling. OOC participants were primarily African-American (38%), MSM (67%), uninsured (48%), recently incarcerated (52%), homeless (78%) and 28% reported recent exchange sex. On average, OOC persons had not seen a provider for 13 months; previously attended 3 separate HIV clinics; and 24% were on ART at enrollment. OOC participants reported an average of 9 sexual partners within the previous 6-months, and 66% had unsuppressed VL prior to enrollment per HIV surveillance data (mean=121,582 copies/ml). It took an average of 31 days to link a participant to HIV care and 7.2 hours of staff time. Among OOC persons, 75% (n=59) were linked to care, and of those enrolled for six months (n=55), 75% were retained in care. Needs for services such as medical care (77%), oral health care (81%) and medical case management (63%) were high, and OOC participants reported barriers such as not knowing where to go, disrespect from clinic staff and paperwork difficulties as major reasons they were unable to obtain HIV care. Program acceptability was high.

Lessons Learned: A combined methodology of snowball sampling and direct recruitment is effective for finding severely marginalized OOC HIV-positive persons and can be critical in supporting linkage to HIV care efforts.

Abstract 2138 - Linkage and Re-engagement to HIV Care: Results from CDC-Funded Demonstration Projects Using HIV Surveillance Data

Author(s): *John Beltrami, Ted Duncan, Cindy Lyles, Angel Sanchez, Pat Sweeney, Erica Dunbar*

Issue: Under CDC Program Announcement PS12-1201 for health departments, Category A funds ongoing comprehensive HIV prevention, and Category C funds four-year demonstration projects based on program and scientific staff closely working together. One Category C goal is the transfer of successful Category C activities to Category A work once Category C funding ends. The focus here is the use of HIV surveillance data as an innovative Category C strategy for linking to HIV care persons who are newly diagnosed with HIV and re-engaging to HIV care persons previously in care, but currently out of care. We compare Category A and C percentages of persons linked and re-engaged, and determine Category C challenges and lessons learned.

Setting: Since 2012, 8 health departments (7 state and 1 city) from all 4 U.S. Census Bureau regions have been funded under Category C for the reporting of results from the use of HIV surveillance data for linkage and re-engagement to HIV care; 5 conduct linkage and re-engagement, and 3 conduct only re-engagement. Linkage and re-engagement are conducted mostly by Disease Intervention Specialists, but staff from clinics, health departments, and community-based organizations also participate. Of the 12 priority populations chosen by the health departments, the most frequently chosen were men who have sex with men (n=4) and minority communities (n=2).

Project: Sources of information used for Category C analyses of these 8 health departments include health department applications, progress reports, conference calls, emails, and site visits during 2012-2014. Sources of information used for Category A analyses of these 8 health departments include progress reports for linkage during 2012-2014 and for re-engagement during 2013-2014 (only available years for comparison). Project definitions vary by grantee, but presented linkage results account for seeing an HIV care provider within 90 days of an HIV diagnosis.

Results: During 2012-2014, the health departments achieved an overall Category C linkage of 80% (1,128/1,413) and re-engagement of 58% (409/705). During 2012-2014, the health departments achieved an overall Category A linkage of 67% (696/1,039) and re-engagement of 68% (376/557). Challenges reported by more than 1 health department included: using HIV surveillance and other databases to identify and locate persons is time consuming and difficult, particularly for re-engagement (n=5), HIV surveillance data do not have needed up-to-date information (n=5), and needed data are in different databases (n=3). Common lessons learned included HIV surveillance data are now more accurate because of feedback from prevention and treatment staff (n=4); Category C activities brought together and enhanced collaborative work among surveillance, prevention, and treatment staff (n=4); and Category C activities provided the foundation for future enhanced health department work (n=3). Seven health departments are already planning to sustain at least some of their Category C activities after Category C funding ends.

Lessons Learned: Results suggest that Category C activities using HIV surveillance data are useful and have potential for transfer to Category A, but have challenges that need to be addressed by surveillance and program staff. Health departments have benefited from enhanced HIV prevention-treatment and program-science collaborations.

Session B12 - Health Communication and Structural Interventions to Prevent HIV Infection

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 1481 - Structural Interventions in HIV Prevention: A Taxonomy and Descriptive Systematic Review

Author(s): *Terrika Barham, Theresa Sipe, Wayne Johnson, Heather Joseph, Malu Tungol-Ashmon, Ann O'Leary*

Background: The National HIV/AIDS Strategy calls for the expansion of efforts to prevent HIV infection using a combination of effective, evidence-based approaches. Biomedical and behavioral approaches have been effective in mitigating the impact of HIV; however, such approaches do not address underlying social, economic, legal, and political structures that might shape HIV risk and vulnerability. Structural approaches (i.e., those that work outside of the control of the individual to alter the environment or choice structure) have the potential to influence multiple health conditions, and those that address HIV are key in preventing new infections. Yet, the current knowledge base for structural interventions must be improved, as these strategies have received relatively little scientific evaluation. A taxonomy of structural interventions is useful to ascertain types of structural interventions and to identify strategies that are over-utilized or under-addressed. This study reviews the literature of structural interventions addressing HIV, and describes the newly developed taxonomy of structural interventions.

Methods: We searched CDC's HIV/AIDS Prevention Research Synthesis (PRS) project's database for relevant interventions published between 1988 and May 2013. Interventions were also identified through hand searching of reference lists of related reports and systematic reviews. A taxonomy of structural interventions was developed using an iterative process that included independent coding and group discussion. Seven categories were created (i.e., Access, Policy/Procedure, Physical Structure, Capacity Building, Mass Media, Community Mobilization, and Social Determinants of Health) and definitions for each category were further refined through independent coding of reports with two trained coders. Discrepancies were resolved through discussion by all team members. Structural interventions were classified in categories from the taxonomy. Classification of structural interventions was not mutually exclusive, and interventions could be classified in multiple categories.

Results: A total of 146 structural interventions were identified. The interventions were conducted between 1983 and 2011 and more than half began in 2003 or later. Seventy-three percent of interventions were categorized as Access, in which the interventions provided health products or services, or made products or services more readily available (e.g., needle exchange programs,). Policy/Procedure (43%) was the next largest category, with 51 studies employing institutional policies/procedures (e.g., clinic policies on HIV testing). Structural interventions were categorized as Physical Structure (36%) (e.g., formation of new HIV primary care youth clinic); Capacity Building (25%); Mass Media (16%); Community Mobilization (8%), and Social Determinants of Health (8%). Before-after research design was the most frequent design used for evaluation (38%). Forty percent of interventions targeted high-risk populations, including people who inject drugs (16%), and men who have sex with men (MSM) (6%), and among these interventions, 81% were Access, and 40% were Physical Structure

interventions. Testing or treatment outcomes were the most frequently reported outcomes (50%), and consisted predominately of HIV testing (35%) or linkage to care (8%).

Conclusions/Implications: A majority of the structural interventions identified in this review improved access to products and services; however, few structural interventions addressed social determinants. Additional research is needed on structural interventions that have been rigorously evaluated, and interventions targeting groups most affected by HIV, particularly MSM.

Abstract 1741 - Let Me See Your App!": Exploring Digital Tools for Improving Partner Communication on HIV/STI Prevention

Author(s): *Kevon-Mark Jackman, Mian Hossain, Lorece Edwards, Kesha Baptiste-Roberts*

Background: Students at Historically Black Colleges and Universities (HBCUs) are at increased risk for HIV /STDs compared to those at Predominantly White Institutions. Discussing testing and status with sexual partners is an HIV/STD prevention strategy supporting effective partner communication. It is not well known how young Black adults perceive facilitating these conversations with electronic personal records (PHRs) that deliver HIV/STD screening results on digital media devices. The Electronic Sexual Health Information Notification & Education (eSHINE) Study is a mixed-methods study exploring perceptions of PHRs as prevention tools among students ages 18 -25 years at a Historically Black College or University (HBCU).

Methods: We used Grounded Theory methods to explore perceptions of using PHRs in prevention conversations among students ages 18 -25 years at an HBCU. Three audio-recorded focus groups and eighteen individual interviews were conducted with a sample of thirty-five students (nineteen men and sixteen women), including participants self-identifying as MSM, members of Greek organizations, and student athletes. Analysis of transcripts and field notes were conducted using ATLAS.ti.

Results: Participants were largely unaware of PHRs; nevertheless, many expressed views highly in favor of its use with sexual partners. Perceived benefits included, convenience, reducing conversation awkwardness, and information verification. Information security vulnerabilities, partner distrust implications and unprotected sex enablement were perceived as risks. Perceptions of PHR use were highly contextual and appear to be influenced by factors on individual, dyadic/relational, social environment and structural levels.

Conclusions/Implications: Findings suggest that prevention conversations facilitated with PHRs may be widely but not universally adopted. The practice was perceived as beneficial to sexual health; however, it was also perceived to potentially increase risk when used as a proxy for determining condom use. Study findings may help to inform the careful design of patient-centered PHR applications and potentially improve the delivery of HIV/STD preventative care. Addressing PHR awareness and access are priority to better determining its preventative value in sexual health.

Abstract 1909 - HIV Prevention among Mexican Migrants at Different Migration Phases: Exposure to Prevention Messages and Association With Testing Behaviors

Author(s): Ana Martinez-Donate, Gudelia Rangel, Xiao Zhang, Norma-Jean Simon, Natalie Rhoads, Ahmed Asadi-Gonzalez, Melbourne Hovell, Carol Sipan, J. Eduardo Gonzalez-Fagoaga

Background: Migration and mobility have been identified as structural risk factors for HIV infection. Migration is a complex process involving multiple phases representing different risk and protective factors. Mexican im/migrants face an elevated risk of HIV infection. A better understanding of prevention gaps and opportunities across migration phases is necessary to reduce their HIV risk. We investigated levels of exposure to HIV prevention messages, factors associated with exposure to HIV prevention, and the association between exposure to prevention messages and HIV testing behavior among Mexican im/migrants at different phases of the migration process.

Methods: We conducted a cross-sectional, probability, interviewer-administered survey of Mexican im/migrants (N=3,149) traveling through the border city of Tijuana, Mexico (response rate = 51%). Sampling venues included the Tijuana International Airport, the largest bus station in Tijuana, and the main deportation station in Tijuana. Based on their trajectory and migration experience, respondents were classified as representing the pre-departure, transit, destination, interception, and return phases. We computed descriptive statistics to characterize HIV testing and levels and sources of exposure to prevention messages by migration phase. Adjusted logistic regression models were estimated to test for significant differences in testing and exposure across migration phases and to identify factors associated with exposure to prevention within each migration phase.

Results: Rates of exposure to HIV prevention messages ranged 57%-75%, being lowest for migrants at the destination, interception, and return phases compared to migrants at pre-departure and transit. Across phases, the content of the messages was most often focused on promotion of condom use followed by STI and HIV testing. The most frequent sources of exposure were television (47% - 69%), family members (45% - 67%), friends (43% - 67%), and health care settings (36% - 50%). Compared to the pre-departure phase, interpersonal sources were significantly more prevalent ($p < .001$) and media (TV and billboards) were significantly less prevalent at all post-migration phases. The likelihood of exposure to prevention messages was significantly higher among those with health insurance across all migration phases, except the return phase (AORs ranged 1.8 – 2.4, $p < .05$). Exposure in receiving communities was also positively associated with length of time in the U.S. (AORs for “> 10 years” vs. “< 1 year” ranged 4.4 - 9.2, $p < .01$). In contrast, time in the U.S. was negatively related with exposure to prevention in sending communities (AOR for “>10 years” vs. “< 1 year” = 0.49, $p < .05$). Between 14% and 25% of migrants reported testing for HIV during the last 12 months. With the exception of the return phase, exposure to prevention messages increased the odds of recent HIV testing (AORs ranged 1.6 – 3.3, $p < .05$).

Conclusions/Implications: Mexican im/migrants present limited exposure to HIV prevention messages and suboptimal last 12-month HIV testing rates across migration phases. Exposure to prevention messages may encourage HIV testing, but the likelihood of exposure decreases after migration to the U.S. Binational efforts need to be intensified to more effectively reach and deliver HIV prevention to Mexican im/migrants across the migration continuum, with emphasis on circular migrants and the return phase.

Abstract 2140 - Targeting Attitudes to Concurrency: Effect of a Radio Campaign in Rural North Carolina
Author(s): *Adaora Adimora, Catalina Ramirez, Victor Schoenbach, Joan Cates, Robert Agans, Anna Barry-Cope, Thierry Fortune, Ziya Gizliye*

Background: Heterosexually transmitted HIV infection among African Americans is a continuing and urgent problem. Overlapping (concurrent) sexual partnerships may be an important contributor to this problem. Although successful control of the US HIV epidemic will require attention to the powerful socioeconomic and other contextual factors that promote concurrent partnerships, less favorable attitudes toward concurrency could reduce this behavior. Mathematical modeling suggests that even small decreases in concurrency could meaningfully reduce population transmission.

Methods: In order to decrease favorability of attitudes toward concurrency among young African American adults, we collaborated with a communications marketing company to develop a radio ad campaign with messages and provocative dramatizations inspired by focus group interviews. We disseminated the campaign with frequent spots per day on 3 radio stations in 6 rural eastern North Carolina counties during an 8-month period. We measured attitude changes in the target population with telephone surveys pre- and 3-months post-campaign among two independent samples of African American men and women, ages 18 to 34 years, using an attitude scale derived from a factor analysis of responses to a series of concurrency vignettes (higher score = more pro-concurrency attitude).

Results: A total of 1,157 people participated in the surveys (678 pre-campaign, 479 post-campaign). Results confirmed high campaign exposure among the target audience, in that a substantially greater proportion of post-campaign respondents (30.9%; 95% CI 26.3%, 35.4%) than pre-campaign respondents (6.3%; 94.1%, 8.5%) reported having seen, heard, or read messages about concurrency. Overall, mean concurrency attitude scores became substantially less favorable to concurrency after the campaign (pre-campaign: 3.4; 3.23, 3.57; post-campaign: 2.62; 2.46, 2.78). This decrease in favorability of attitudes toward concurrency was noted in essentially all demographic and risk categories. Post-campaign respondents reported less favorable attitudes regardless of whether they acknowledged exposure to concurrency messages or correctly defined concurrency during the survey, consistent with our expectation that the campaign messages would spread by word-of-mouth.

Although pre- and post-campaign samples had similar characteristics, we used multiple regression to adjust pre-post comparisons for demographic and risk characteristics and also for participant and partner's concurrency, with and without stratification by gender. All models revealed less favorable attitudes to concurrency after the campaign (e.g., pre: 3.45; 3.28, 3.62; post: 2.77; 2.59, 2.95), suggesting that the differences observed were not a function of differences in the composition of the populations surveyed.

Conclusions/Implications: Our results suggest that a carefully targeted, intensive mass media campaign can change attitudes about concurrency - a preliminary step in behavior change.

Session B20 - Home HIV Testing in MSM

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1159 - Democratized Testing at a Los Angeles Commercial Sex Venue: Should Vending Machines and Home Testing Augment Point-of-Care Testing in High-Risk Venues?

Author(s): *Mark McGrath, Emily Huang, Lauren Natoli, Jeffrey Klausner*

Issue: Commercial sex venues (CSVs) such as bathhouses are frequented by men who have sex with men (MSM) seeking sexual liaisons. To operate within the jurisdiction of the Los Angeles County Department of Public Health (LACDPH), CSVs are required to offer onsite HIV testing administered by trained personnel. Testing volumes within these settings has been low. It has been hypothesized that internalized stigma may be a barrier to CSVs clients seeking testing within setting.

Setting: A commercial sex venue (CSV) located within the County of Los Angeles.

Project: Beginning December 1, 2014, the AIDS Healthcare Foundation installed an electronic vending machine dispensing free HIV home test kits in the lounge of a 24-hour CSV in the Los Angeles area. The vending machine is available to CSV clients 24 hours per day, 7 days per week, and is adjacent to the testing station set up by the LACDPH-trained staff. The frequency of vending machine use was tracked with web-based software.

Results: Within a four-month period the vending machine dispensed 620 HIV home test kits (average: 39 per week). Over the same period, the LACDPH-trained personnel administered 104 point-of-care HIV tests (average: 7 per week).

Lessons Learned: Within a high-risk venue, vending machine distribution of HIV home test kits significantly outperforms LACDPH-sponsored HIV testing in terms of testing volume. Vending machine distribution has exceeded traditional testing methods, and requires fewer staffing resources as the machine can be monitored remotely and restocked periodically. Future work should examine actual usage of the test kits as well as test results.

Abstract 1373 - High Risk Men Who Have Not Recently Tested Take Free HIV Self-Testing Kits Offered at a Gay Bathhouse

Author(s): *William J Woods, Sheri A Lippman, Emily Agnew, Scott Carroll, Diane Binson*

Background: Men who have sex with men (MSM) who have not tested in the past 6 months may require alternative testing strategies to meet the U.S. Centers for Disease Control and Prevention (CDC) recommendation that sexually active MSM test for HIV every 3 to 6 months. This may be especially true for young, ethnic minority and non-gay-identified MSM. We distributed free OraQuick In-home HIV Test® kits to men at a gay bathhouse to assess if infrequent HIV-testers, specifically young, minority MSM, would accept self-testing.

Methods: To avoid selection bias, men were systematically selected to receive a test-kit coupon at entry or at exit (depending on the recruitment shift). A recruiter estimated the age and race/ethnicity of every selected man, regardless of whether he accepted the coupon. The coupon could be redeemed for a single test kit only that night and picked up a few feet away. Those who presented the coupon took an

11-item survey about testing history, HIV status and other demographic characteristics. The kit included information about obtaining confirmatory testing.

Over six 3-hour shifts, among the eligible population of 509 men counted entering the venue during study recruitment, 181 were systematically selected to receive coupons, of whom 92 (51%) accepted the coupon. Among those accepting coupons, 61 (66%) men redeemed the coupon, with 54 kits distributed overall (30% of those selected to receive a coupon). Recruiter-estimated age was highly correlated with survey responses (Pearson $CC=0.8$, $p<.01$).

Results: Those who redeemed the coupon were more ethnically diverse ($z=2.61$, $p<.01$) than the recruiter-estimated race of all those selected to receive a coupon. There was no difference in age between men offered a coupon and those electing to pick-up a self-test.

Those who completed the survey were mainly “gay” identified, although 18% identified as bisexual. More than half had not tested in the past 6 months (57%), including those who had never tested (7%). While most respondents who had previously tested did so at a medical/clinical setting (53%), nearly half had used non-clinical settings. Some men who took the kit reported that they were HIV-positive (10%) and, of these, 80% were on therapy. Among those reporting negative HIV-status, 9% reported being on PrEP. Though only approaching significance (perhaps due to small sample size), survey respondents who were ethnic minority ($p=.06$), non-gay-identified ($p=.10$) or who had previously tested in non-medical settings ($p=.10$) were less likely than other men who took the test kits to have tested recently for HIV.

Conclusions/Implications: The bathhouse served as an excellent venue for offering HIV self-testing kits to a population likely to be at risk for HIV. Importantly, MSM from ethnic minority backgrounds, who had never tested and those who last tested more than 6 months ago were among those most likely to take the free test kit. Offering HIV self-test kits in the bathhouse is a viable strategy to reach some minority populations and those who may not be inclined to test in a medical setting, and thus are not testing as frequently as recommended by CDC guidelines.

Abstract 1393 - Extending HIV Testing Access through Vouchers for Home Testing

Author(s): *Beth Meyerson, Larry Jimison, Nate Rush, Cedric Carter, Deidre Coleman, Relton Harvey, Aaron King, Debra Buckner, Terrell Parker, Anthony Gillespie*

Background: The 2012 FDA approval of home HIV tests created the opportunity to think broadly about public health systems access to HIV testing. In Indiana, pharmacists were supportive of expanding HIV testing through pharmacies, and they understood unique opportunities for consultation when selling an over-the-counter HIV test. Further, gay and bisexual Indiana men preferred access to a home test as compared with pharmacy-based testing; particularly men who did not know their status. We hypothesize that people who are stigmatized about HIV testing may also prefer home testing; but because the price of the test is high, it may be a barrier to test access. This study evaluated the feasibility of removing the price barrier for home HIV tests through HIV test voucher distribution and redemption in three low to moderate-income African American communities in Indianapolis.

Methods: The African American HIV Action Team (AHIT) led this community-based participatory research project. AHIT members were organizations serving primarily African American communities, and specialized in outreach to chemically dependent populations (Bethlehem House), LGBT populations

(Brothers United) and providing public health services generally (Marion County Health and Hospitals Corporation). Our study evaluated the implementation of voucher distribution by these organizations, and the redemption of vouchers at three designated Walgreens pharmacies serving primarily low to moderate-income African American communities. Vouchers could be redeemed for a free Oraquick HIV home test. Distribution was conducted on a one-on-one basis with those identified by outreach workers as having likely interest in an HIV test, but potentially feeling stigmatized if having to seek one from a health care provider or a community organization. Implementation was measured by weekly distribution rates, and field notes gathering feedback from distributors during the study period. Voucher redemption rates were calculated as an initial proxy of intent to test at home. Three 30-day voucher distribution waves occurred between February-April 30 2015.

Results: During the first two waves, 234 vouchers were distributed, 37 vouchers were redeemed, for a redemption rate of 15.8%. The initial number distributors reduced from 8 people in 3 organizations to 5 people in 2 organizations. All three pharmacies redeemed vouchers, and pharmacists were highly supportive of the project. There were 8 occurrences of multi-voucher redemptions of 2-tests a time.

Conclusions/Implications: This feasibility study demonstrated that HIV home test vouchers could be distributed by outreach organizations, that pharmacists would support the effort, and that people would redeem the vouchers for an HIV home test. Future studies should explore how voucher distribution can expand the current HIV testing system.

Abstract 1599 - Home HIV Testing among Young, African American Gay, Bisexual, and Other MSM: Who Uses It and Who Intends To Use It in the Future

Author(s): *Greg Rebchook, Susan Kegeles, Lance Pollack, Judy Tan, David Huebner, John Peterson*

Background: Young, African American gay, bisexual, and other MSM (YAAMSM) are at high risk for HIV infection. Encouraging YAAMSM to know their current HIV status in order to reduce the number of undiagnosed HIV cases is an important part of the National HIV/AIDS Strategy. When YAAMSM know they are HIV-positive, they can engage in care to suppress their viral load to improve their health and to reduce the risk of transmitting HIV. HIV stigma, concerns about privacy, inconvenience, and lack of culturally competent testing sites may prevent some YAAMSM from testing regularly. Home HIV testing provides an opportunity for YAAMSM to learn their HIV status in private settings at self-chosen times and locations; however, little data exist about YAAMSM's experience with and attitudes towards home testing. Such information could be valuable to the HIV prevention workforce's decision-making around policies and programs to integrate home testing technologies into community-based HIV prevention programs.

Methods: As part of a multi-year evaluation of an Mpowerment Project (MP) adapted for YAAMSM in Texas, we collected cross-sectional data from YAAMSM annually in Houston and Dallas. In 2013, we surveyed 660 YAAMSM and included questions about their experience with and attitudes towards home testing. We defined home testing within the survey, and we also measured a variety of psychosocial variables, HIV risk behaviors, and participation in the MP, a community-level HIV prevention intervention.

Results: Among the 590 HIV-negative or status unknown participants, 18.5% reported ever using a home HIV test kit, and 61% said that they are either extremely likely (39%) or somewhat likely (22%) to use a home kit in the future. Sixty percent said that they are either extremely likely (42%) or somewhat likely (18%) to ask a partner to use a home kit in the future. Previous home test kit users are significantly more likely than non-users to say they are extremely likely to use the test in the future ($p < .01$) or ask a partner to use the test ($p < .01$). Compared to non-users, previous users: are more likely to report participation in the MP ($p < .01$); have higher self-rated SES ($p < .01$); are more likely to have a health care provider (HCP) ($p < .01$), but are LESS willing to tell their HCP that they have sex with men ($p < .05$); perceived that community norms were less supportive of safer sex and HIV testing ($p < .05$); were less resilient ($p < .05$); had lower levels of belief that one's health is in God's hand ($p < .01$); and reported less pride in being gay ($p < .05$).

Conclusions/Implications: Given the strong interest in home testing as a testing option for YAAMSM, the HIV prevention workforce should consider developing strategies to make home testing more widely available and affordable—especially to those who may be unlikely to disclose same sex sexual activity to healthcare providers. Guidance about how home testing could be used with potential sex partners may be an important contribution to the field. Programs that seek to link newly diagnosed HIV positive individuals into healthcare need to find innovative ways to reach home test kit users who test HIV positive.

Session B26 - PrEP Implementation in Community-Based Clinical Settings

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1795 - Real-Time Biomarkers of TDF/FTC Use Support a Staged-Intensity Adherence Support Intervention in a Pre-Exposure Prophylaxis Demonstration Project

Author(s): *Raphael Landovitz, K. Rivet Amico, Christina Psaros, Ryan Kofron, Risa Flynn, Robert Bolan, Wilbert Jordan, M. Keith Rawlings, Peter Anderson, Amy Rock Wohl*

Background: Pre-exposure Prophylaxis (PrEP) is highly effective for HIV prevention for men who have sex with men (MSM). However, its effectiveness is tightly correlated with adherence to daily administration of TDF/FTC. Although adherence was a major issue in many placebo-controlled trials of PrEP efficacy, rates of PrEP adherence among adopters of open label PrEP are only now entering the evidence-base. Early evidence suggests that adherence may be adequate for high PrEP protection among most MSM adopting PrEP. Identifying when low adherence occurs to activate targeted support may facilitate tailored approaches to address non-adherence in clinical settings.

Methods: We deployed a PrEP demonstration project at two community-based sites in Los Angeles, California. The project first stratified participants into a low/moderate (LM) risk cohort and a higher (H) risk cohort based on a computer assisted self-interview (CASI) assessment. Cohort LM participants received a comprehensive needs-based HIV prevention program including education about free Post-exposure prophylaxis (PEP) in the event of suspected HIV exposure. PEP was provided free to participants during the study. Cohort H participants received an identical needs-based prevention program that included daily oral TDF/FTC. Participants were re-evaluated and allowed to escalate from LM to H based on serial CASI assessment. Cohort H participants all received integrated Next Step

Counseling (iNSC) to support PrEP adherence; individuals with plasma TFV levels below limits of quantitation (BLQ, < 10 ng/mL) were escalated to a more intensive adherence support intervention (targeted NSC), and a second BLQ sample triggered further support escalation (PrEP-STEPS).

Results: As of April 13, 2015, 302 individuals had screened, and 274 enrolled (91%) out of planned 300 participants; enrollment is expected to complete in May 2015. 250 initially were stratified into H (91%); of 24 initially assigned to LM, 17 (71%) have escalated to H. One transgender woman (TGW) has enrolled. Participants have a median age of 34 (range 20-69). 54.3% are non-Hispanic white, 9.0% African-American, 23.2% Latino, 13.5% mixed race/other. Retention ranged from 97% (week4) to 73% (week48). Overall, 1 participant seroconverted (incidence 0.77 per 100 py) approximately 1 month after self-discontinuing PrEP; his diagnosis-sample virus contained the M184V mutation. To date, 17 participants have had BLQ samples for TFV and have undergone escalation in adherence support; 2 participants had a second BLQ sample prompting further escalation of support. Of the 2 maximally escalated-support participants, one voluntarily entered substance abuse inpatient treatment and exited the study; one was unable to adhere to daily TDF/FTC and opted to cease PrEP treatment and was followed on-study but off study medication. There have been three permanent discontinuations for adverse events: one Grade 2 CK elevation, one Grade 2 gastrointestinal distress, and one Grade 4 psychosis (unrelated to study product); no discontinuations for nephrotoxicity have occurred.

Conclusions/Implications: Daily TDF/FTC for PrEP is safe and acceptable for a racially and ethnically diverse sample of at-risk MSM in Los Angeles. Using real-time TFV plasma levels to support a staged-intensity adherence intervention is acceptable and feasible. HIV incidence was low, suggesting high levels of protective efficacy. More data are needed in TGW.

Abstract 2063 - Pilot Implementation of PrEP: Active Referral Model in a Chicago Public STI Clinic
Author(s): *Tarek Mikati, Ramona Bhatia, Daniel Pohl, Kristen Keglovitz, Bryan Buatista-Gutierrez*

Background: PrEP is an effective HIV prevention biomedical approach. Multiple observational studies among MSM attending STI clinics showed that rectal gonorrhea (GC), rectal chlamydia (CT) and early syphilis are associated with increased risk of HIV acquisition. As such, STI clinics, particularly in high morbidity areas with large number of MSM clients, are well positioned to identify individuals who may benefit from PrEP. However, many STI clinics are not yet structured, staffed, or resourced to provide PrEP on site. Different models of PrEP implementation in STI clinics need to be explored.

Methods: A PrEP active referral model between Chicago Department of Public Health (CDPH) Lakeview STI Clinic and the PrEP clinic at Howard Brown Health Center (HBHC) was piloted between September 2014 and March 2015. Eligibility for active referral was any patient who tested HIV negative at the STI clinic in combination with any of the following criteria: MSM with early syphilis ; MSM with rectal GC/CT; sexual partners (any gender) of HIV infected STI clinic patients. Active referral model consisted of the following steps 1) STI clinic provider offered active referral to an eligible patient 2) a referral form with indication and contact information of interested patient was faxed to HBHC. 3) HBHC PrEP coordinator contacted the patient via e-mail or phone to schedule an appointment with a PrEP provider. The major outcome of this study was linkage of actively referred patients to PrEP, defined as completion of an

appointment with a PrEP provider. Charts of referred patients were reviewed at both clinics to abstract demographic, sexual history, lab, clinical visit data.

Results: Fifty-two STI clinic patients accepted PrEP active referral: 24 (46%) had early syphilis, 23 (44%) had rectal GC, 19 (37%) had rectal CT, and 10 (19%) were sexual partners of HIV infected individuals. Thirty patients (58%) had more than one indication for referral. All patients were MSM with median age of 26 years (IQR24, 28). The major racial/ethnic groups were Hispanic (40%), white non-Hispanic (29%), and black non-Hispanic (25%). In the last 3 months prior to referral, 77% had multiple sexual partners (median 4 partners) and 62% reported receptive anal intercourse. Among the referred patients, 63% had inconsistent condom use during anal sex and 67% had sex while intoxicated with drugs or alcohol. A PrEP coordinator attempted contact with all referred patients 3 times. Twenty-seven patients (52%) responded of which 21 (40%) scheduled an appointment with HBHC PrEP provider. Seventeen patients (33%) completed the scheduled visit. All linked patients were prescribed PrEP at the initial visit except for one who tested HIV positive.

Conclusions/Implications: Partnership between CDPH STI clinic and HBHC provided PrEP to MSM with STI's the majority of which engage in high- risk sexual practices. CDPH is expanding the active referral model to its other 4 STI clinics and partnering with additional PrEP clinics across Chicago. Further research is needed to understand the barriers to linkage to PrEP services using the active referral model in order to increase PrEP uptake among patients at high risk of HIV acquisition.

Abstract 2091 - One-Step PrEP: A Pharmacist-Run HIV Pre-Exposure Prophylaxis (PrEP) Clinic in a Community Pharmacy Setting

Author(s): *Elyse Tung, Annalisa Thomas, Ryan Hansen, Peter Shalit*

Issue: PrEP has been demonstrated to be effective in several clinical trials and supported by the CDC for the prevention of HIV in high-risk populations. Current HIV PrEP access has been limited to traditional medical clinic visits or physician appointments. The success of PrEP is highly dependent on counseling, medication adherence, HIV testing, drug monitoring and follow up care. For years, pharmacists have been demonstrating success in managing other clinic-based protocols to aid in the management of other disease states such as hypertension, hyperlipidemia, tobacco use and anticoagulation. Pharmacists are one of the most highly accessible health care professionals in the community, and in order to improve access to PrEP, a pharmacist-run HIV PrEP service in a community pharmacy setting was established.

Setting: One-Step PrEP is a novel pharmacist-run HIV PrEP clinic set in a community pharmacy at Kelley-Ross Pharmacy in Seattle, Washington. This is the first PrEP clinic based at a pharmacy and operated by pharmacists. The initial goal of One-Step PrEP is to prove service implementation and feasibility in a pharmacy setting. If sustainable, PrEP in pharmacies would provide an additional option for accessing this mode of HIV prevention for high-risk individuals who do not have a primary care provider (PCP) or whose PCP is not experienced with this type of treatment.

Project: Under physician oversight with a collaborative drug therapy agreement (CDTA), the service was established in March 2015. The One-Step PrEP service allows for a single patient encounter to provide access to PrEP. The CDTA allows pharmacists to meet with patients individually, make a risk assessment,

provide counseling and testing, evaluate results, prescribe and dispense PrEP when appropriate, and provide follow up care as outlined by the 2014 US Public Health Service Clinical Practice Guidelines for PrEP. Sustainability and barriers to providing PrEP in a pharmacy setting were identified and addressed.

Results: From July 2014 to March 2015, primary barriers for service implementation were identified. A prediction model was created to identify if the service would be a sustainable business. During the first year of operation with a patient panel of 100, profitability is predicted to be at 6%. Marketing costs and equipment costs are the highest at 43% and 18% respectively. Training costs are the lowest at 1%. Phlebotomy training was the most time consuming, requiring 24 hours of pharmacist time over 5 weeks and an additional 5 weeks for licensure. Other barriers identified include screening and monitoring for HIV/STI and medication toxicity.

Lessons Learned: A pharmacist-run HIV PrEP clinic in a community pharmacy is feasible and prediction models prove it to be financially sustainable. Additional revenue may be generated from administration of routine immunizations in high-risk populations. The clinic has been operational since March 2015. A majority of One-Step PrEP patients do not have primary care providers. Equipment and technology are currently available on the market place for successful implementation of the program. Phlebotomy training and licensing are the most time consuming barriers but are technically and intellectually manageable for pharmacists.

Abstract 5113 - High linkage to PrEP care in St. Louis Using a Pilot Linkage to PrEP Care Community Partnership Program

Author(s): *Rupa Patel, Dale Wrigley, Kenneth Mayer, William Powderly*

Background: There are over 400 new HIV infections per year in Missouri and incidence has been stable. Pre-exposure prophylaxis for HIV (PrEP) is effective in preventing HIV and has been incorporated into national HIV prevention guidelines. However, little is known about the implementation of PrEP, especially in medium-sized Midwestern cities and in states where there is no Medicaid expansion. We describe a pilot linkage to PrEP care program affiliated with the Washington University in St. Louis (WUSTL) Infectious Diseases PrEP program which incorporates health insurance navigation and linkage to PrEP care.

Methods: We describe a pilot linkage to PrEP care program over 12 months (July 2014 - July 2015) that incorporated referrals to the (WUSTL) PrEP program and a linkage to PrEP care telephone line. This pilot program was formed as a partnership between WUSTL and St. Louis Effort for AIDS (EFA), a local community-based HIV prevention organization, to connect those interested in PrEP with a provider. A telephone line was used to receive calls and to make follow up calls for referrals. EFA was a community partner for referrals and provided health insurance navigation and literacy counseling among those interested. We describe the number of calls and referrals, demographics of PrEP seekers, and outcome of linkage to care. Linkage to care was defined as those attending a PrEP clinical care visit.

Results: We had a total of 90 referrals and calls to the pilot linkage to PrEP care program. Seventy-nine of 90 individuals (86.7%) were contacted. Of potential PrEP users (n = 74), 7 people (9.0%) only sought information about PrEP whereas 67 individuals (90.5%) wanted to schedule an appointment for PrEP

care. Of the 67 individuals requesting PrEP care, the median age was 30.5 years (interquartile range 27 - 35), 33 (50.0%) were between the ages of 20 to 30 years, 60 (89.5%) were male, 31 (46.3%) were non-white, 50 (74.6%) were men who had sex with men (MSM), and 37 (55.2%) had an HIV positive sexual partner. Surprisingly, 78.2% (36 of 46 individuals) had a primary care physician (PCP), were insured, and were requesting another provider for PrEP. Reasons for requesting a PrEP provider in addition to a PCP (n = 36) included 25 individuals (69.4%) felt uncomfortable discussing their sexual practices. A total of 64.2% (43 of 67 individuals) were linked to care. Of the uninsured (n = 21), 42.9% (9 individuals) were linked to care. Among the uninsured who requested to speak to an insurance navigator (n = 18), 8 individuals (44.4%) had follow up and 75.0% (6 of 8 individuals) obtained insurance.

Conclusions/Implications: PrEP dissemination and implementation strategies are being devised across the US. We describe a pilot linkage to PrEP care program, based on a community-academic partnership, that promoted PrEP implementation in St. Louis, Missouri. Among those who were motivated and previously engaged in community-based organization services, there was a high success rate.

Session B29 - Women and HIV

Room: A707 (Atlanta Marriott Marquis)

Abstract 5023 - Evaluating the Impact of Perinatal HIV Medical Case Management on the HIV Care Continuum of Pregnant and Postpartum HIV-infected Women, Philadelphia, 2005-2013

Author(s): *Emily Anderson, Florence Momplaisir, Kathleen Brady*

Background: To reduce morbidity of pregnant women with HIV, engagement in HIV care during pregnancy and postpartum is critical. Perinatal Medical Case Managers (PCM) reduce barriers to care by providing psychosocial and supportive services (transportation, food, housing, substance abuse treatment), and outreach services to women with missed medical visits during pregnancy. We evaluated the impact of PCM on retention and viral suppression of HIV+ women during pregnancy and up to 1-year postpartum.

Methods: Using the population-based Enhanced Perinatal Surveillance system and PCM records, we compared demographic and clinical characteristics of HIV+ pregnant women in Philadelphia by receipt of PCM defined as having ≥ 2 encounters with a PCM from 2005-2013. Encounters were weighted equally and included face-to-face, phone interactions, contacts with other agencies, and transportation vouchers. We then conducted multivariable regression analyses to evaluate the association between receipt of PCM and four outcomes: (1) viral suppression at delivery defined as a viral load (VL) ≤ 200 copies/mL closest to delivery, (2) re-engagement in HIV care postpartum defined as ≥ 1 CD4 or VL within 90-days of delivery, (3) 1-year postpartum retention defined as ≥ 1 CD4 or VL in each 6-month interval of the 12-months postpartum with ≥ 60 -days between tests, (4) 1-year postpartum viral suppression defined as a VL ≤ 200 copies/mL closest to the end of the first-year postpartum. Variables were included in the multivariable models based on a p-value < 0.05 in bivariate analysis. For viral suppression at delivery, all significant variables were included in the regression model; for the postpartum outcomes, variables were included if they were significant with 2 of the 3 outcomes. All models were adjusted for age, race/ethnicity, time period, adequacy of prenatal care, and ART prescription during pregnancy. Suppression at delivery was also adjusted for timing of HIV diagnosis, HIV

exposure category, most advanced serostatus, drug use, and sexually transmitted infection during pregnancy.

Results: Of the 841 mother-infant pairs analyzed, 48.5% of women were suppressed before delivery, 38.6% re-engaged in HIV care postpartum, 41.1% were retained in HIV care at 1-year, and 33.9% were suppressed 1-year postpartum. In 401 (47.7%) pregnancies, PCM was initiated during pregnancy or within 60-days postpartum. Women in PCM were younger, $p < 0.0001$; otherwise no differences were noted between the 2 groups. After controlling for covariates, women enrolled in PCM during pregnancy were twice as likely (AOR 2.06, 95%CI 1.45-2.91) to achieve viral suppression at delivery. Those enrolled in PCM during pregnancy and up to 60-days postpartum were more likely to re-engage in HIV care within 90-days of delivery (AOR 1.38, 95%CI 1.02-1.88) and more likely to be retained in HIV care 1-year postpartum (AOR 1.45, 95%CI 1.08-1.97). Viral suppression at 1-year postpartum was similar among both groups (AOR 1.04, 95%CI 0.76-1.43).

Conclusions/Implications: These results suggest that the PCM Program is effective in supporting HIV+ women in achieving optimal adherence to ART during pregnancy and re-engaging them in HIV care postpartum. Further evaluation is warranted to determine if there is an intensity threshold of PCM encounters on outcomes and to determine the cost effectiveness of the program.

Abstract 5096 - Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence

Author(s): Courtney Peasant, Tami Sullivan, Nicole Weiss, Isabel Martinez, Jaimie Meyer

Background: HIV disproportionately affects women who experience intimate partner violence (IPV). IPV-exposed women are three times more likely to engage in sexual risk behaviors, including condomless sex, than those without a history of IPV. Beyond this epidemiological association, IPV exposure and sexual risk-taking behaviors seem to be causally related in complex ways. For example, substance use, depression, and posttraumatic disorder (PTSD) are conditions that often co-occur, and, independently, affect women's ability to negotiate condom use and use condoms with partners. Therefore, it has been hypothesized that these interconnected experiences may synergistically impair condom negotiation, or the act of advocating for condom use, and, as a result, increase condomless sex. The current study is the first to 1) apply a syndemic framework to study the collective effects of problematic drug use, hazardous alcohol use, depression, and PTSD on fear of condom negotiation, condom negotiation, and condom use, and 2) evaluate condom negotiation as a mediator of the association between syndemic severity and condom use among IPV-exposed women.

Methods: Participants were 158 women living in the community and experiencing ongoing IPV who completed face-to-face, computer-assisted interviews including measures of problematic drug use, hazardous alcohol use, depression, and PTSD. Eligibility criteria included a) English speaking; b) aged 18 years or older; c) physical victimization from their male partner in the past six months; d) face-to-face contact with their male partner at least twice per week; e) less than 2 weeks apart from their male partner in the last month; and f) a household income of less than or equal to \$4,200/month.

Results: Almost three-fourths of participants reported problematic drug use, hazardous alcohol use, depression, and/or PTSD; many of these factors were significantly correlated, indicating a syndemic. Multivariate logistic and linear regression analyses revealed associations between syndemic severity and fear of condom negotiation (OR = 1.57, $p = .02$), condom negotiation ($\beta = -8.51$, $p = .001$) and condom use ($\beta = -8.26$, $p = .01$). Meditation analyses identified condom negotiation as a mediator of the association between syndemic severity and condom use (Effect = - 6.57, SE = 2.01, [95% CI: - 10.66, - 2.77]).

Conclusions/Implications: Our results support the hypothesis that women who are exposed to IPV experience a myriad of psychosocial challenges related to sexual risk. Therefore, prevention strategies that target IPV-exposed women should address the multiple challenges that these women face as it relates to practicing safe sex. Policies to reduce the HIV burden among IPV-exposed women cannot only focus on IPV and HIV prevention and care, but must address access to substance abuse and mental health services for these women. Results also fill a critical gap by identifying condom negotiation as a mechanism through which this syndemic affects condom use. HIV and IPV prevention programs should address condom negotiation to reduce sexual risk among IPV-exposed women. IPV-exposed women often experience fear related to condom negotiation, therefore intervention efforts for this population should offer skills to safely negotiate condom use or other tools such as PrEP to reduce HIV risk.

Abstract 5099 - Findings from the Sexual Health and Aging Program (SHAPE) for Older Women with HIV Pilot Study

Author(s): *Tonya Taylor*

Issue: There are few sexual risk reduction interventions that prioritize the unique needs of older women with HIV (OWH). The lack of proven interventions is particularly problematic in light of documented risk behaviors in this population, including unprotected anal and vaginal intercourse (UAVI), often with serodiscordant partners.

Setting: We conducted a pilot study to test the feasibility and acceptability of the program and procedures to reduce UAVI among OWH in an HIV clinic in Brooklyn, NY. Inclusion criteria included: OWH, aged 45 years old and older that reported UAVI in last 3 months.

Project: The Sexual Health and Aging Program (SHAPE) is a small-group (5-8 women), peer-led, skills-based behavioral intervention for OWH designed to reduce participants' stress related to HIV disclosure and maintaining safer sexual behaviors and promote successful aging with HIV. SHAPE is a novel program that addresses sexual health and aging needs of OWH, and incorporates High-Impact Prevention methods, such as PrEP and PEP. SHAPE is an innovative combination intervention that has multiple beneficial effects (i.e., improve sexual health and promote successful aging to reduce UAVI) and support sustained behavior change and prevention maintenance in this population. An ACASI survey was administered to all participants at baseline (pre-intervention) and at 3- and 6-month follow-up. Assessments include: disclosure and safer sex self-efficacy, coping self-efficacy, sexual function, social support, loneliness and quality of life. SHAPE participants received 4, 2-hour long, sessions administered over two days (2 sessions per day). The SOC arm received provider-administered motivational interviewing and successful aging literature.

Results: Thirty-three women participated in the SHAPE program and 22 participated in the SOC arm. There was no statistical difference between study arms. Of the of 58 women recruited, 97% were Black, 83% single, 60% had a high school education or higher, 79% were unemployed, and 79% reported an undetectable viral load. At baseline, 24% reported multiple sex partners, 52% reported having HIV-uninfected partners, 14% reported not knowing their partner's HIV status, 48% reported that there was very little risk of transmitting HIV to their partner, and 12% reported non-disclosure with UAVI. At baseline the median (range) UAVI events in the prior 3 months was 5 (0-96) for the SHAPE arm and 7(0-378) in the SOC arm. In a preliminary analysis (N=31 SHAPE; N= 15 SOC) these frequencies declined to 2 (0-70) in the SHAPE arm and 4 (0-45) in the SOC arm. Change over time pooled across arms was statistically significant ($p<.001$), but there was no statistical difference ($p=0.232$) between study arms in extent of change.

Lessons Learned: We found that the SHAPE program, study procedures and evaluation processes were feasible, safe, and acceptable to reduce UAVI and enhance HIV disclosure self-efficacy. We were able to validate the outcome measures, confirm the effectiveness of recruitment procedures and estimate attrition rates. Findings from this study have the potential to expand our understanding of factors that facilitate the maintenance of safer sex practices for OWH, and will provide a foundation for the implementation of effective HIV prevention in this population.

Abstract 5127 - Barriers and Facilitators to HIV Prevention and Testing Services within an Innovative Partnership Serving Women who have Experienced Domestic Violence

Author(s): *Tiana Pearson, Shevlin John, Kenia Leriano, Samuel MacMaster*

Issue: Women who have experienced the trauma of domestic violence face a challenging transition from a state of not feeling safe to health and wholeness. During this transition basic needs and physical safety often take a priority to HIV needs, despite high levels of vulnerability and risk. Women who have been involved in domestic violence situations may be at high risk, but often do not perceive any risk at all—nor do they independently seek HIV testing. Within Staten Island, it appears that HIV is a neighborhood phenomenon, where the risk of infection is a function of living in a high seroprevalence neighborhood combined with individual behavioral risk factors.

Setting: The program, Strong Steps, works with the Richmond County District Attorney's Office to facilitate a seamless transition for women who are involved as plaintiffs in domestic violence cases to a full continuum of substance abuse, HIV prevention and CTR, and trauma-based services. Additional community-based outreach services are provided in concert with other agency outreach efforts that utilize a neighborhood approach to HIV prevention with a specific focus on minority women.

Project: As part of a comprehensive outreach strategy, community events are held for all CHASI services with a specific focus on services for women. In the past, we recognized that our outreach efforts could be negatively impacted by those who may feel stigmatized and may avoid engaging with domestic violence or HIV service for fear of being identified with either population. Outreach for these services are conducted simultaneously along side outreach for services that have less negative perceptions within the community. Community residents are encouraged by peers to come to the event for

exploration of services that might be applicable to them. A process evaluation was conducted to assess barriers and facilitators to program development and whether the program was implemented as planned. An outcome evaluation was conducted to examine the impact on the lives of the women who engaged with these services. This presentation will highlight barriers, facilitators, and strategies to address barriers for this population.

Results: During 144 events, a total of 322 women were tested. To date, we have served more than 176 women with our full continuum of care. As a group, participants have experienced improvements in substance use (30.2%), employment (9.7%), income (181.5%), housing (4.8%), criminal justice (5.3%), as well as positive changes in HIV risk and mental health categories.

Lessons Learned: Our findings suggest that 1) coupling trauma, and substance abuse, HIV prevention, and mental health services with employment, housing, and advocacy services provides women with both the emotional support and material resources they need to transition to the next phase of their lives; and 2) combining outreach for all of these services reduces barriers related to stigma and misperception of risk. Due to the tremendous challenges presented by the women we serve--many of whom have very limited resources and horrific recent experiences of violence, rape, and trauma—significant positive change requires this full continuum of services and approach to outreach.

Track C

Session C15 - Culturally Competent Population Engagement

Room: Regency V (Hyatt Regency Atlanta)

Abstract 1360 - Reducing the Impact of Discrimination on HIV Risk Behaviors for Rural African American Adolescents through Culturally Tailored Family-Based Prevention

Author(s): *Cady Berkel, Velma McBride Murry, Na Liu*

Background: Racism continues to be a major source of stress for African Americans in our society, especially in the rural South, where vestiges of slavery and Jim Crow laws produce unequal distribution of economic, educational, and health resources. Racism can impair psychological functioning, producing hopelessness, anger, and depression.^{1,2} Adolescents experiencing discrimination may engage in self-soothing, but risky behaviors, such as sexual behavior or substance use³ which may serve as a temporary coping mechanism, but leave them at risk for acquiring HIV. A developing body of evidence links discrimination to HIV risk behaviors for racial and ethnic minority adolescents.^{4,5} Despite the negative effects of racism, it is important to recognize individual differences. Racial identity has been identified as a key factor in explaining how some youth thrive despite exposure to discrimination.⁶⁻⁹ Racial socialization is a determining factor in nurturing this key element of resilience¹⁰⁻¹² and is thus an important target for family-based prevention programs serving racial and ethnic minorities.¹³⁻¹⁵ The current study tested a set of hypotheses regarding the effectiveness of a family-based program in preventing HIV risk behavior among rural African American youth in response to persistent exposure to discrimination. We hypothesized: 1) exposure to racism will negatively affect psychological functioning, sexual risk behavior, and substance abuse; and 2) a culturally tailored family based prevention program

can facilitate positive racial identity, through the enhancement of adaptive racial socialization, which will buffer adolescents from engaging in risky behaviors in response to racism related stress.

Methods: Six waves of data from the Strong African American Families (SAAF) efficacy trial,¹⁵ with 667 African American families in rural Georgia, were used for this study. Children were 11 at Pretest and 16 at W6. Child gender was 47% male and 53% female. There was minimal attrition across waves, with 571 families at W6. Intent to treat analyses¹⁶ using Structural Equation Modeling in Mplus¹⁷ were employed to test study hypotheses. Models testing both hypotheses demonstrated good model fit.¹⁸

Results: Discrimination at age 15 predicted concurrent psychological functioning and HIV related risk behaviors at age 16. Mediation analyses¹⁹ demonstrated that psychological functioning was a significant mediator of these relations. The SAAF program was associated with increases in racial socialization, which in turn fostered gains in adolescent racial identity. Racial identity and racist hassles independently predicted adolescent psychological functioning, which in turn predicted sexual risk behavior and substance use. Moderation analyses²⁰ demonstrated that the negative effect of discrimination on psychological functioning was less for children with higher racial identity.

Conclusions/Implications: This study confirm the negative impact of adolescents' experiences with discrimination for HIV risk behavior. It is also the first study to demonstrate the results of a culturally relevant, evidence-based parenting program in protecting adolescents from the consequences of discrimination.

Abstract 1394 - Let's Have a Kiki: Culturally Relevant Strategies for Outreach and Engagement in a High Risk YMSM Community of Color

Author(s): *Lindsay Slay, Johnny Guaylupo*

Issue: The incidence of HIV among young men who have sex with men (YMSM) and transgender youth of color has steadily increased over the last decade. Uniquely associated to this population in NYC is the Kiki community, which is a subculture of the House ball community, where high HIV prevalence and risky behaviors have been documented among young African Americans and Latinos. In 2011, Housing Works developed culturally relevant youth services specifically catered towards the Kiki community and youth in East New York, Brooklyn, providing access to vital services to a community that has historically been difficult to reach.

Setting: Central Brooklyn and East New York are areas disproportionately affected by poverty. Health status indicators in these neighborhoods are notably worse than the average compared with NYC overall and have a higher HIV case rate. With limited services in the area for LGBTQ youth, Housing Works has created a safe space for YMSM and Transgender youth of color to get tested for HIV, access healthcare and substance use services in a nonjudgmental environment.

Project: The cornerstone of Housing Works youth services is effective outreach and enrollment of high-risk populations. To recruit and enroll participants into youth services, Outreach Specialists utilize innovative methods to reach target populations, including (1) rapid testing, (2) connecting program participants to comprehensive services, (3) access to PEP/PrEP, (4) the provision of incentives for viral

load suppression. In addition, staff that reflect the client population immerse themselves within the Kiki community, developing relationships with “house parents” in order to collaborate on Kiki balls and offer a space for regular meetings and practice.

Results: In 2014, multiple youth programs operating out of East New York conducted a total of 769 HIV tests, identifying 16 new positives under the age of 29. This was achieved in part due to participating in approximately 140 Kiki Events, including balls, practices and weekly activities hosted on site and at partner organizations. Testing and program enrollment provided an opportunity to connect these youth to vital services. As a result, 159 youth were referred to primary care and 68 were referred to mental health services. In addition, 15 youth were connected to emergency PEP after high risk exposure. In 2015, 10 youth have been referred for PrEP evaluation and currently 12 youth are enrolled in the Viral Load Suppression program called The Undetectables.

Lessons Learned: Housing Works youth services’ success is owed to their commitment in cultivating relationships within the Kiki community, which enables the outreach staff to reach young black MSM who were not previously connected to services. Often within this population an HIV-test is the gateway for other essential services. By partnering with the Kiki community, Housing Works has conducted a significant number of HIV tests, as well as screenings for and linkages to highly needed medical, behavioral and supportive services to underserved populations with high-rates of HIV.

Abstract 1623 - Meaningful Use of Community Assessments with Prevention Applications for the Latino Population

Author(s): *Nicole Chisolm, Manisha Maskay*

Issue: There is strong evidence supporting the need for culturally appropriate programs for the Latino community. The most recent report from the Dallas County Health and Human Services (DCHHS) reveals that, in Dallas County, Latinos represent 25% of new HIV/AIDS diagnoses and 22 % of people living with HIV/AIDS (PLWHA). Between 2005 and 2009, 36% of Latino Texans were diagnosed with AIDS within the first year of their HIV diagnosis. Community assessments are conducted to provide guidance for effectively impacting these outcomes however there are often major gaps between conducting community assessment activities and ensuring population feedback is integrated into the development of and evident in the implementation of community based programs.

Setting: Viviendo Valiente is a program of AIDS Arms, Inc. located in Dallas, Texas. The findings presented in the “2014 Mexican Community Needs Assessment Report” carry translational applications within group and individual level intervention development, capacity building strategies for stakeholders, and applications within broader community level outreach and environmental strategies. The translational applications of the findings from the community assessment are intended to enable people of Mexican-descent to become active participants in their health care.

Project: The goal of the Viviendo Valiente program is to create a healthier community by linking people to care earlier as well as reducing barriers to services. The community assessment was conducted as a key formative component of the development of a culturally tailored intervention for people of Mexican-descent living in the Dallas community. Findings include information gathered from 3 primary

community assessment activities: 1) a literature review; 2) a stakeholder survey distributed to service providers in the Dallas area; and 3) focus groups conducted among Latinos in the Dallas community. This presentation will highlight the findings of the 2014 Mexican Community Needs Assessment conducted by *Viviendo Valiente*, and how these findings were used to develop tools and strategies for implementing a Mexican-centric program.

Results: A total of 10 focus groups were held, with 108 Latino adult residents of the Dallas community. Findings were summarized within the areas of primary health concerns, primary health resources, facilitators to care, barriers to access, opinions regarding interest in HIV interventions and prevention messages. Checklists were developed as tools to articulate and guide the translational applications of findings from the community assessment. These checklist tools were developed specifically for 1) cultural tailoring, 2) educational content development and 3) intervention design. Findings were also used to determine additional training needs of implementation staff and community stakeholders.

Lessons Learned: Cultural tailoring of interventions must move beyond linguistic accommodations. Culturally and linguistically appropriate care should employ cultural values as a strengths-based strategy for improving engagement and retention in HIV prevention, education, and treatment initiatives. It is imperative that findings of community assessments are shared with and discussed with implementation staff as well as community partners to ensure application of strategies to address key findings.

Abstract 5044 - Promising Outcomes and Lessons Learned from a Cultural Adaptation and Implementation of an HIV Behavioral Intervention with American Indian Youth

Author(s): *Robert Foley, Corey Smith, Dylan Fills Pipe, Renee Iron Hawk, Denise Casillas, Delf Schmidt-Grimminger*

Issue: In South Dakota in 2013, American Indians (AIs) comprised 9% of the population, but 33% of HIV, 42% of chlamydia, and 65% of gonorrhea diagnoses. A statewide needs assessment and formative research cited increased risk for AI youth due to a low perception of risk, norms supportive of substance use, lack of access to prevention materials, and lack of self-efficacy to communicate with peers/partners about risk.

Setting: The project team adapted and implemented an HIV prevention intervention with AI youth, ages 14-19, who reside on a reservation in South Dakota. The reservation is approximately 3 hours from the nearest urban center. The intervention sessions were implemented at a school or a community center on days when school was not in session.

Project: The research team adapted *Street Smart* - an evidence-based, group-level HIV intervention targeting youth. The adaptation, *Rez Smart*, includes 8 interactive, gender-exclusive group sessions, 1 individual session, and 1 group fieldtrip to a community resource. Group sessions focused on increasing knowledge and perception of risk; practicing cognitive-behavioral coping mechanisms for dealing with risk and peer influence; and, discussion of how traditional Lakota values influence behaviors and decision-making.

Results: 3 female and 3 male cohorts were completed in 2 different reservation communities (n=37). Likert scales were used in pre- and post-test questionnaires examining knowledge, attitudes, skills self-assessment, and intentions.

When the Wilcoxon Signed Rank Test was applied to 6 indicators of intentions and self-efficacy (α=0.05), the intervention led to 1 statistically significant result, and mixed results for others:

- The intervention clearly indicated that participants learned how to put on a male condom (p-value=0.002)
- There was little change in intention to use a condom the next time they have sex (p-value=0.47)
- The intervention did not have much impact on whether or not participants will know their partner the next time they have sex (p-value=0.96), and whether they will have sober sex the next time they have sex (p-value=0.53)
- Increases in pre-post test scores for intention to get an HIV or STD test existed (p-values=0.12 and 0.08, respectively)

The intervention was effective in developing skills, and slightly effective at increasing intentions around testing, condom use and sober sex (although not statistically significant). However, the intervention proved ineffective at raising knowledge of high versus low risk behaviors, and displayed mixed results for the alteration of attitudes regarding sex while high, and drug use.

Lessons Learned: Preliminary analyses suggest that this adaptation was effective at developing skills; the intervention showed little impact on knowledge. A major conclusion is that the intervention sought to affect change across too many behavioral determinants. The implication of these findings is that Rez Smart may be more effective if fewer behaviors are targeted for intervention. Similar programs should identify strategies to talk about sexual risk that are appropriate for AI worldviews. Examples include holding gender-exclusive groups, differentiating activities by gender, inviting a traditional advisor to address the youth, and the examination of the impact of cultural values on contemporary decision-making.

Session C20 - Youth Engagement: Models of Intervention with LGBTQ Youth in School, Community, and Venue-Based Settings

Room: A601 (Atlanta Marriott Marquis)

Abstract 1116 - How to be an Ally to Lesbian, Gay, Bisexual, Transgender and Questioning Youth

Author(s): *Sherry Lehman, Ellen Essick*

Issue: In North Carolina HIV infection disproportionately impacts young men who have sex with men. In 2008, 70% of HIV/AIDS diagnosis among youth 13-24 were among black youth, yet they only represented 17% of the age group population. Schools systems in the state teach comprehensive sexuality education including HIV prevention, however very little education addresses the lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth needs.

Setting: The North Carolina Department of Public Instruction, Healthy Schools Section is funded by the CDC through the Promoting Adolescent Health through School-Based HIV/STD Prevention grant to work

with 15 schools systems impacted by high rates of HIV infection. "How to be an Ally to LGBTQ Youth" is a seven hour professional development for teachers, administrator and school staff to educate them about the disproportionate risk of HIV infection for LGBTQ youth. The training also challenges participants to reflect on their personal values and how they may impact interactions with LGBTQ youth.

Project: They project is a seven hour professional development training that includes the objectives of;
Describe the experiences of sexual and gender minority youth in public schools
Identify the disproportionate rates of transmission of HIV among young men who have sex with men
Explain the higher rates of suicide, suicide attempts, and self-destructive behaviors among LGBTQ youth
Model how to be an ally in the school setting
This professional development is interactive and requires participants to role play, share values and demonstrate educational knowledge.

Results: Between December 2013 and March 2014, the North Carolina Department of Health and Human Services/Division of Public Health (NC DPH), in partnership with the North Carolina Department of Public Instruction (NC DPI), conducted the "How to Be an Ally for Lesbian, Gay, Bisexual, Transgender, Questioning Youth" training ("How to be an Ally"). The primary objective of the short-term evaluation was to assess immediate changes from pre- to post-training related to training participants' preparedness as advocates for LGBTQ youth overall and for the purpose of preventing suicide. The primary objectives of the intermediate evaluation were to assess a) maintenance of changes in preparedness and b) changes in participants' specific actions to support and advocate on behalf of LGBTQ youth overall and for suicide prevention. In total, 57 individuals participated across the three trainings, of which 42 reported working with teens in middle, junior, and high schools, the target population. The evaluation findings indicate that there were several likely effects of the training on participants' preparedness to serve as advocates for LGBTQ students—overall and for the prevention of suicide.

Lessons Learned: While the training seems to have been successful with regard to preparedness, the training may need to focus more attention on specific ways in which trainees can be active as advocates for LGBTQ teens—overall and for suicide prevention. However, it may be important to explore further whether and how participants were able to make progress in asserting themselves as LGBTQ advocates within their schools during the months following the training.

Abstract 1253 - House and Ball Dreams: Using Strategic Planning and High Impact Outreach to Engage young MSM of Color and Transwomen in Los Angeles County

Author(s): *Francisco Cabas, Markqes Johnson*

Issue: One in four Black gay men will become HIV positive by the time they are 25 and one in two will have HIV by the time they are 35. Despite previous efforts, connecting these populations to high impact prevention services continues to be a challenge. The main objective is to present a cost-effective and scalable outreach model that combines traditional forms of outreach, business strategies, and social media to connect young MSM and transwomen of color with high impact prevention services at community-based clinics.

Setting: Urban-Los Angeles County

Project: In May 2014, the Los Angeles LGBT Center formed an outreach team and marketing strategy to address HIV disparities. The objectives were two-fold: 1) launch an aggressive PEP street outreach campaign in areas where MSM of color congregate in order to avert new HIV infections and 2) Build sustainable relationships with public opinion leaders within the House and Ball and Hip Pop Community in Los Angeles to ensure continued service delivery.

Results: During the first month after launching outreach strategy, the Center saw a 9.5% increase in the number of Latinos accessing PEP. House and Ball Community Outreach, allowed numerous African-American youth to test for HIV with a high proportion testing for the first time.

Lessons Learned: In order to reduce HIV incidence among high risk communities, high-impact outreach strategies must combine results-driven objectives, a strong underlying strategic structure, and cultural competence with target communities. The demonstrated model is one effective way of both improving biomedical prevention access and building sustainable community partnerships.

Abstract 1966 - Finding The Unknown's: CDC's Social Network Strategy (SNS) Housing Works: Programmatic, Best Practice and Results in a Clinical Setting

Author(s): *Johnny Guaylupo, Lindsay Slay*

Issue: In New York State, the number of new HIV infections has decreased overall; in one certain age group and community, however, the proportion of new infections has increased. For those that are not aware of their status, the Social Network Strategy (SNS) Testing Initiative engages these two key populations: Young Men who Have Sex with Men (YMSM) and Transgender Youth. In the United States, an estimate of 62,400 youth are living with HIV and 32,000 are unaware of their HIV Status.

Setting: Housing Works is one the largest Community Based Organizations in NYC. Project Voice is a program under the CDC's Social Network Strategy focused on Counseling, Testing and Referring those that are unaware of their HIV status to Primary Care and supportive services by using a harm reduction approach.

Project: Housing Works SNS Program focused on enlisting YMSM and transgender youth that are considered to be at high-risk or HIV positive to recruit their peers to get tested. The program targeted a specific group through: 1) Targeted Case Finding for recruiters, 2) Marketing via Social Network Applications, 3) Working with the Kiki Scene in New York City, 4) Hosting Kiki events at Housing Works East New York location, 5) Staffing a drop-in center for the target population in the East New York section of Brooklyn, 6) Providing prevention tools to sex workers at hotels, 7) Providing a \$10 gift card for all recruiters that successfully referred a Network Associate for an HIV test. This presentation will talk about the best practices and implementation of the SNS Testing Initiative.

Results: From March 2013- January 2015, the program, enrolled and provided HIV Tests to 634 individuals, hosted 17 kiki events in the East New York section of Brooklyn, and conducted 50 targeted case findings. From the 634 HIV test conducted, 22 newly diagnosed clients were identified through

testing and referred by a recruiter. In addition, 27 HIV-positive individuals that were previously out of care were linked to care at Housing Works Community Health Center in Brooklyn, NY and referred by a recruiter. During the 22-month period, the program was able to maintain a 2% newly diagnosed positivity rate using the SNS testing initiative.

Lessons Learned: The program showed that when conducting a testing initiative to a target population, the best results come with a structured program such as the SNS model compared to the traditional testing programs funded through the CDC. The SNS Program works well because of the flexibility provided by the program staff especially in a community that experiences stigma, poverty, homelessness and issues trusting service providers.

“This project was funded in part by the New York City Department of Health and Mental Hygiene through a contract with Public Health Solutions. Its contents are solely the responsibility of Housing Works and do not necessarily represent the official views of the funders.”

Abstract 2181 - Closing the GAP: Non Traditional Venue Testing, Case Management and Motivational Interviewing to Diagnose, Link and Retain Youth in HIV Care

Author(s): *Andres Camacho-Gonzalez, Scott Gillespie, LaTeshia Thomas-Seaton, Krystal Frieson, Traci Leong, Chanda Graves, Rana Chakraborty*

Background: Background: African-American youth carry the highest burden of HIV infection in the US, with Georgia ranking among the top five states nationally in HIV incidence rates. The US National HIV/AIDS Strategy (NHAS) calls for improvements throughout the HIV care continuum. The Metropolitan Atlanta Community Adolescent Rapid Testing Initiative (MACARTI) addresses NHAS goals in at-risk adolescents and young adults (AYAs) from metropolitan Atlanta by combining non-traditional venue HIV testing, motivational interviewing, and case management support.

Methods: Methods: Newly HIV+ participants were enrolled into the MACARTI intervention arm and compared to standard of care participants. Demographic, behavioral and clinical variables, in addition to linkage and retention rates were collected. Data were summarized using means and standard deviations for continuous variables, frequencies and percents in discrete cases both at baseline and follow-up time periods (1, 3, and 6 months). Clinical values were compared between arms using parametric and non-parametric statistical tests.

Results: Results: Ninety-eight participants were enrolled, 49 in each of the MACARTI and standard of care arms; 85% were male, 95% were Black, with a mean age of 21 years (SD: 1.8). The MACARTI arm screened 435 participants for a positivity rate of 11.3%. Forty-three participants were successfully linked (90%) within a mean of 3.4 weeks (95% CI: 2.3 – 4.5) after diagnosis. Visit retention rates for the MACARTI arm when compared to the standard of care arm were significantly higher [93.0 (95% CI: 87.2 – 96.4) vs. 75.2 (95% CI: 69.1 – 80.5) attended visits per 100 visits scheduled, respectively]. Mean CD4+ T-cell counts significantly increased within both arms; however, values were significantly higher in the MACARTI arm after 6 months of follow-up (173.3 vs. 58.5 cells/mm³; p=0.014). Similarly, median HIV-1 RNA levels decreased significantly within both arms after 6 months of follow-up, but there was no

significant difference across the standard of care and MACARTI arms [-15,880 (IQR 25th-75th: -75,780 – (-680)) vs. -22,410 (IQR 25th-75th: -144,590 – (-1830)) copies/ml, respectively].

Conclusions/Implications: Conclusions: The MACARTI model of intervention successfully achieved NHAS care continuum goals in HIV-infected AYAs from metropolitan Atlanta after 6 months post-enrollment. Further follow-up is required to ascertain sustainability of the intervention beyond 6 months.

Session C26 - PrEP: Infrastructure and Intervention Models

Room: A704 (Atlanta Marriott Marquis)

Abstract 1474 - Establishing a PrEP Drug Assistance Program – The Washington State Experience

Author(s): *David Kern, Richard Aleshire*

Issue: U.S. Public Health Service guidelines recommend that daily oral PrEP be considered for people who are HIV-negative and at substantial risk for HIV infection. Despite supportive guidance, PrEP uptake has been slow among eligible individuals and healthcare providers. Cost of Truvada®, the anti-retroviral used for PrEP, is a likely driver of low uptake.

Setting: The Washington State Department of Health (WA DOH) PrEP Drug Assistance Program (PrEP DAP) is the first program in the U.S. to pay for Truvada® for PrEP. PrEP DAP is a state-based program built on the backbone of Washington’s AIDS Drug Assistance Program (ADAP).

Project: WA DOH launched PrEP DAP in April 2014. The program is a collaborative effort between the WA DOH HIV Prevention and HIV Care/Treatment programs. PrEP DAP uses the state’s ADAP infrastructure (eligibility processing, pharmacy benefits management), but is funded exclusively with state resources. WA DOH currently allocates \$2 million annually to support this program. PrEP DAP pays for Truvada® for HIV-negative persons with risk factors that expose them to HIV. Eligibility criteria require participants to be WA State residents and meet one of two risk profiles: 1) HIV-negative persons who have partners known to be HIV-infected or 2) high-risk HIV-negative gay and bisexual men. Participants must also have a healthcare provider, who is required to certify an HIV-negative test result and complete part of the eligibility application. PrEP DAP has no income requirements at this time. PrEP DAP strongly encourages, but does not require, routine medical visits for HIV testing and STD screening.

Results: In 2014, PrEP DAP received 177 applications, and 148 were approved for the program. Of these, 96 percent were male, three (3) percent female and one (1) percent “other.” A majority of participants live in King County (82 percent), the most populous county in Washington. Eighty-five (85) percent are insured. Thirty (30) percent of participants reported having partners who are known to be HIV-infected. Seventy-eight (78) percent reported being a gay/bisexual man with risk factors associated with HIV transmission. Most common risk factors included: ten or more partners in the last year (82 percent), unprotected anal intercourse with a partner of unknown HIV status (57 percent) and having a bacterial STI in the last year (37 percent). The total cost for prescriptions in 2014 was \$152,000.

Lessons Learned: -PrEP DAP is a structural level intervention that reduces barriers to Truvada and creates dialogue among communities and providers.

-Eligibility criteria are necessary – broad to allow for robust enrollment or narrow to limit?

-PrEP DAP must have a way to manage eligibility and prescription access.

-Managing adherence and recommended testing adds to the complexity and cost of PrEP DAP.

-A local / state funding source is necessary since federal funding cannot be used.

-PrEP DAP is likely easier at the state level because of ADAP infrastructure.

-Costs for PrEP DAP were significantly lower than estimated, likely because a majority of participants have health insurance.

-Sustainability is always a concern – what level of risk is OK?

Abstract 1930 - PrEP and Local Health Departments: Building the Infrastructure

Author(s): *Gretchen Weiss, Alyssa Kitlas*

Issue: Pre-exposure prophylaxis for HIV prevention has great potential to revolutionize HIV prevention and change the course of the epidemic. However, data shows that many communities are not aware of PrEP, the provider infrastructure for PrEP delivery is lacking, and many health departments do not know what they could or should be doing to support PrEP implementation. To increase local health department (LHD) awareness and knowledge of PrEP, the National Association of County and City Health Officials (NACCHO) developed an educational series about PrEP, which includes examples of and models for what LHDs are or could be doing to build the infrastructure to support PrEP implementation.

Setting: LHDs play an important role in connecting individuals at risk for HIV with medical providers who can offer preventive services, such as PrEP and post-exposure prophylaxis (PEP), as well as HIV testing and other sexual health services. Additionally, LHDs play key roles in educating providers and community members; conducting community needs assessments and identifying resources; monitoring and evaluating the impact of interventions; and directly providing services, including PrEP, PEP, HIV and STI testing, and risk reduction counseling.

Project: Curriculum development was informed by an online survey regarding PrEP implementation and educational needs and an in-person consultation with stakeholders (17 LHDs, 1 academic institution, and 1 community health center) to assess the current landscape for LHDs and PrEP, identify roles and expectations for LHDs in providing or supporting PrEP, and discuss educational and programmatic needs related to PrEP.

The resulting educational series includes seven webcasts organized into three modules: (1) The Science of PrEP for HIV Prevention and the US Public Health Service Clinical Practice Guidelines for PrEP; (2) Who Might Benefit from PrEP? Assessing Benefit at a Population and Individual Level; and (3) Thinking About Incorporating PrEP into Your HIV Prevention Programs? Examples and Models from Local Health Departments. The modules were released from October to December 2014. Each module release was followed by an interactive live webinar to provide an opportunity for participants to ask questions of the course instructor and to promote peer-to-peer engagement and learning. NACCHO also developed a PrEP Story Bank to share examples of how LHDs are supporting PrEP implementation in their communities.

Results: LHD interest in PrEP and the educational series has been significant. Between October 1, 2014 and April 15, 2015, there were 2,844 views of the series homepage (1,930 unique views), 256 webcast views, and 291 views of the archived webinars. Two-hundred and fifty individuals attended the live webinars.

Lessons Learned: As a primary liaison between the community and clinical care settings, LHDs play a critical role in PrEP implementation. Achieving the full promise of PrEP requires that more LHDs are knowledgeable of PrEP and equipped to participate in its implementation. Many are already leading the way and there is much that can be learned from their successes. LHDs should continue to expand their understanding of and engagement with PrEP implementation, and work with their community and healthcare partners to share this understanding and move implementation forward.

Abstract 2159 - Client Centered Care Coordination: Development and Implementation of a Multi-Level Intervention Model to Support the HIV Sexual Risk Reduction and PrEP Adherence Goals of BMSM

Author(s): *Blake Rowley, Christopher Chauncey Watson, LaRon Neldon, Sheldon Fields, Jonathan Paul Lucas, Darrell Wheeler*

Issue: Across all stages of HIV, Blacks are disproportionately affected, from diagnosis to viral suppression. The impact of the epidemic is even more pronounced among Black men who have sex with men (BMSM), who accounted for 36% of new infections among all MSM in the United States in 2009. Even more startling, infection rates have dramatically increased among young BMSM, who saw a 48% increase in new infections from 2006 to 2009. As new modalities of prevention arise, like pre-exposure prophylaxis (PrEP), incorporating them into individual risk-reduction is paramount. PrEP has the potential to significantly decrease HIV infection rates among HIV negative BMSM; however, few existing models of care have been designed to understand and support the psychosocial complexities of BMSM who are interested in incorporating PrEP as a component of their HIV risk reduction strategy.

Setting: Demonstration Project

Project: HPTN 073 uses client-centered care coordination (C4) as a multi-level structural (health service delivery) and behavioral (high-intensity behavioral counseling) intervention model to support HIV risk reduction in BMSM. C4 is based on the comprehensive risk counseling and services (CRCS) public health strategy and was adapted to support informed decision-making by BMSM with regard to their HIV sexual risk reduction and PrEP initiation/adherence goals. C4 is grounded in self-determination theory (SDT), positing that people are more likely to adopt and sustain behaviors that they value and endorse. Healthcare personnel can activate a patient's motivation towards targeted health behaviors (such as PrEP use and adherence) by (1) supporting the person's decision-making autonomy, (2) facilitating their acquisition of necessary resources to make progress towards their risk-reduction goals, and (3) demonstrating that one is personally invested in the person's goal attainment. These three principles undergird all counseling (e.g., sexual risk-reduction, PrEP decision making, and adherence) and care coordination activities. Essential to implementation of C4 is the support of a person's autonomy to decide what is best for them and the unconditional positive regard that the counselor expresses towards the person's decision.

Results: HPTN 073 is an ongoing study and outcome data are not yet available, thus C4 demonstrates theoretical promise as a model for PrEP delivery, uptake, and adherence among BMSM. This session will demonstrate how services offered via C4 and the autonomy-supportive approach by counselors and other healthcare personnel serve as a potential model for PrEP initiation and adherence for BMSM. Participants will learn the various clinical and non-clinical services offered via C4 through case examples based on the presenters' experiences implementing the model. Healthcare personnel and patients will learn strategies to support HIV risk reduction goals of BMSM.

Lessons Learned: Few successful models exist for engaging and retaining BMSM in healthcare services. These models are fewer when it comes to PrEP initiation and adherence management. This session is a unique opportunity to share the process of developing and implementing C4 with BMSM. Additionally, this workshop will provide participants with a theoretical model that they might consider incorporating into the design of other intervention models, and offer some key points for consideration when implementing PrEP programs designed for BMSM.

Abstract 2434 - PrEP and Prevention Sustainability: A Health Systems Integration Approach
Author(s): *Amy Killelea, Edwin Corbin-Gutierrez*

Issue: Multiple factors promise to make Pre-exposure Prophylaxis (PrEP) a game-changer in HIV prevention efforts, including a dramatic increase in the number of individuals that have access to public and private health insurance coverage, coverage of preventive services and flexibility granted by the Centers for Medicare and Medicaid Services (CMS) for state Medicaid programs to include non-clinical staff, such as community health workers, in the provision of these services.

Setting: State and local health department HIV prevention programs and community-based providers.

Project: In this workshop, we will use best practices and information gleaned from a series of expert consultations focused on systems-level sustainability conducted with over 43 state health departments by the National Alliance of State and Territorial AIDS Directors (NASTAD) to address the need for revenue generation strategies for HIV prevention programs in clinical and non-clinical settings, particularly PrEP initiatives.

Results: Specifically, the presentation discusses three considerations for state health departments to ensure that PrEP programs serving highly vulnerable populations remain sustainable.

Considerations:

- 1) Advocacy with managed care organizations to set outcome measures that incentivize HIV prevention services, including PrEP, and publicizing PrEP models of revenue-generation for providers, including pharmacy rebate partnerships and managed care incentive agreements.
- 2) Assessment of new coverage options for PrEP – including formulary adequacy, prior authorization and other utilization management concerns, and cost sharing.
- 3) Coordination of insurance application and enrollment assistance across HIV care and prevention programs in order to leverage existing expertise and maximize opportunities for a payer source for PrEP.

Lessons Learned: Four lessons learned on the financing of community-based PrEP programs from the expert-consultations will be discussed:

- 1) Health department advocacy to state Medicaid in using provider category flexibilities from CMS, particularly for the reimbursement of PrEP adherence support, insurance enrollment and other support services provided by non-clinical staff.
- 2) Case study identification of favorable health plan contracting policies for PrEP providers.
- 3) Scope of private and public insurance coverage for PrEP and PrEP support services, as well as gaps, including laboratory tests, client retention, and medication adherence;
- 4) Cost of coverage for PrEP and PrEP support services: HIV care program coordination (particularly ADAP) regarding insurance assessment expertise (and pharmaceutical co-pay assistance programs), as well as expertise in promoting health plans that reduce co-pays for PrEP clients.

Session C33 - Using Partner Services Data for Monitoring Progress and Improving Services to Priority Populations

Room: A706 (Atlanta Marriott Marquis)

Abstract 1347 - Using HIV Partner Services Performance Indicators to Monitor Progress towards National HIV Prevention Goals: Results for 2014

Author(s): *Michele Rorie, Wei Song, Mesfin Mulatu, Shubha Rao, Hui Zhang, Erica Dunbar*

Background: CDC's National HIV Prevention Monitoring and Evaluation (NHM&E) is a framework used to collect and report HIV prevention program data from CDC-funded grantees. Partner Services (PS) program indicators are standardized measures to evaluate the key components of PS program planning, activities, and service delivery. The current HIV PS indicators address the following national monitoring and evaluation questions on how successful PS programs are at:

identifying and interviewing individuals with HIV infection;
eliciting partner information from persons with HIV infection;
notifying partners of their exposure to HIV and testing partners; and
linking positive partners to care services.

We will provide an overview of the key PS indicators along with their definitions, present the indicator calculations resulting from January 1- June 30, 2014 (Q1 and Q2) client-level PS data submissions, and discuss how CDC plans to use the indicators to improve service delivery.

Methods: A set of standardized variables was used to collect client-level data from individuals who receive HIV PS, including clients' demographic characteristics, risk behaviors, number and type of partners, HIV testing of partners, and linkage of HIV-positive partners to HIV medical care. We analyzed HIV partner services data submitted to CDC by 52 state and local health departments after selecting records with a "Case Open Date" between January 1 and June 30, 2014. These client-level data were then analyzed using SAS version 9.3 to calculate the program performance indicators. Missing and invalid records were excluded from each denominator used for the calculations.

Results: For the period of January 1-June 30, 2014, 14,454 index patients were identified by PS programs; 86.3% of index patients were interviewed and enrolled in PS; 7,047 partners were named by index patients and participated in PS programs; 99.4% of named partners were notified of their potential HIV exposure; 86.5% of notified partners were tested for HIV; 29.4 % of tested partners were newly identified as HIV-positive; and 12.3% of newly identified HIV-positive partners were linked to HIV medical care.

Conclusions/Implications: Partner Services is a critical component in the continuum of activities designed to increase the number of persons diagnosed with HIV who receive treatment and care to disrupt the transmission of the disease. It functions as a prime opportunity for the delivery of HIV services to partners of persons diagnosed with HIV. CDC funding to health departments to implement HIV prevention interventions such as PS will help to reduce new infections, increase access to care and improve health outcomes for people living with HIV. These findings suggest that health departments are exceeding the expectations of the current funding announcement by enrolling at least 80% of HIV-positive persons in PS. While health departments are effectively identifying new cases, an expansion of services, including better tracking systems may be required to reduce under reporting and increase the linkage to care statistics.

Abstract 1695 - Factors Associated with Enrollment of MSM in Partner Services Programs in the United States, 2013

Author(s): *Shubha Rao, Wei Song, Mesfin Mulatu, Michele Rorie, John Gilford*

Background: Approximately 40,000 new HIV infections are identified annually in the U.S. More than half of all new infections are among gay, bisexual, and other men who have sex with men (collectively referred to as MSM) who are at increased risk for sexually transmitted diseases. In 2011 in the U.S., black/African American MSM accounted for the largest estimated number and percentage of HIV diagnoses (11,805, 39%), followed by white MSM (10,375, 34%), and Hispanic/Latino MSM (6,949, 23%). CDC's approach to addressing the HIV epidemic among MSM involves engaging communities and expanding prevention programs for disproportionately affected communities. Partner services (PS) programs are an integral component of this high-impact HIV prevention strategy.

Methods: We examined the demographic characteristics and risk behaviors of MSM by analyzing 2013 client-level data for index patients enrolled in PS. The data were submitted to CDC by 55 CDC-funded state and local health departments. The analytical sample consists of 27,914 index patients, excluding persons with missing data on gender and sexual risk. An index patient is categorized as MSM when the self-reported current gender is "male" and the self-reported behavior is "Sex with male". Multivariate logistic regression was conducted to identify demographic and risk factors associated with enrollment among MSM in PS.

Results: Of the 27,914 index patients who were contacted by health departments, 17,109 (61%) were MSM. Of these, 16,611 (97%) were located and 15,768 (95%) were enrolled. Among the non-MSM groups, 9,720 (90%) were located and 9,041 (93%) were enrolled in PS. MSM living in the Northeast (aOR=1.22, 95% CI=1.03-1.46) or West (aOR=3.63, 95% CI=3.10-4.26) were more likely to be enrolled in PS. MSM living in the South (aOR=0.61, 95% CI=0.52-0.71) were less likely to enroll in PS. Compared to

whites, blacks/African Americans (aOR=0.71, 95% CI=0.63-0.78), Hispanics/Latinos (aOR=0.80, 95% CI=0.71-0.89) were less likely to be enrolled in PS. MSM who self-reported as having sex without a condom (aOR=0.77, 95% CI=0.70-0.84) were less likely to be enrolled in PS. There were no statistical differences between enrollment and age-groups or MSM who reported having a history of injection drug use.

Conclusions/Implications: More than 60% of PS clients are MSM, suggesting that PS programs are successfully reaching, locating and enrolling MSM. However, MSM enrollment varied significantly by demographic and risk characteristics. Understanding the factors associated with MSM enrollment is critical for designing interventions to increase access to PS and subsequently to HIV medical care, prevention, and support services.

Abstract 1702 - Factors Associated with HIV Positivity among Partners of HIV-Diagnosed Persons Participating in Partner Services Programs in the United States, 2013

Author(s): *Wei Song, Mesfin Mulatu, Hui Zhao, Michele Rorie, Shubha Rao, John Gilford*

Background: Partner services (PS) programs provide assistance to HIV-positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV, offering them HIV testing, prevention counseling, and linking newly-identified positives to medical services. Studies indicate that HIV PS programs are effective in identifying new HIV cases. However, there are limited data from prevention programs that examine the predictors of HIV positivity among partners of HIV-diagnosed persons (index patients). The purpose of this analysis was to determine which demographic and behavioral risk characteristics of index patients or partners are associated with HIV acquisition among partners using partner services data submitted by CDC-funded health departments.

Methods: We used a subset of 2013 partner services data submitted by CDC-funded state and local health departments (n=40). The analytical sample consists of 4,811 pairs of index patients and their partners who were not previously diagnosed with HIV and had been tested for HIV as part of a partner services program. We conducted a series of multivariable logistic regression analyses to determine the associations between the partners' HIV positivity and the index patients' or the partners' own demographic and risk characteristics.

Results: Of the 4,811 partners tested 1,616 (33.6%) were HIV-positive. The multivariable analyses revealed that partner HIV positivity was significantly associated with index patient age. Compared to age group 13-24, partners of older index patients were more likely to be HIV-positive [aged 35-44 (aOR = 1.34, 1.06-1.69) and aged 45+ (aOR = 1.36, 95% CI = 1.06-1.75)]. On the other hand, partners' own age, region, gender, race/ethnicity, and risk characteristics were all significantly associated with their HIV positivity. Compared to age group 13-24, those aged 25-34 (aOR = 1.27, 95% CI = 1.03-1.56) and aged 35-44 (aOR = 1.53, 95% CI = 1.20-1.94) were more likely to be HIV-positive. Partners living in the Northeast (aOR = 2.26, 95% CI = 1.43-3.66), West (aOR = 2.16, 95% CI = 1.37-3.50), and South (aOR = 9.71, 95% CI = 6.34-15.35) were more likely to be HIV-positive than those living in the Mid-West. Female partners were less likely than male partners to be HIV positive (aOR = 0.66, 95% CI = 0.54-0.80). African American partners were more likely than white partners to be HIV-positive (aOR = 1.73, 95% CI = 1.46-2.06). Finally, partners who reported MSM (aOR = 3.36, 95% CI = 2.73-4.13) and heterosexual contact

(aOR = 5.84, 95% CI = 4.55-7.52) were more likely to be diagnosed with HIV than partners who reported no sexual or drug-use risk.

Conclusions/Implications: Our findings revealed that partners' HIV risk was associated with their own age, being male, being African American, residing in regions with greater HIV burden, having MSM or heterosexual contact, and being partner of older index patients. Efforts to expand PS programs should take into account these disparities in vulnerability for HIV infection among partners of HIV-positive individuals.

Session C34 - Transgender Women of Color: Engagement and Intervention Models

Room: A602 (Atlanta Marriott Marquis)

Abstract 1287 - Best Practices and Key Elements of Feasible and Acceptable Interventions to Engage Transgender Women of Color in HIV Care

Author(s): *Andre Maiorana, Jae Sevelius, Enzo Patouhas, JoAnne Keatley, Luis Gutierrez-Mock, Starley Shade, Deepalika Chakravarty, Madeline Deutsch, Greg Rebchook,*

Background: HIV disproportionately impacts transgender women of color (TWOC). However, individual, clinical, and structural issues interfere with the identification, engagement, and retention of HIV+ TWOC in HIV care. This qualitative study assessed the feasibility, acceptability, and best practices related to implementing distinct individual and/or group level interventions at the 9 demonstration projects conducted by community based organizations, medical settings or research centers in 4 large U.S. urban areas currently part of the "Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color Initiative" funded by the HRSA Special Projects of National Significance.

Methods: Transcripts of 78 audio-recorded qualitative interviews with 36 staff implementing, and with 42 clients/patients (most of them AA and Latinas) participating in the interventions were coded and analyzed to identify salient themes.

Results: The interventions consist of one-on-one meetings with navigators/case managers and/or educational, support, outreach, and community building groups to address individual, clinic, and structural-level barriers to engaging TWOC in quality HIV care. The interventions function at different overlapping and synergistic levels that include 3 key elements: 1) Client-centered services, including: linkages, referrals, advocacy and/or provision of HIV care and hormones; social and emotional support; health education; and access and referrals to address unmet immediate needs (e.g., housing, employment, mental health, substance use, legal issues); 2) Supportive messages that contribute to health literacy and personal and community development (e.g., importance of engagement in care and treatment adherence; development of self-esteem, responsibility, and empowerment; establishment of trust, boundaries and confidentiality; and emphasis on the importance of the Initiative for the well-being of the TWOC community; 3) Increasing social support by cultivating caring relationships and interactions: between staff and TWOC; among TWOC intervention participants; and between TWOC in the interventions (taking the role of advocates and educators) and their peers in the community not receiving HIV care.

In some interventions, HIV care and other services are available on a drop-in basis and try to address as many issues as possible during the same appointment. Addressing unmet needs to stabilize TWOC with a history of trauma, homelessness, sex work, substance use and/or mental health is often a precursor or facilitator to their engagement in care. Good rapport and trust between staff and clients/patients also facilitates engaging TWOC in care. Staff, that “go the extra mile” and show they care, many times are seen by clients/patients as mothers, sisters, friends, or confidantes, provide social and emotional support and help alleviate the isolation many TWOC experience. Often, those staff, TWOC themselves, become peer role models to their clients/patients.

Conclusions/Implications: Interventions that function at different synergistic levels and include 3 key elements: Client-centered HIV care and complementary services, supportive messages, and caring relationships are feasible and acceptable and may be effective to engage or reengage TWOC in HIV care while addressing other basic unmet needs in their lives.

Abstract 1886 - Associations Between Self-Reported Hormone Use Patterns and Indicators of HIV Care among Transgender Women of Color in four US Cities

Author(s): *Madeline Deutsch, Deepalika Chakravarty, Greg Rebchook, Starley Shade, Jae Sevelius, Andres Maiorana*

Background: Transgender women of color are at high risk for HIV infection. Transgender women are also less likely to be engaged in HIV primary care or to achieve virologic suppression. The Health Resources and Services Administration (HRSA) has funded 9 demonstration sites nationwide to develop and implement model interventions to improve engagement in care among transgender women of color living with HIV/AIDS. One of the hypotheses being tested is the impact of bundling gender affirming hormone therapy with HIV primary care and antiretroviral therapy. This analysis aimed to examine the impact of several measures of hormone usage on selected HIV related indicators.

Methods: Cross sectional baseline survey of 400 HIV-positive transgender women of color at time of entry into the project on self-reported: hormone use patterns, engagement in and characteristics of HIV care, antiretroviral adherence, viral load, HIV-related illnesses, and CD4 count. Bivariate analysis was conducted, and ordered logistic regression was used to calculate odds ratios.

Results: There were a total of 184 (46%) current hormone users, and 190 (47.5%) had some use within the past 6 months. Current use of hormone therapy was associated with a decreased incidence of HIV/AIDS-related illnesses in the past 6 months (OR 0.25, 95% CI 0.09 to 0.73). Current hormone users as well as those with any hormone use in the past 6 months were more likely to have received HIV primary care in the last 6 months (OR 1.97, 95% CI 1.27 to 3.05 and OR 2.43, 95% CI 1.56 to 3.79). Increasing level of adherence to the prescribed hormone regimen was positively associated with the likelihood of having an undetectable viral load (OR 1.52, 95% CI 1.13 to 2.03), while taking higher or lower than the prescribed dose was associated with decreased likelihood of having an undetectable viral load (OR 0.26, 95% CI 0.09 to 0.72 and OR 0.39, 95% CI 0.17 to 0.93). Adherence to the prescribed hormone regimen all of the time was associated with a reduced likelihood of missed antiretroviral (ARV) doses in the past week (OR 0.18, 95% CI 0.05 to 0.63). When the source of the hormone prescription was the participant’s HIV primary care provider, there was an increased likelihood of current ARV use

(OR 1.62, 95% CI 1.01 to 2.60), undetectable viral load (OR 3.03, 95% CI 1.86 to 4.94), and receipt of HIV primary care services within the past 6 months (OR 3.38, 95% CI 2.13 to 5.35). Higher CD4 counts and fewer number of missed ARV doses were associated with increased likelihood of having obtained a hormone prescription from their HIV primary care provider (OR 0.71, 95% CI 0.55 to 0.92, and OR 0.68, 95% CI 0.53 to 0.88).

Conclusions/Implications: Bundling of gender affirming hormone therapy with HIV treatment programs may increase ARV adherence and reduce HIV/AIDS related illnesses. Viral load and CD4 outcomes may improve in HIV primary care settings which include the provision of hormone therapy. Further study is needed to explore behavioral characteristics which underlie the positive association between hormone and ARV adherence.

Abstract 1964 - Associations Between Trauma, Depression, Antiretroviral Medication Adherence, and Gender Affirmation among Transgender Women of Color Living with HIV

Author(s): *Jae Sevelius, Deepalika Chakravarty, Greg Rebchook, Starley Shade, JoAnne Keatley, Luis Gutierrez-Mock, Madeline Deutsch, Andres Maiorana*

Background: Transgender women of color experience disproportionate rates of HIV, and previous research has demonstrated that trans women living with HIV are less likely to be on antiretroviral therapy (ART) than non-trans comparison groups. Furthermore, transgender women taking ART report lower levels of adherence and lower levels of viral suppression than other groups, both critical issues in preventing HIV transmission. Additionally, transgender women of color experience disproportionate rates of depression, violence, and discrimination as a result of transphobia. The trans-specific Model of Gender Affirmation posits that in the context of transphobia, access to and satisfaction with gender affirmation is vital for improving the physical and mental health of transgender women of color.

Methods: Nine demonstration sites enrolled 400 transgender women of color living with HIV between December 2013 and March 2015 in a HRSA-funded initiative to evaluate interventions to engage and retain trans women of color in HIV care. Sample descriptive statistics were calculated and bivariate associations were examined using SAS 9.4. Outcome variables were depression (measured using the short CES-D) and good adherence to ART. Predictor variables included experiences of transphobia (ever and in past 6 months), stress attributable to transphobic experiences in the past 6 months, childhood sexual abuse, satisfaction with gender affirmation, and importance of gender affirmation.

Results: Average age of participants was 38 years (SD=11) and 41% were Latina. Fifty percent of the participants reported one or more incidents of childhood sexual abuse, 84% reported having experienced transphobia in their lifetime. Mean level of transphobic experiences (past 6 months) was 5.93 (range 0 – 22), mean level of stress attributable to transphobic experiences in the past 6 months was 7.1 (range 0 – 20). Mean depression score was 12.06 (range: –0-30), mean satisfaction with gender affirmation was 3.52 (range: 1-5), and mean importance of gender affirmation was 3.95 (range: 1-5). Higher levels of depression were reported by those who reported transphobic experiences in the past 6 months ($b=.59, p<.0001$), greater stress attributable to transphobia ($b=.38, p<.0001$), and childhood sexual abuse ($b=.42; p=.004$). Those who reported higher levels of satisfaction with gender affirmation reported lower levels of depression ($b=-1.36, p=.0006$), while those who reported higher levels of

importance of gender affirmation reported higher levels of depression ($b=.99$, $p=.0033$). Higher levels of depression were also associated with lower odds of good adherence to ART ($OR=.914$; 95% $CI=.867$, $.963$).

Conclusions/Implications: The current analysis provides support for the Model of Gender Affirmation by demonstrating relationships between transphobic violence, depression, constructs of gender affirmation and ART adherence. Increasing access to gender affirmation and mental health services for transgender women of color living with HIV may improve ART adherence, which may lead to improved HIV-related outcomes for this group. While the current analyses only explored bivariate relationships, future analyses will explore multivariate models testing the hypothesis that access to gender affirmation mediates relationships between trauma and negative mental and physical health outcomes among transgender women of color living with HIV.

Abstract 1974 - Vicarious Trauma among Peer Intervention Staff Working with transgender Women of Color Living with HIV

Author(s): *Jae Sevelius, Andres Maiorana, Enzo Patouhas, Luis Gutierrez-Mock, JoAnne Keatley, Madeline Deutsch, Deepalika Chakravarty, Greg Rebchook, Starley Shade,*

Background: Transgender women living with HIV report disproportionate levels of trauma, including intimate partner violence, sexual abuse (both in childhood and as adults), survival sex work, family dysfunction, poverty, and homelessness. Transgender women living with HIV can benefit tremendously from services using peer-based support and health navigation, which have been shown to increase engagement in care and address issues of medical mistrust. However, peer staff may experience vicarious trauma, or secondary traumatic stress, due to exposure to highly traumatic stories and situations experienced by their clients coupled with high levels of identification with clients based on their peer status.

Methods: Nine demonstration sites enrolled trans women of color living with HIV between December 2013 and March 2015 in a HRSA-funded initiative to evaluate interventions to engage and retain trans women of color in HIV care. Qualitative interviews (total $N=45$) were conducted and audio-recorded with project staff ($n=24$) and clients ($n=21$) at 6 of the sites. Recordings were transcribed and coded by a team of 3 researchers in an iterative process to identify themes. For the current analyses, we report on preliminary themes related to trauma and vicarious trauma.

Results: High levels of trauma, both past and recent, were reported by clients of the interventions. As a result of being exposed to these high levels of trauma and being tasked with supporting women who are highly traumatized, all of the peer intervention staff mentioned struggling to varying extents with issues of burnout, boundaries, and feeling limited in their abilities to meet the multiple needs of this population. Being a member of the trans community themselves, peer staff often feel highly identified with and emotionally invested in their clients, and because they often have experienced much of the same type of trauma as their clients, may feel emotionally triggered by their clients' stories. Staff ability to cope with vicarious trauma and prevent or avoid burnout differed. Employing organizations ability to help those staff how to address vicarious trauma also differed.

Conclusions/Implications: Vicarious trauma is a pervasive experience among peer staff working with transgender women living with HIV due to extremely high levels of trauma experienced by this population. This phenomenon should be considered more explicitly in peer-based interventions to adequately support staff and prevent burnout. Considerations for preventing burnout and supporting staff include provision of skills training in positive coping strategies, helping staff develop and maintain healthy boundaries with clients, debriefing traumatic content in supervision, and following up with staff regularly to identify ongoing difficulties and early signs of burnout.

Track D

Session D02 - Start Talking. Stop HIV.: A National Social Media Campaign Promoting HIV Communication

Room: Baker (Hyatt Regency Atlanta)

Abstract 1117 - Start Talking. Stop HIV. A Comprehensive Social Marketing Campaign Encouraging Gay and Bisexual Men to Talk Openly about HIV

Author(s): *Alberto Santana, Jacqueline Rosenthal, Jessica Lacy, Nick De Luca*

Issue: Gay and bisexual men of all races continue to be most severely affected by HIV. Though representing only four percent of the overall adult population, they account for more than half (59%) of the 1.2 million people living with HIV in the United States and approximately two-thirds (66%) of all new HIV infections each year.

Setting: Start Talking. Stop HIV. (STSH) is a national HIV Prevention campaign for gay and bisexual men under the CDC's Act Against AIDS campaign initiative. STSH promotes open communication about HIV prevention among sexual partners. The campaign encourages men in all types of relationships to talk about HIV testing, their HIV status, condom use, and medicines that help prevent and treat HIV (PrEP and PEP – pre- and post-exposure prophylaxis, and ART – antiretroviral therapy).

Project: STSH uses an integrated health marketing approach to reach gay and bisexual men and is designed to reach and influence men in their everyday lives with messages that engage, inspire, and spark conversations about HIV prevention strategies between sexual partners. Formative research was conducted with over 500 gay and bisexual men to guide and inform campaign focus, messaging, and strategies. STSH is currently disseminated through: (1) campaign ad placement on digital and broadcast media; (2) mobile, online, and national and local print advertising; (3) social media engagement; (4) PRIDE events; (5) materials distribution; (6) campaign website, including conversation starters and campaign videos; (7) community engagement; and (8) partnerships.

Results: STSH was launched at an event in Fort Lauderdale, FL in May 2014. The campaign also rolled out in the following cities during their LGBT PRIDE events: Atlanta, GA; Charlotte, NC; Chicago, IL; Dallas, TX; Jackson, MS; Philadelphia, PA; and Seattle, WA. At these PRIDE events, STSH: (1) activated booth presence at festivals; (2) held community engagement meetings; (3) implemented a robust social media strategy; (4) activated moving billboards that participated in parade routes and or navigated LGBT neighborhoods; and (5) placed additional ads in PRIDE editions print and digital media. The booth

activation at PRIDES and community engagement activities in these cities reached over 141,000 persons, mostly gay and bisexual men. In additional cities with high HIV incidence among gay and bisexual men, the campaign placed ads on mobile, online, broadcast, and print media. Through December 2014, ad placements garnered over 165,353,627 impressions. STSH distributed over 16,480 campaign materials and had 3,480,104 video views through March 2015. STSH has also had high levels of social media engagement with over 47,700 likes on Facebook.

Lessons Learned: One approach to addressing the HIV/AIDS epidemic among gay and bisexual men is the continued development, dissemination, and saturation of HIV prevention messages. Such efforts require an integrated marketing approach to ensure the campaign's messages are reaching the intended audience. CDC has resources available for community-based organizations, health departments, and partners to reach gay and bisexual men with HIV prevention messages. Communities are able to leverage these resources to supplement their HIV existing prevention efforts or use lessons learned to support their local social marketing and social media efforts.

Abstract 1266 - Start Talking. Stop HIV.: Partner Communication about HIV

Author(s): *Euna August, Chassidy Hanley, Vanessa Boudewyns, JoEllen Stryker, Nick DeLuca*

Background: CDC estimates that gay, bisexual, and other men who have sex with men (collectively referred to as MSM) represent approximately four percent of the adult population in the United States; however, male-to-male sex accounted for nearly two-thirds (63%) of all new infections and more than three-fourths (78%) of new HIV infections among men in 2010. Effective partner communication about HIV can reduce HIV transmission by supporting HIV testing, HIV status disclosure, condom use, and the use of medicines to prevent and treat HIV. However, many MSM may still find it difficult to talk openly with their sexual partners about HIV prevention. In response, CDC launched Start Talking. Stop HIV. (STSH) – a social marketing campaign for MSM that promotes open communication about HIV prevention among sexual partners – in May 2014. STSH is a national campaign under the CDC's Act Against AIDS initiative and the first national-level HIV prevention effort with a focus on MSM of all races.

Methods: A web-based survey was conducted among sexually active gay and bisexually identified men from December 2014-March 2015 (N=3,104, but results reported here are from provisional dataset N=2,194). Participants were recruited from an online LGBT consumer panel. The survey oversampled younger (18-39 years), African American/black, and Hispanic/Latino men. Statistical analyses were conducted using SPSS. Measures included baseline knowledge, attitudes, and practices related to HIV communication.

Results: More than half (53.7%) of respondents had main or primary sexual partners, while 80.9% reported having at least one casual partner in the last 12 months. Communication regarding HIV prevention strategies among MSM is generally higher between main sexual partners (81.3%) vs. casual sexual partners (70.8%). Frequently discussed topics include HIV testing and condom use (>80%). While conversations about pre-exposure prophylaxis (PrEP) were less common among both main and casual sexual partners (<45%), they were reported more often among MSM who were HIV-positive. For conversations with main partners, HIV status was significantly associated with conversations about HIV status, while HIV status impacted conversations about condom use with casual partners.

Conclusions/Implications: While some MSM reported discussing HIV prevention with their partners, distinctions in communication practices by the types of relationships and topics were evident. Furthermore, HIV status plays a significant role in the conversations that MSM have with their sexual partners. Consequently, messaging for MSM should consider relative risk for HIV (i.e., behaviors, status, relationships) and stages of change (i.e., current communication practices and readiness to communicate).

Abstract 1755 - Start Talking. Stop HIV.: Leveraging Strategic Partnerships to Reach Gay and Bisexual Men

Author(s): *Francisco Ruiz, Sophia Nur, Jessica Lacy, Nick DeLuca*

Issue: Gay and bisexual men and other men who have sex with men (MSM) — including those who inject drugs — account for more than half of the 1.2 million people living with HIV in the United States (59%) and approximately two-thirds of all new HIV infections each year (66%). While CDC estimates that only four percent of men in the United States are MSM, the rate of new HIV diagnoses among MSM in the country is more than 44 times that of other men.

Setting: As part of the Act Against AIDS initiative, CDC launched a new campaign — Start Talking. Stop HIV. —encouraging gay and bisexual men to talk openly about a range of HIV prevention strategies with their sexual partners. Understanding that strategic partnerships have the potential to extend the reach and impact of social marketing campaigns, CDC worked collaboratively with a set of diverse partners with historical credibility and influence among gay and bisexual men of all races and ethnicities.

Project: In effort to support local community-level engagements efforts, CDC worked with national organizations to leverage their existing organizational structures, networks, and communication platforms to disseminate the campaign. Partner organizations included: Human Rights Campaign Foundation (HRCF), the largest LGBT group in the country with a membership of over 500,000; National LGBTQ Task Force, the oldest LGBTQ group in the country; and CenterLink, a member-based coalition of over 200 LGBT community centers across 45 states. CDC also developed a partnership with Grindr for Equality (GfE), the philanthropic arm of Grindr, which is the largest all-male geo-social network with more than 1.2 million users every day. Partners incorporated the campaign materials and related HIV prevention messaging into new and/or existing national engagement efforts and employed a variety of vehicles.

Results: For the campaign launch, HRCF supported virtual dissemination via the organization's website and Facebook page. HRCF also provided a donated ad placement and editorial blurb in the Equality Magazine. The National LGBTQ Task Force supported campaign dissemination via e-blasts, social media posts, and engagement efforts at the Creating Change Conference, the largest LGBT conference in the country, with nearly 4,000 attendees. CenterLink supported the campaign with a member-specific webinar, mass mailings of printed materials, and engagement efforts at the annual conference. GfE provided a series of donated mass messages that generated approximately 4,000 click-throughs to the campaign website per message and representing \$12,000 in donated media per message. GfE also used social media platforms to disseminate HIV messaging and promote the campaign website.

Lessons Learned: National partnerships played a vital role in the success of the campaign. By investing in partnerships, CDC was able to expand the reach of campaign activities, tap into outside knowledge and expertise, leverage external resources and reach new populations with HIV messaging. As CDC continues to assess, plan and engage in partnerships, the Agency will work with national partners to improve coordination with local community-based efforts and ensure maximization of national partner relationships to obtain the greatest benefit from the investments in those partnerships.

Session D10 - PrEP: From Knowledge to Action

Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1325 - Community Engagement Practices During the Planning and Implementation of a Bio-medical HIV Prevention Study Among Black Men Who Have Sex With Men (HPTN 073)

Author(s): *Jonathan Lucas, Cheryl Cokley, Jontraye Davis, Rhonda White, Phaedrea Watkins, Christopher Watson, S Wakefield, Craig Hutchinson, Sheldon Fields,*

Issue: Black men who have sex with men (MSM) in the United States are disproportionately impacted by HIV despite having no greater risk profile than their White counterparts. Deficits in AIDS/HIV knowledge and distrust in research among Black MSM have been cited as common barriers to vital research engagement. To address potential concerns and build community rapport, community engagement planning for HIV Prevention Trials Network (HPTN) 073, a demonstration project designed to assess the initiation and correlates of daily pre-exposure prophylaxis (PrEP) use by Black MSM, required innovative approaches to ensure robust community engagement and involvement during the study design and pre-implementation process.

Setting: In 2013 the HPTN 073 Community Working Group utilized AVAC's guidance document "Good Participatory Practice Guidelines for Bio-medical Prevention" (GPP) to conduct three half-day community consultations with Black MSM service providers, community-based organizations and stakeholders in Washington, DC; Chapel Hill, North Carolina; and Los Angeles, California.

Project: Consultation attendees (n=138) were provided overviews of global PrEP research and the HIV epidemic among Black MSM in the United States, as well as a description of research methodologies being utilized in the conduct of HPTN 073. Participants provided feedback on HPTN 073 study design and implementation plans. Group-level cultural responsiveness training organized around 4 interactive, experiential learning and reflexive thinking sessions was also provided for staff (n=48) at each of the sites in an effort to mitigate cultural insensitivity and unintended micro-aggressions.

Results: Feedback from the community consultations resulted in alterations to the HPTN 073 social marketing campaign to address concerns related to demographic diversity and to ensure the de-stigmatization and de-eroticism of Black MSM. Images utilized for the social marketing campaign were selected to reflect the broad diversity within the Black MSM community focusing on subcultures, age, and body type to encourage study participation from a wide array of individuals. Modifications to HPTN 073's participant recruitment, retention and adherence plans were made to better support community engagement practices, encourage study enrollment and increase Black MSM awareness of PrEP. These

modifications included multi-pronged low cost approaches utilizing community-based organizations, social networks, web-based outreach and print media. These adjustments assisted in achieving the targeted study enrollment (n=226) in 12 months with an overall study participant retention rate of 92%. Cultural competency training for site staff and healthcare providers enhanced each of the protocol implementation sites' capacity to engage marginalized communities and address health disparities resulting in improved dispersion of information between study patient and provider.

Lessons Learned: Engaging community members in problem-solving solutions to issues that affect them is one of the fundamental principles of HIV prevention research. It is a critical strategy for partnership building to advance HIV prevention efforts, particularly with marginalized groups. Effective utilization of GPP can aid in the development of shared responsibility and community ownership of HIV prevention research initiatives.

Abstract 1434 - Institutionalizing the Strength-Based Approach: A Strategy to Engage Patients and Clients in the Continuum of Care

Author(s): *Deborah Wyatt-O'Neal, Tim Vincent, Duran Rutledge, JaDawn Wright, Stacy Vogan*

Issue: The need for a strategy to effectively engage clients in HIV prevention and care services can be a daunting task. Despite coordinated efforts to improve linkage and engagement, only 38% of persons living with HIV in California are successfully retained in care. Three diverse health departments in California requested the support of the California Prevention Training Center (CA PTC) to assist their providers in utilizing a strengths-based approach, which has shown efficacy in improving linkage to care, as well as all aspects of the continuum of care. The jurisdictions each wanted to integrate this approach across provider roles and programs. The CA PTC developed trainings specifically incorporating the skills, knowledge and tools of the Strength Based Approach (SBA) to build institutional capacity at the local health department level to promote continuity of care and improve client engagement.

Setting: Five trainings on the SBA were conducted for 92 providers representing a variety of roles and disciplines in an effort to institutionalize this approach in three different local and/or state Health Departments and their community partners, between July 2014 and March 2015.

Project: In developing the SBA trainings, the CA PTC consulted with the different health departments to assess barriers and specific needs related to engaging clients. These concerns informed the final content and delivery of the training. The strength-based approach uses tools and techniques to assess and identify strengths from clients past experiences and current capabilities to use in solving their identified barriers. It was important for all disciplines to understand how to use this approach to effectively engage clients in a variety of contexts. We created and included assessment tools, video examples and case studies to demonstrate how the approach could be used with relevant challenges identified in their patient populations. Inclusion of interactive activities and opportunities for role-play and a section to identify strategies to sustain and monitor the approach were included to solidify the project's goal.

Results: Responses from 56 retrospective surveys demonstrated increased abilities to explore different ways to use client strengths to address concerns' (+1.42 on a 5 pt. Likert); elicit client strengths using SBA techniques (+1.38); identify ways in which a SBA can be used in a specific role (+1.67) and; describe

how SBA can be used to engage people throughout the continuum of care (+1.13). A majority of respondents (77%) reported specific areas in which to integrate SBA at their worksites including counseling, partner services, support groups, referrals, hospital care and linkage to care. Additionally, 88% indicated feeling confident to transfer knowledge and skills back to their work environments.

Lessons Learned: Participants reported understanding the importance of recognizing and helping clients identify their resiliencies and strengths and how SBA could augment engagement. Post training analysis revealed that further technical assistance is needed to effectively integrate this approach across all programs. Follow up with further technical assistance to get buy-in from key stake holders, develop appropriate tools, protocols, and amend forms and medical records to monitor and fully integrate SBA is recommended.

Abstract 2012 - From Fear to Facebook: How Social Media Launched The PrEP Revolution

Author(s): *Damon Jacobs*

Issue: New HIV infections in the U.S. have remained consistent at approximately 50,000 each year for the past decade. New transmissions continue to rise in MSM communities, especially amongst youth ages 13-24. Despite the FDA's approval for use of Truvada as Pre-Exposure Prophylaxis (PrEP) in 2012, most MSM remained unaware and uninformed about this biomedical prevention strategy. Those who did use PrEP were often confronted with stigma and disapproval by medical providers, friends, family, peers, and potential partners. Meanwhile most "condom only" prevention messages used fear-based paradigms to encourage healthier sexual practices.

Setting: Facebook is a global interactive social media networking service which surpassed one billion active monthly users in September, 2012. It has been utilized not only for personal connections, but for individuals seeking information, resources, support, and community. It has become a favored tool of communication for many international groups, national organizations, local activists. Despite such a high volume of interactions, there were no Facebook groups that offered facts, data, science, resources, or support about PrEP by June, 2013.

Project: The Facebook group, "PrEP Facts: Rethinking HIV Prevention and Sex," was launched on July 1, 2013, as a response to the lack of online information and education about PrEP's science, efficacy, and accessibility. The group was intended to promote access to scientific data, medical facts, local resources, as well as frank discussions about sexuality, intimacy, and love, that were not typically integral in prevention messaging. The goal was to use discussions of sexual pleasure and emotional joy as a means to promote empowered decisions, community-based support, tools for coping with stigma, and consistent adherence.

Results: Since July 1, 2013, over 6100 members of various racial backgrounds, nationalities, and ages, have joined the "PrEP Facts" group. Members have assisted one another with:

- successfully navigating insurance company barriers,
- educating medical professionals about the advantages of PrEP,

- coping with stigma and rejection in their local communities and on dating apps,
- holding community forums about PrEP in their local (often rural) areas,
- learning tools for adherence,
- reinforcing sense of agency and locus of control in sexual decision making.

This innovative and unique approach to discussing pleasure and prevention led to a mention on the front page on the New York Times on May 15, 2014. PrEP implementation in the U.S. more than doubled during the first three quarters of 2014 (from 526 in Q1 to 1217 in Q3) while membership in the Facebook Group tripled during the same time frame (from 1285 members to 4342). About 1000 out of the current 6100 members openly identify as active users of PrEP, and not a single seroconversion on PrEP has been reported.

Lessons Learned: We are at an unprecedented juncture in the battle against HIV. Social media offers a crucial tool for providing education, outreach, information, and empowerment for consumers of all ages, races, experiences. Access and adherence to PrEP is more successfully implemented in a context of supporting sexual pleasure, emotional gratification, community strengths, and personal agency, versus approaches of increasing fear, avoiding disease, averting pain.

Abstract 2485 - Fear, Sex, Agency, and Pre-exposure Prophylaxis

Author(s): *Robert Grant, Kimberly Koester, David Glidden*

Issue: Fear of HIV in the 1980s led to fewer numbers of sexual partners, more condom use, and lower HIV incidence. In the 1990s, these trends in behavior reversed, especially after the advent of suppressive antiretroviral therapy and seroadaptive practices. These trends have been attributed to “complacency” due to decreased fear of HIV infection, leading to “risk compensation” or “behavioral disinhibition.” Using information from surveys and ethnography during recent trials of pre-exposure prophylaxis (PrEP), we propose an alternative explanation: that fomenting fear over long periods of time leads to trauma that undermines agency, planning for sexual and social goals, and healing that might otherwise occur with intimate social, sexual and somatic connections.

Setting: Daily oral FTC/TDF PrEP prevents acquisition of HIV infection when taken. The impact of PrEP depends on agency required for uptake, use, and linkage between viral exposure and PrEP.

Project: This is a review of information regarding sexual practices during the randomized and open label phases of PrEP studies, including information from ethnographic research conducted among PrEP users in the United States. We also review information regarding the linkage, or dislinkage, between HIV exposure and PrEP use. Information from PrEP clinical practice is also available from the UCSF 360 Sexual Health Improvement Project and the San Francisco AIDS Foundation.

Results: PrEP users report feeling safer during sex, and such safety is regarded to be a direct and highly valued benefit. Under the theory of risk compensation, the feeling of safety is predicted to lead to more sexual partners and less condom use. In contrast, PrEP users report trends toward safer sexual practices over time, including fewer numbers of sexual partners and more condom use. These self-reported trends toward safety are commensurate with laboratory indices, when available, including decreases in

the prevalence of acute HIV infection and the incidence of syphilis. Among men who have sex with men (MSM), PrEP users describe feeling safer when contemplating sexual possibilities, thereby facilitating planning for sex in calm moments when a range of goals and alternatives can be considered. Such feelings of safety were transformative for some, occasioning the appearance of relationship goals and a greater focus on sexual health including discussions with partners about non-HIV sexually transmitted infections. Agency among MSM also drives strategic dosing, involving greater use of PrEP during “seasons of risk.” In contrast, two PrEP studies in women reported negative associations between HIV exposure and PrEP use, leading to unmitigated HIV incidence.

Lessons Learned: PrEP may foster feelings of safety during sex, which were associated with trends toward safer behaviors. Safer behavior, including more strategic PrEP dosing, likely reflects agency that may arise from planning for sex in calm moments and the healing benefits of intimate social, sexual and somatic connection. Contemplation of HIV in calm moments with a goal to preserve safety and foster human connection may be a more effective strategy than fostering fear of HIV in hot moments when sexual opportunities could be lost.

Session D13 - African American Women and HIV: Mobilization, Communication, Stigma, and Structural Issues

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1128 - Results of a Pilot Study on HIV Risk among African American Daughters with HIV+ Mothers

Author(s): *Ndidi Amutah, Rodney Hammond, Winston Abara, Debbie Humphries, Barbara Guthrie*

Background: In New Jersey, African American women ages 18 and over, accounted for 63% of the new HIV cases among all females. The objective of this pilot study was to examine the context and quality of the mother-daughter relationship as it pertains to HIV+ women and their daughters with regard to future HIV risk and sexual behaviors of the daughters.

Methods: The study utilized a mixed-methods approach in which structured interviews and cross sectional surveys were used. The total number of participants (n=74) included mothers and daughters, who completed demographic surveys and a subset of mothers and daughters (n=30) who completed in-depth interviews. The interviews with HIV+ mothers, and female daughters elicited perceptions, beliefs and attitudes about HIV/AIDS and sexual behaviors. The cross-sectional survey allowed for assessment of HIV risk-related behaviors (i.e., non-condom use), knowledge, attitudes, and beliefs among daughters and their HIV+ mothers.

Results: Data from the survey indicated that 58% of mothers reported being Quite Close with their daughters. In addition more than two-thirds (68.3%) responded as strongly agreed to being satisfied with communication with daughters. The results were similar to those of daughters, in which 65% indicated they were extremely close to their mothers 70% reported they could count on their mothers and 65% reported liking the relationship they have with their mother. This result was consistent with structured interviews, in which both mothers and daughters expressed having a close relationship with each other.

Our analysis of the qualitative interviews focused on 1) HIV and health 2) Barriers to healthcare access for the HIV+ mothers 3) Social support. HIV and health: Participants reported having average to good health, however co-morbidities played a significant role in participants having average health. Healthcare access: With regard to health care access, many participants reported not having health facilities in their neighborhoods or close enough to them that offers health services needed. Social Support: When it came to social support majority of participants reported family, friends, significant other and support groups as their main source of support. Mothers and daughters both reported that they are “close” with each other, however this closeness does not always facilitate candid conversations about HIV risk in the daughter. The mixed methods results affirm that the opportunity exists to strengthen the mother/daughter relationship and influence the sexual behaviors of daughters.

Conclusions/Implications: This study was able to capture information from mother-daughter pairs. This was valuable in being able to observe the direct connection between mothers and daughter surrounding issues of sex, HIV/AIDS, and the quality of inter-generational communication. Findings from this study have the potential to guide the development of a larger study to: 1) elucidate elements of the mother-daughter relationship, in the context of HIV+ mothers, that can protect females against sexual behaviors and HIV risk, 2) identify modifiable risk factors that increase a female’s risk for HIV/AIDS, 3) develop interventions specifically targeting mother-daughter sexual communication to reduce HIV risk for the female daughter.

Abstract 1647 - Food Insecurity and Psychosocial Factor among African American Women Living with HIV on Antiretroviral Drugs in Rural Alabama

Author(s): *Andrew Zekeri, Cordelia Nnedu*

Background: In response to the increased emphasis on food insecurity (not having enough nutritionally adequate food for an active healthy lifestyle) as a public health problem in the past decade, an extensive literature on the predictors of food insecurity in the U.S. has emerged. However, less is known about the prevalence and predictors of food insecurity among African American women living with HIV on antiretroviral drugs. The purpose of this study is to estimate the prevalence of food insecurity among HIV-positive women accessing antiretroviral therapy in rural Alabama and determine whether psychosocial factor and socioeconomic variables are associated with food insecurity.

Methods: Using cross-sectional design, I collected data on food insecurity and demographic data from 256 HIV-infected African American Women attending two HIV Clinics in Alabama. The United States Department of Agriculture (USDA) Food Security Module was used to assess food insecurity and psychosocial factor in the analysis was assessed using The Center for Epidemiological Studies-Depression Scale (Radloff, 1977). Demographic variables were also collected. I used regression analysis to identify variables associated with food insecurity.

Results: Food insecurity is prevalent among this sample of HIV-positive women in rural Alabam. Forty percent of the sample is classified as food insecure. This is more than three times the national rate of 14.5% in 2012. In multivariate analyses, HIV-positive women were more likely to have higher levels of depressive symptoms, lower income level, and participating in SNAP (food stamp program).

Conclusions/Implications: Food insecurity is associated with psychosocial factors. These findings can help inform public health programs and policies designed to lower food insecurity and health disparities. In clinical settings, health care providers should ascertain whether the HIV-positive patient is likely to be at risk for food insecurity. Treatment regimens should acknowledge the importance of access to food in selecting antiretroviral drugs.

Abstract 1745 - HIV Stigma and Study Experience Predict HIV-Positive African American Women's Reactions to HIV Research

Author(s): *Nicole Overstreet*

Background: African American women living in underserved communities have a higher incidence of HIV infection and their participation in HIV research is critical to understanding and reducing barriers to HIV treatment. However, recruitment may be stymied by women's concerns about participation harms related to perceptions of HIV stigma. Further, there may be IRB restrictions on recruitment and research methods based on empirically untested assumptions regarding potential research harms for this population. To better inform these issues, this study empirically examined psychological and experiential factors influencing positive and negative reactions to research participation of HIV-positive African American women.

Methods: 61 African American women living with HIV who participated in a study examining the relation between HIV, contextual factors and mental health at an HIV care clinic were asked to reflect on their reactions following study completion. Women responded to an online survey in a private section of the clinic that included assessment of internalized HIV stigma, perceptions of research risks and benefits, confidentiality and safety concerns, and reactions to responding to sensitive topics, such as sexual risk behaviors and substance abuse.

Results: Overall, participants expressed more positive than negative attitudes and reactions toward their research experience. However, internalized HIV stigma and study experience were significantly related to these reactions. We found that HIV stigma is associated with more negative emotional reactions to research participation, $\beta = .39$, $t(59) = 3.18$, $p = .002$, $R^2 = .18$ and that first timers had lower global appraisals of the benefits of the research protocol (e.g., lower beliefs that the research was for a good cause and useful to others) than those with repeat study experience, $\beta = -.28$, $t(59) = -2.21$, $p = .03$, $R^2 = .11$. We also found a significant stigma x study experience interaction, $\beta = .33$, $t(60) = 2.21$, $p = .03$, $R^2 = .29$. Women who were first timers to HIV research with higher levels of HIV stigma reported the greatest difficulty being open and honest in response to study questions about their experiences living with HIV; however, there were no significant differences in difficulty for women who were low in HIV stigma regardless of their study experience.

Conclusions/Implications: The perspectives of African American women living with HIV are critical to enhancing the responsible conduct of HIV research. Often, in the absence of empirical evidence, IRBs assume participation elicits intense emotional reactions and consequently categorize social-behavioral research in this area as greater than minimal risk. Overall, our results contradict this assumption and suggest that African American sero-positive women do not find responding to socially sensitive

questions related to HIV and other risk behaviors stressful. However, the data also indicate that HIV stigma and lack of research experience can heighten negative reactions, which in turn may create barriers to recruitment and jeopardize the validity of participant responses. This suggests that incorporating HIV stigma-reducing messages in recruitment, informed consent and throughout the research process will increase participation in research essential to understanding how to increase fair access to services for HIV positive African American women.

Abstract 2359 - Community Mobilization, Outreach, & Engagement: The Effectiveness of a Community-Driven Initiative Addressing Black Women in South Florida

Author(s): *Krystle Kirkland-Mobley, Janelle Taveras, Chandra Carter*

Issue: To reduce HIV-related health disparities and address the goals of the National HIV/AIDS Strategy, CDC recommends a HIGH-Impact Prevention (HIP) approach. The identification of strategies that are deemed effective and have an overall impact on HIV outcomes is necessary for HIP implementation. However, specific methodologies for determining HIP activities are still needed.

Setting: In South Florida Black women are disproportionately affected by HIV in comparison to Hispanic and White women. In Florida, 1 in 61 Black women were living with HIV/AIDS in 2013; compared to 1 in 1,092 White women and 1 in 466 Hispanic women. Various social, psychosocial, and structural barriers are all contributing factors to the HIV disparities.

Project: The Sista's Organizing to Survive (SOS) is an initiative, revitalized in 2014, to address HIV disparities among Black women and encourage communities to expand and strengthen their response to the HIV/AIDS epidemic through grassroots community mobilization, outreach, and community engagement targeting communities that are most heavily impacted by HIV. The aims of SOS are to encourage HIV testing; increase access to HIV prevention and care services; reduce barriers to HIV testing, prevention, and care by reducing HIV/AIDS stigma and developing detailed work plans. By drawing on the role of Black women as gatekeepers, nurturers, and leaders in their communities, SOS utilizes social networks to provide opportunities to build on existing relationships between family members, friends, neighbors, and colleagues. On December 5th, 2014, in partnership with the Florida Department of Health, Miami-Dade, Broward, and Palm Beach counties, women from South Florida were brought together to engage in a one day mobilization summit that consisted of panel presentations, education, and interactive discussions on a variety of topics covering relationships, HIV testing, viral suppression, empowerment and mobilization.

Results: Over 280 South Florida women, including 70 young women from local high schools, attended the SOS Summit. From evaluation feedback provided, most women, 96.5% (n=114) thought that HIV/AIDS is a problem in Florida, 68.4% felt that they knew a lot or all about HIV/AIDS, 92.1% felt comfortable talking about HIV/AIDS, 88.6% felt comfortable speaking to members of their community about HIV/AIDS, and 96.4% would like to participate in other SOS events. Qualitative information collected addressed what is needed to mobilize black women with overall themes of increasing community involvement (48.6% of responses) and engagement in various types of community activities (28.6% of responses). To date, 58 SOS Ambassadors have been recruited.

Lessons Learned: The utilization of community ambassadors is a best practice approach for community mobilization among Black women. Tailored evaluation tools, to collect qualitative and quantitative information, are essential to monitor and guide SOS development and success. Preliminary evaluation predicts that SOS may be categorized as a HIP community mobilization initiative. The indicators of SOS impact are: 1.) numbers of Black women testing for HIV, 2.) the rates of new HIV case diagnosis among Black women, and 3.) the rates of AIDS related deaths among Black women in Florida. Additionally, measures of effective community mobilization must be collected and monitored.

Track E

Session E07 - 2014 Federal Recommendations for HIV Prevention with Adults and Adolescents with HIV

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1819 - Updated Federal Guidance on HIV Prevention with Adults and Adolescents with HIV: Highlighting A Comprehensive Approach to HIV Prevention

Author(s): *Amrita Tailor, Kathleen Irwin, Gema Dumitru, Abigail Viall, Priya Jakhmola*

Issue: The scientific, structural, and social contexts of HIV prevention and care delivery have undergone a transformation in the last decade. In response to this evolving landscape, the Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services issued Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014. The Recommendations updated the 2003 federal Recommendations for Incorporating HIV into the Medical care of Persons Living with HIV that was primarily directed to HIV medical care providers. The new Recommendations highlight the importance of a comprehensive and collaborative approach to HIV prevention that includes better understanding of related contextual factors as well as the need for adaptive learning and continuous process improvements.

Setting: The new Recommendations are directed to providers working in clinical settings, nonclinical settings, and staff of health departments, and HIV planning groups. This broad audience highlights opportunities for collaboration across different health sectors to promote a comprehensive approach to HIV prevention.

Project: The new Recommendations were developed using an evidence-based process that involved extensive vetting with > 150 HIV prevention experts and stakeholders. The updated guideline compiles new and longstanding federal recommendations that were based on research, program evaluations, and/or expert opinion. The Recommendations include these topics: linkage to and retention in HIV care; antiretroviral treatment and adherence; behavioral risk-reduction interventions; partner services; sexually transmitted disease services; reproductive health and pregnancy-related services; other medical and social services that affect HIV transmission; and quality improvement.

Results: This presentation will focus on new and longstanding, including underutilized recommendations related to two main topics: 1) Contextual issues, i.e., individual, social, structural, ethical, legal, and policy issues that influence access to, use of, and delivery of HIV prevention and care services. Examples include laws and policies about disclosing HIV status and unintentional or intentional exposure of others to HIV; provider duties about case reporting, confidentiality, and informed consent; public- and private-sector financial and program support for services that influence HIV care engagement (e.g., housing or transportation to care site); and training of and access to qualified culturally competent providers. 2) Quality improvement and program monitoring and evaluation to improve the quality, acceptability, and efficiency of individual-level and population-level prevention services.

Lessons Learned: The Recommendations' emphasis on contextual factors reflects greater awareness and appreciation among HIV prevention providers and stakeholders for legal frameworks, policies, systems, and structures that influence HIV transmission. Similarly, the Recommendations' attention to quality improvement and program evaluation reflects growing national imperatives for performance measurement and accountability in public and private-sector health facilities, community organizations, and health departments as well as public demand for high quality, efficient HIV prevention and care services.

Abstract 1827 - Highlights of Recommendations & Implementation Resources for Risk Screening and Risk Reduction, Partner Services, and STD Screening and Treatment for Persons with HIV

Author(s): *Nicole Crepaz, Amrita Tailor, Matthew Hogben, Kimberly Workowski, Yuko Mizuno, David Purcell*

Issue: To date, many behavioral and biomedical interventions are shown to improve the health of persons with HIV and reduce HIV transmission to others. To maximize impact on an individual's and a community's health, providers can use a comprehensive approach that combines up-to-date recommendations on prevention, treatment, care, and support services for persons with HIV. Since the release of the 2003 federal Recommendations for Incorporating HIV into the Medical care of Persons Living with HIV, additional recommendations have become available for risk screening and risk-reduction interventions, partner services, and STD screening and treatment. This presentation provides an overview and highlights the most important recommendations on these three topics.

Setting: The 2014 guideline is directed to providers working in clinical settings, nonclinical settings, and staff of health departments, and HIV planning groups. This broad audience highlights opportunities for collaboration across providers working in care and prevention.

Project: For each topic, a team of subject experts conducted systematic reviews of the respective literature, reviewed current federal guidance, and drafted the recommendations. The final recommendations are based on an evidence-based process that involved extensive vetting with HIV prevention experts and stakeholders. Each chapter compiles new and longstanding federal recommendations that were based on research, program evaluation, and/or expert opinion. The chapters also describe: methods used to compile evidence; evidence supporting the recommendations; issues that influence implementation of the recommendations; policy, legal, and ethical considerations; considerations for special populations; and link to implementation resources.

Results: In addition to summarizing new evidence published since 2003, the 2014 guideline recommends the following: conducting regular screening for behavioral (e.g., sex and drug behaviors), biologic (e.g., STD infection), and biomedical (e.g., HIV treatment status, viral load level) factors that may influence the risk of HIV transmission; engaging clinical and nonclinical providers to provide risk-reduction services tailored to HIV-discordant couples and inform persons with HIV about availability of biomedical interventions (preexposure prophylaxis [PrEP], non-occupational postexposure prophylaxis [nPEP]) for HIV-uninfected partners; expediting interviews of index patients with laboratory or clinical evidence of acute HIV infection; building relationships between health departments and HIV service providers to expedite partner services to index patients who have been newly diagnosed with HIV or are at high risk of exposing others to HIV; engaging health departments to integrate STD and HIV surveillance data to identify populations or individuals with HIV and STD coinfection; and using the STD treatment regimens that have been most recently recommended by the Centers for Disease Control and Prevention.

Lessons Learned: Several commonalities in the recommendations across the three topics are observed: establishing infrastructure and procedures to better support prevention and services; integrating behavioral, biologic, and biomedical screening information to inform tailored prevention and services for persons with HIV and their partners; and emphasizing the involvement and collaboration among providers working in clinical, nonclinical, and other health sectors and health departments. A concerted effort to incorporate these recommendations into existing practices for HIV care and prevention is likely to maximize effects on the reduction of HIV transmission.

Abstract 1852 - Updated Federal Guidance on HIV Prevention with Adults and Adolescents with HIV: Recommendations for Linkage and Retention in Care, Referral, and Antiretroviral Therapy and Adherence

Author(s): *Jeanne Bertolli, Cynthia Lyles, John Brooks*

Issue: Too few individuals diagnosed with HIV infection are linked to HIV medical care, remain in care, and achieve viral suppression. Barriers include misperceptions about antiretroviral therapy (ART); lack of sustained access to affordable medications, stable housing, and effective treatment of mental illness; substance abuse; or other medical conditions. The updated Federal HIV Prevention Guidelines include comprehensive prevention and care strategies that address these issues and promote access and adherence to ongoing HIV medical care, including ART, and other medical and social services.

Setting: These updated guidelines speak not only to the role of clinical and nonclinical providers, but now also emphasize the vital part played by health departments to deliver and support effective interventions that link and retain HIV-infected persons in care and promote and sustain ART use. Several types of providers can assist with linkage to, retention in, and reengagement in care, adherence to ART, and referral to other medical and social services. They include staff of nonclinical and clinical HIV testing sites, such as prevention specialists, health care providers, case managers, linkage facilitators, navigation assistants, outreach specialists, and clinic administrators. They also include disease investigation specialists, partner services specialists, or other health department staff.

Project: The updated guidelines for linkage to care, referral, treatment, and adherence are consistent with guidance from the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the U.S. Department of Health and Human Services. They all recommend that persons be linked to HIV medical care shortly after a positive HIV test. However, the updated guidelines place greater emphasis on proactive linkage and retention strategies instead of passive referral methods, on starting ART immediately regardless of CD4 cell count, and on encouraging health departments to establish infrastructure and services that support linkage to and retention in care.

Results: These guidelines provide more detailed recommendations regarding the implementation of evidence-based interventions, including individual-level and population-level strategies. The updated guidelines also include the following recommendations about ART for clinical and nonclinical providers: clinical providers and nonclinical providers should inform persons with HIV about the benefits of ART to prolong their disease-free lifespan and to reduce the risk of transmitting HIV to others; should highlight the limitations and risks of ART (e.g., that ART substantially reduces but may not eliminate the risk of HIV transmission); and should make persons aware of options to obtain and pay for ART. Consistent with the most recent federal guidelines on using antiretrovirals to reduce the risk of HIV transmission to uninfected partners of persons with HIV infection, these guidelines include recommendations that clinical and nonclinical providers should inform high-risk uninfected persons about the use of antiretrovirals for both pre-exposure and post-exposure prophylaxis.

Lessons Learned: Comprehensive prevention and care strategies promoting continuous HIV care and receipt of, and adherence to, ART need to be optimally implemented at the patient, facility, system and population levels and often require formal coordination and collaboration among nonclinical providers, clinical providers, health systems, and health departments for maximal impact and sustained benefits.

Abstract 1859 - 2014 Federal Recommendations for Human Immunodeficiency Virus (HIV) Prevention with Women and Their Referred Partners

Author(s): *Madeline Sutton, Steve Nesheim, Kathleen Irwin, Gema Dumitru*

Issue: This new federal guideline describes interventions to reduce HIV transmission by decreasing the infectiousness of persons with HIV and their risk of exposing others to HIV. This guideline updated 2003 guidance for clinicians to incorporate HIV prevention into HIV medical care by adding recommendations about reproductive health and pregnancy-related services for women (who comprise ~20% of HIV-infected Americans) and partners they refer. This guideline for clinicians, nonclinical providers and health department staff aims to advance the goals of the National HIV/AIDS Strategy: preventing new HIV infections and reducing HIV-related illness, death and health disparities.

Setting: The new guideline compiled the latest evidence-based federal guidance on biomedical, behavioral and structural interventions to reduce HIV transmission and new recommendations based on research, program evaluations or expert opinion. Recommendations address linkage to and retention in HIV care; antiretroviral treatment (ART) and adherence; STD, reproductive health and pregnancy services; partner services; and other topics.

Project: The most important recommendations for clinicians include: prompt, proactive linkage to HIV medical care; offering ART to all patients, regardless of CD4 count, for improving health and reducing HIV transmission; supporting ART adherence; informing persons with HIV about the availability of pre-exposure (PrEP) and post-exposure prophylaxis for HIV-uninfected partners; routinely screening genital and extra-genital sites for STDs that facilitate HIV transmission; promptly linking HIV-infected persons exposed to STD to presumptive STD treatment; providing reproductive health counseling and contraception to persons not seeking conception; providing information and services to reduce HIV transmission when attempting conception (including timed PrEP for uninfected partners) or during pregnancy; and ensuring that referred partners are offered screening for HIV, STD and viral hepatitis and proactively linked to medical care.

Results: Women's health care providers will continue to provide many of these recommended services and can advise primary care providers how to deliver selected reproductive health services in their practices. CDC, HRSA and partner organizations are promoting guideline awareness among reproductive health professionals and providing training, decision-support tools and other resources to encourage uptake of recommendations.

Lessons Learned: Guidelines are currently being disseminated in multiple venues.

TUESDAY, DECEMBER 8 | ORAL SESSIONS | 3:30 PM – 5:00 PM

Track A

Session A04 - Using Data Mapping and Visualization to Inform HIV Prevention

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1747 - What Can the NCHHSTP Atlas Do for You?

Author(s): *Kim Elmore, Gustavo Aquino*

Issue: The National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention's (NCHHSTP) Atlas is an interactive application which allows the CDC to disseminate data, while allowing users to explore HIV, viral hepatitis, STD and TB surveillance data to create maps, charts, and tables

(<http://www.cdc.gov/NCHHSTP/Atlas>). Historically, each Division had separate web sites the public could use to access surveillance reports, but there was no unified location or queryable data available.

Setting: The current data for the Atlas are HIV (HIV diagnoses, persons living with diagnosed HIV, HIV deaths, HIV stage 3 (AIDS), persons living with HIV stage 3 (AIDS), and HIV stage 3 (AIDS) deaths), acute viral hepatitis (A, B, C), STDs (chlamydia, gonorrhea, primary and secondary syphilis, early latent syphilis, congenital syphilis), and TB surveillance data collected by state/local health departments. The primary audience is state and local health department staff, community planning groups, community-based organizations (CBOs), as well as academicians and the general public.

Project: Some unique features of the atlas include the user's ability to:

- query 14 disease variables, comprised of state-level surveillance data and county-level HIV, STD and TB surveillance data;
- view more than 10 years of data, which allows for showing disease trends over time;
- query by race/ethnicity, sex, and age group (also transmission category for HIV);
- examine recommended queries with contextual narrative and links to CDC web sites;
- toggle between rates or cases;
- export graphics to PDF and data to Excel; and,
- compare selected state to national data (and county where available).

The NCHHSTP Atlas is an interactive tool with sortable tables and graphics that display national data. The Atlas also provides users with detailed and complete footnotes and illustrates spatial and temporal variation in disease diagnosis patterns. Users can submit questions or ideas for improvements using an anonymous feedback button. The Atlas provides CDC with a data repository and a mechanism for annual releases of surveillance data.

Results: Interest in the NCHHSTP Atlas has been demonstrated by the increasing number of users. In 2014, the NCHHSTP Atlas home page had about 48,600 page views, and it has had almost 166,000 page views since its release in January 2012. In addition, CDC staff have received many positive emails about

the Atlas. We have also been told that the functionality of the NCHHSTP Atlas is outstanding and that the sophistication of the tool is above and beyond that of other similar applications. So far this tool has fulfilled the needs of many researchers, students, and public health professionals.

Lessons Learned: A challenging aspect of designing the Atlas was to identify common points of ‘data harmonization.’ Finding key common variables across multiple disease registries was vital to our success. Working with four divisions, there are preexisting confidentiality agreements between each division and their state and local partners with data suppression rules which prevent the display and stratification of certain data, as well as differing formats for age groups, race definitions, and population/denominator data.

Abstract 2102 - Using Business Intelligence for HIV Data to Care: Merging Surveillance and Clinical Data into Meaningful Indicators to Assess and Improve Metrics of the Care Continuum

Author(s): *Lauren Snyder, Dean McEwen, Art Davidson, Emily McCormick, Christie Mettenbrink, Edward Gardner, Robert Beum, Moises Maravi, Mark Thrun,*

Issue: Most health jurisdictions now require the reporting of limited HIV clinical data including CD4 cell counts and HIV viral load. When merged with historically collected HIV case data, the resulting larger surveillance dataset can inform public health and clinical providers not only about HIV diagnoses and prevalence, but also on metrics such as linkage to care, retention in care, and viral suppression. By aggregating data, a reporting system for population indicators can be created. In addition, this data can be used to drive patient-level interventions such as improved linkage, retention, and reengagement into care by health department, prevention provider, or clinical staff. We describe our utilization of Business Intelligence (BI) technology to facilitate the merger of this data and its display in a real-time user-friendly format.

Setting: Once data security and confidentiality issues are addressed locally, an HIV BI tool can be used in any of the above settings to allow access to real-time, current HIV metrics along the continuum and can potentially be utilized to intervene at the patient level.

Project: Using a standard data model, demographic, geographic and HIV-specific data (including clinical visits, viral load and CD4 counts) were integrated from multiple public and personal healthcare sources to define HIV care indicators. Data were assessed for cleanliness, accuracy and where necessary surrogates were developed (e.g., use of AIDS diagnosis date when the HIV diagnosis was missing) before storing in the BI data model. Additionally, interfaces were created through a visualization process to promote comprehension of meaningful data through easy to use webpages.

Results: Joint development sessions allowed HIV indicators to be developed consistent with the quality and accuracy of the data. To describe engagement in and outcomes of HIV care, each stage of the HIV continuum of care cascade was specifically defined and a corresponding indicator identified (i.e., estimated number of HIV infected, number diagnosed, number linked to care, number retained in care, and number with a suppressed viral load). The now deployed tool allows users with appropriate security clearance to not only access filterable (e.g., race, age, HIV risk) aggregate data for care continuum

metrics but also to drill down to patient level data to generate lists for clinical and public health outreach purposes.

Lessons Learned: HIV continuum of care population indicators were developed and calculated for our jurisdiction using data from a variety of public and personal healthcare sources. The HIV BI tool increased disease surveillance capacity, incorporated novel indicators, and now supports and supplements clinical decision making. This has allowed for more precise prevention planning, timelier data analyses, and has begun to facilitate improved linkage and reengagement locally.

Abstract 2444 - Exploring AIDSvu: A Mapping Resource for Local Action

Author(s): *Cory Woodyatt, Travis Sanchez, Alexandra Ricca, Jennifer Taussig, Patrick Sullivan*

Issue: The United States National HIV/AIDS Strategy calls for intensifying HIV prevention efforts in communities where HIV is most heavily concentrated; however, information about HIV prevalence and new HIV diagnoses are not consistently available at fine geographic resolutions (e.g., ZIP Code- or county-level) across the US. AIDSvu.org is a free, publicly available website that addresses this important need through a highly interactive and simple interface designed to give users easy access to this information for program planning, policy development, and resource allocation.

Setting: AIDSvu.org provides data visualizations of HIV prevalence and new diagnoses in the US at state- and county-levels, as well as at ZIP Code-, census tract, and neighborhood-levels for cities most highly impacted by HIV infection.

Project: AIDSvu.org is a free, online mapping resource that increases the accessibility and utility of HIV surveillance data in the US. Its development represents a unique public-private collaboration, in which public health surveillance officials share, deidentified aggregated data on the number of persons living with HIV infection, and Emory University supports the production of interactive online maps illustrating the most heavily HIV-impacted states, counties, ZIP Codes and, in some cases census tracts and neighborhoods. Other public data, such as Census data on poverty, education, and health insurance, can be used to generate tandem-tethered interactive maps and provide context considering social determinants of health. Consumer-oriented features include locator functions for HIV testing and HIV care facilities. Downloadable resources include data sets, high resolution images of maps, and PowerPoint slide decks of HIV prevalence maps for the US overall, US regions,, every US state, and selected US cities.

Results: AIDSvu currently maps HIV prevalence and new diagnoses data for all US states, all counties in 48 states, ZIP Codes in 33 cities, neighborhoods in two cities, and census tracts in three cities. The maps are also available to be viewed by demographic populations. HIV testing and treatment service locations can be overlaid on the maps to enable examination of these resources relative to HIV prevalence and diagnosis data at fine geographic levels.

Lessons Learned: AIDSvu continues to be a useful tool for prevention program planning. There are some aspects of AIDSvu that may be particularly useful for this planning, such as downloadable resources and service locators. Those aspects will be highlighted in this presentation.

Abstract 2456 - AIDSvU as a Tool to Identify Gaps in Rural Alabama

Author(s): *Michael Murphree, Will Rutland*

Issue: Despite the prevalence of HIV in the Southeast US region, there is a dearth of treatment resources and services available to Alabama residents. In a state where there are only three American Academy of HIV Medicine credentialed physicians, patients with HIV/AIDS commonly have to travel more than an hour to reach a treatment center and often forgo treatment. A lack of public transit also may exacerbate the associated effects of not being treated or in care.

Setting: The agency provides telemedicine connections to HIV-positive populations in Selma, Sipsy, Florence, Dothan, Clayton, Montgomery, Tuscaloosa, and Huntsville, AL.

Project: In 2011, Medical AIDS Outreach in Montgomery, Alabama established a statewide telemedicine network in collaboration with partner agencies. The network allows MAO, and its collaborators, to provide quality medical care, mental health counseling, and pharmaceutical consultations to HIV/AIDS clients in rural Alabama using high-speed data connections, spoke-site RN support, and high definition video/diagnostic tools.

Results: The telemedical intervention addresses the problem by using technology to bridge the gap between “need” and “resources” – allowing HIV experts to be in two places at one time. Since 2012, over 300 patients have been treated using telemedicine. Of those, 95 percent are virologically suppressed and 60 percent have undetectable viral loads. In particular, AIDSvU maps are used to increase the understanding of HIV at state and county levels and to determine where treatment needs are most urgent.

Lessons Learned: By overlaying AIDSvU maps with CDC maps of Health Professional Shortage Areas, MAO has been able to determine where more telemedicine sites should be added in an effort to increase access to medical care and support services, decrease viral loads, and transmission of HIV infection. Secondly, with the recent addition of AIDSvU new HIV diagnoses maps, MAO is better equipped to engage in future prevention planning efforts, policy development, resource allocation, and advocacy.

Session A06 - Young MSM: HIV Risk, Testing, Incidence, and Retention in Care

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1469 - HIV Incidence Estimates for Young MSM in Los Angeles County (LAC) by Race/Ethnicity and Small Age Subgroups

Author(s): *Shoshanna Nakelsky, Amy Wohl*

Background: The most recent national HIV incidence estimates released by the Centers for Disease Control and Prevention (CDC) indicate that 64% of new HIV infections occurred among MSM, including MSM who use injection drugs. Furthermore CDC identified Black MSM 13-29 years old as the group most at risk for acquiring new HIV infections. In LAC, MSM compose 85% of annual diagnoses. We

estimated incidence by race/ethnicity and smaller age groups for young MSM in LAC to identify the most at-risk sub-groups.

Methods: We used the HIV Incidence Surveillance methodology developed by CDC, to estimate the number of new HIV infections among young MSM in LAC over two 3-year periods: 2008-2010 (Time 1) and 2011-2013 (Time 2). The method incorporates the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS), which uses the BED HIV-1 capture enzyme immunoassay to detect recent HIV infections by testing remnant serum from new HIV cases. We estimated that 8.2% of males in LAC are MSM to calculate rates.

Results: We estimated a trend toward increasing incidence in MSM age 13-29 years from Time 1 to Time 2 (2,031 (95%CI: 1,432-2,628) and 2,348 (95%CI: 1,590-3,106), $p < 0.01$). Overall the estimated incidence rate for MSM age 18-24 years increased from 8 to 12 new infections per 1,000 MSM ($p < 0.01$). Estimated incidence rates also increased for Black, White and Latino MSM age 18-24 years from Time 1 to Time 2 ($p < 0.01$). Estimated incidence rates significantly decreased for White and Latino MSM age 25-29 years from Time 1 to Time 2 (12 to 9 per 1,000 White MSM and 13 to 12 per 1,000 Latino MSM, $p < 0.01$). However, estimated rates for Black MSM age 25-29 years significantly increased from 33 per 1,000 in Time 1 to 35 per 1,000 in Time 2 ($p < 0.01$). With less than 40 MSM age 13-17 years diagnosed in either time period, we were unable to calculate an estimate for adolescent MSM.

Conclusions/Implications: While it is common practice to present surveillance data in wide age groups, this analysis demonstrates that providing data in smaller age groups presents a clearer picture of those at risk for new HIV infection. For example in this analysis very few MSM under age 18 years were HIV infected within a 3-year period. This finding highlights an opportunity for prevention programs targeted to adolescent MSM to intervene before high-risk behaviors increase in an effort to reverse the trend of increasing incidence in young MSM age 18-24 years. Furthermore, we estimate incidence rates for 25-29 year old Black MSM continued to increase while incidence rates decreased in White and Latino MSM. Black MSM remain the most heavily impacted racial/ethnic group across age groups emphasizing the need for ongoing culturally specific prevention strategies.

Abstract 1488 - Disparities in Retention in HIV Care among Young Men who have Sex with Men in the District of Columbia, 2005-2012

Author(s): Mercedes Morales-Aleman, Jenevieve Opoku, Michael Kharfen, Yzette Lanier, Madeline Sutton

Background: Young men who have sex with men (YMSM) in the United States (US) had the greatest percentage increase in diagnoses of HIV infection from 2008-2011 (26%). In 2011, black/African American (black) YMSM and Hispanic/Latino (Latino) YMSM accounted for 58% and 20%, respectively, of new HIV infections in the US. In the District of Columbia (DC), YMSM of color are disproportionately affected by HIV infections. Retention in HIV care improves health outcomes for persons living with HIV infection, but has not been well described for YMSM in DC. We characterized correlates of retention in care among YMSM in DC to inform and strengthen local HIV care efforts and reduce HIV-related health disparities.

Methods: We analyzed data from DC's HIV surveillance system for HIV-infected YMSM ages 13-29 years diagnosed between 2005 and 2012 and alive in 2013. Analyses were limited to men who had US Census sociostructural information by census tract; data were adjusted for reporting delays. We combined demographic and clinical variables with social data from the U.S. American Community Survey (years 2006-2010) by census tracts. We calculated frequencies and prevalence ratios (PR) and utilized logistic regression to estimate the relationships between each study variable and retention in care (2 visits within 12 months of diagnosis). For multivariate analyses, we ran full adjusted models with backward elimination and calculated adjusted PRs, with 95% confidence intervals (aPR, CI).

Results: From 2005-2012, 1034 YMSM were diagnosed and living with HIV infection in DC; 83% were black or Latino. Of the 1034 YMSM, 837 (80.9%) YMSM had been linked to care, had census tract data available and were included in analyses (71% black, 11% Latino and 18% white). Among those linked, 535 (64%) were retained in care. In bivariate analyses: men diagnosed between ages 13-24 years were more likely to be retained in care (PR = 1.28, CI 1.07-1.54) compared with men diagnosed between ages 25-29 years; black YMSM were significantly less likely to be retained in care compared with white YMSM (PR = 0.69, CI 0.56-0.85); and men who had never been virally suppressed were significantly less likely to be retained in care (PR = 0.35; CI 0.28-0.43). In multivariate analyses, being retained in care was more likely among white YMSM compared with black YMSM (aPR = 1.24 CI=1.07-1.44), and among YMSM who were ever virally suppressed compared with YMSM who were never virally suppressed (aPR = 1.67 CI 1.48-1.88). For social variables, there were no associations noted among YMSM retained in care by insurance, poverty and HIV stage at diagnosis ($p > 0.05$).

Conclusions/Implications: Our data suggest that HIV-related disparities exist in retention in care. Expanded efforts to further improve linkage and subsequent retention in HIV care among YMSM may help improve HIV-related health outcomes and health equity goals.

Abstract 1691 - HIV Testing Patterns and Awareness of Self-Testing Options among Young, Black MSM and Transgender Women in North Carolina

Author(s): *Christopher Hurt, Karina Soni, William Miller, Lisa Hightow-Weidman*

Background: Young, Black men who have sex with men (YBMSM) are disproportionately impacted by incident HIV in the Southeastern United States, yet we know relatively little about patterns of testing outside major metropolitan centers. We sought to understand testing behaviors and determine awareness and use of HIV self-testing among YBMSM in North Carolina (NC).

Methods: We used geosocial networking applications, social networking websites, and print flyers to recruit sexually active, 18-30 year-old, HIV-uninfected YBMSM and transgender women residing in NC. Eligibility was determined with screening questions at the beginning of an online survey. Survey respondents answered questions covering demographics, sexual identity and behavior, HIV testing history and practices, and familiarity with self-testing options for HIV. All who finished the survey were compensated with a gift card sent by certified mail.

Results: From July 2014 - March 2015, 2758 individuals completed the screening questions; 317 (11.5%) were eligible to participate and 212 (7.7%) finished the survey. Median age was 24 (interquartile range,

21-27) and 7 were trans women. Nearly one quarter (n=52) had not tested for HIV in the prior 12 months; 17% (n=37) had never tested. Among those previously tested, 124 (71%) reported testing at least every 6 months and 71 (40%) tested at least quarterly. Of 116 insured, HIV-tested participants, only 29% had their most recent test in a clinician's office; 46% last tested at a health department (n=35) or sexually transmitted infection (STI) testing site (n=13). Primary motivators for testing were "to know where [they] stood" (55%), concern about exposure through sex (13%), and having it as part of a medical checkup (9.7%). Compared with those previously tested, never tested individuals were younger ($p<0.001$) and less likely to: be out to family ($p=0.04$) or their healthcare provider ($p=0.005$); ask sex partners about their HIV status ($p<0.001$); have had an STI ($p<0.001$); or know someone who died from HIV/AIDS ($p=0.002$).

Seventy-seven percent (n=164) were aware self-testing kits for HIV were available; 35 (17%) had ever purchased rapid (n=27) or dried blood spot-based kits (n=14). Participants aware of kits (n=164) had greater intention to test in the next 6 months ($p=0.04$); were more likely to consistently have sufficient income for basic necessities ($p<0.001$) and ask sex partners about their HIV status ($p=0.003$); they were less likely to have a main sex partner ($p=0.03$) or have ever had transactional sex ($p=0.013$). Among 142 participants at least somewhat likely to buy a self-test kit in the future, convenience (35%), privacy protection (23%) and rapid delivery of results (18%) were the most frequently cited motivations.

Conclusions/Implications: Though most sexually active YBMSM in NC have been tested for HIV in their lifetime, a minority is testing on a quarterly basis. Public testing venues are frequently used, even among those with insurance. Awareness of self-testing options was high, and could offer a way to increase the frequency of testing. In high-risk populations, limitations of antibody-based self-tests in terms of linkage to care and diagnosis of acute HIV infection must be considered.

Abstract 1714 - Incongruence Between Self-Perceived HIV Risk and Reported Sexual Risk among Social Media-Using Black, Hispanic and white YMSM

Author(s): *Roland Merchant, Melissa Clark, Joshua Rosenberger, Tao Liu, Jose Bauermeister, Kenneth Mayer*

Background: Identification of HIV infection and subsequent linkage-to-care among young adult men-who-have-sex-with-men (YMSM), especially Black and Hispanic YMSM, is a high priority in the United States. A common reason for lack of HIV testing is self-perception of not being infected or not being at risk for HIV, although this self-perception might be incongruent with reported HIV risk-taking behaviors and HIV testing history. Among a national sample of social media-using Black, Hispanic, and white YMSM, we examined the prevalence of self-perception of not currently being infected with HIV. We also examined potential incongruence between this self-perception and lack of HIV testing and reported HIV sexual risk from condomless sex, as well as ethnic/racial differences in this self-perception. In addition, we identified factors associated with self-perception of not currently being infected with HIV.

Methods: 18-24-year-old Black, Hispanic or white YMSM were solicited using eight social media platforms August-December 2014. YMSM were study eligible if they lived in the United States; ever had anal sex with another man; and were not known to be HIV infected. Participants completed an anonymous online study questionnaire in English or Spanish about their demographic characteristics,

HIV testing history, self-perception of currently being HIV infected on a five-point scale (“very likely” to “not possible at all”), and lifetime history of condomless sex. Potential incongruence between self-perception of not currently being HIV infected and reported condomless sex among those who had never been tested for HIV was measured by ethnic/racial group. Multivariable logistic regression models were constructed to determine factors associated with lower self-perception of currently being HIV infected.

Results: Among the 2,535 YMSM participants, 20% were Black, 36% were Hispanic, and 44% were white. Black YMSM (83%) were more likely ever to have been HIV tested than Hispanic (78%) or white YMSM (78%); $p < 0.01$. Black (25%) and Hispanic (22%) YMSM were more apt than white (20%) YMSM to self-perceive themselves as not currently being HIV infected (“not possible at all”); $p < 0.001$. Of those who self-perceived themselves as “not likely” or “not possible at all” of being HIV infected and who had never been tested for HIV ($n=49$): 59% Black, 80% Hispanic, and 65% white YMSM reported a lifetime history of condomless sex with any male; and their lifetime median number of male sexual partners was Black (4 [IQR 0-9]), Hispanic (4 [IQR 1-10]) and white (4 [IQR=1-10]). Among all participants, self-perception of not currently being HIV infected was more often found among white than Hispanic YMSM (OR 1.4 [1.1-1.8]), those who had a primary care provider (OR 1.4 [1.1-1.8]), increasing years of formal education, prior HIV testing (OR 1.52 [1.1-2.01]), and no history of condomless sex with other men (OR 3.5 [2.3-5.6]).

Conclusions/Implications: Among these social media-using YMSM, ethnic/racial differences exist in prevalence of self-perception of absence of an HIV infection. Of importance to HIV testing efforts, incongruence between risk for and self-perception of HIV infection remains a problem among this higher HIV-risk population. Interventions to decrease incongruence between self-perceived and actual HIV risk appear needed for these men.

Session A16 - Co-Infection Data from a Cross-Section of Locations

Room: Baker (Hyatt Regency Atlanta)

Abstract 1338 - Neisseria Gonorrhoeae Antimicrobial Susceptibility among Men by HIV Status, Gonococcal Isolate Surveillance Project

Author(s): Robert Kirkcaldy, Olusegun Soge, Carlos del Rio, Grace Kubin, Stefan Riedel, Edward Hook

Background: Gonorrhea, caused by *Neisseria gonorrhoeae* (NG), is the second most commonly reported infection in the U.S. (>300,000 cases in 2013), is an important cause of pelvic inflammatory disease and ectopic pregnancy, and increases risk for HIV acquisition and transmission. NG has developed resistance to each antimicrobial used for treatment. Currently, dual therapy with ceftriaxone (an injectable cephalosporin) and azithromycin is the only recommended treatment. Although this regimen remains highly effective, cephalosporin susceptibility has declined, threatening to undermine treatment options. NG antimicrobial resistance in the US can vary by gender of sex partner in the US: infections in gay, bisexual, or other men who have sex with men (MSM) often exhibit greater prevalence of resistance than infections in men who have sex exclusively with women (MSW). Little is known, however, about whether NG resistance differs by HIV status.

Methods: The Gonococcal Isolate Surveillance Project conducts surveillance of antimicrobial susceptibility among urethral isolates from men attending U.S. STD clinics. HIV status at the time of the clinic visit is based on patient report or documentation of a positive test. Antimicrobial susceptibility is determined by measuring minimum inhibitory concentrations (MICs) by agar dilution. We interpret MICs according to Clinical and Laboratory Standards Institute (CLSI) criteria for resistance to penicillin (MIC ≥ 2 $\mu\text{g}/\text{mL}$), tetracycline (MIC ≥ 2 $\mu\text{g}/\text{mL}$), and ciprofloxacin (MIC ≥ 1 $\mu\text{g}/\text{mL}$) and reduced susceptibility to cefixime (MICs ≥ 0.5 $\mu\text{g}/\text{ml}$) and ceftriaxone (MICs ≥ 0.5 $\mu\text{g}/\text{ml}$). In the absence of CLSI criteria, we consider reduced azithromycin susceptibility as MIC ≥ 2 $\mu\text{g}/\text{ml}$. Proportions of isolates with resistance or reduced susceptibility were compared by chi-square or Fisher's exact test.

Results: 25,249 isolates were collected during 2010–June 2014; 21,483 (85.1%) had gender of sex partner and HIV data. Of those men, 33.1% (n=7,103) were MSM. MSM were more likely to be HIV-infected (25.3%) than MSW (1.5%, $p < 0.001$). Across nearly all antimicrobial classes examined, isolates from MSM had greater prevalence of resistance or reduced susceptibility than isolates from MSW. Among MSM, no significant differences in resistance or reduced susceptibility were observed by HIV status except for reduced azithromycin susceptibility (which was more common in HIV-uninfected MSM [1.3%] than HIV-infected [0.6%] $p = 0.013$). Among 14,380 MSW, however, the prevalence of resistance or reduced susceptibility was substantially higher among isolates from HIV-infected than HIV-uninfected men (penicillin resistance 19.4% vs. 9.6% [$p < 0.001$], tetracycline resistance 27.5% vs. 16.1%, [$p < 0.001$], ciprofloxacin resistance 17.9% vs 8.2% [$p < 0.001$], reduced azithromycin susceptibility 2.3% vs 0.4% [$p < 0.001$] and reduced cefixime susceptibility 0.5% vs. 0.04% [$p = 0.002$]).

Conclusions/Implications: To our knowledge, this is the first analysis of NG resistance by HIV status using U.S. surveillance data. Prevalence of NG resistance is high among HIV-infected and uninfected MSM. In HIV-infected MSW, the prevalence of NG resistance also appears high; misclassification of gender of sex partner is possible and might influence these findings. To prevent transmission and sequelae (including among partners), providers should screen sexually active HIV-infected persons at least annually and should treat gonorrhea with currently recommended therapy: ceftriaxone 250 mg intramuscularly and azithromycin 1 g orally.

Abstract 2173 - Incidence and Persistence of Oral, Vaginal, and Anal Human Papillomavirus (HPV) Infections in Rural HIV-Infected Women

Author(s): *Ping Du, Fabian Camacho, John Zurlo, Eugene Lengerich, Craig Meyers, Neil Christensen*

Background: HIV-infected (HIV+) women have a higher risk of developing human papillomavirus (HPV)-associated cancers, but the natural history of non-cervical HPV infections in HIV+ women is not well understood. To date no consensus clinical guidelines have been developed for prevention of HPV-related oral and anal cancers due to insufficient evidence in human research. We examined the prevalence, incidence, and persistence of oral, vaginal, and anal HPV infections in a cohort of HIV+ women living in a rural environment.

Methods: In this longitudinal study, HIV+ women were recruited from HIV/AIDS outpatient clinics that serve HIV populations in south central Pennsylvania, and were followed at approximately 6-month intervals during 2011 to 2013 to assess HPV infections over time. At each visit, a behavioral survey, and

oral, vaginal, and anal swabs collected. The swab specimens were tested for the presence of DNA for 37 HPV types. HIV-related clinical information was obtained from the medical records. A prevalent HPV infection was determined by the presence of HPV DNA in the swab at the baseline visit. An incident HPV infection was defined as detection of new HPV DNA from the swab that was not present at previous visit(s), and a persistent HPV infection was defined as continuous detection of the same type of HPV DNA from the swab for ≥ 2 visits. A multivariate exact logistic regression model was performed to identify factors related to prevalent or persistent HPV infection. A multivariate generalized linear mixed model with negative binomial distribution was used to assess factors associated with incident HPV infections.

Results: Among 103 HIV+ women enrolled in this study, the majority were older than 40 years (72%) and had been infected with HIV for >10 years (67%). Whites accounted for 54%, followed by blacks (24%) and Hispanics (16%). High risk sexual behaviors and uses of tobacco/alcohol/drug were commonly reported. Overall, HPV DNA was detected among 55% of women at the baseline visit. The prevalence of oral, vaginal, and anal HPV infection were 10%, 40% and 46%, respectively. About 15% had multiple-site infection (≥ 2 anatomical sites) or multiple-type infection (≥ 2 HPV types). During the follow up visits, new types of HPV infections in the oral cavity, the vagina, and the anus were detected among 13%, 28%, and 28% of women with repeated visits; persistent oral, vaginal, and anal HPV infections were observed among 1%, 29%, and 23% of women, respectively. Current smoking behavior was significantly associated with the incident HPV infection (adjusted rate ratio=5.8, $p<0.05$). Multiple sexual partners (adjusted odds ratio [aOR] =21.7) and self-reported history of having sex with a woman (aOR=3.85) seemed related to the persistent HPV infection.

Conclusions/Implications: Incident oral and anal HPV infections are common in HIV+ women. Anal HPV infection is also likely to persist over time. Further medical evaluations are needed for HIV+ women to detect HPV-related precancerous lesions at non-cervical sites. Because HIV+ women have other cancer cofactors including tobacco and alcohol use, behavioral counseling that targets reducing tobacco and alcohol consumption needs to be routinely provided to HIV+ people.

Abstract 2298 - The Effects of HCV Co-infection on HIV Clinical Outcomes in the District of Columbia

Author(s): *Jenevieve Opoku, Maryam Iqbal, Adam Allston, Garret Lum, Amanda Castel, Michael Kharfen*

Background: Hepatitis C virus (HCV) is highly prevalent among HIV+ persons due to common transmission routes. Approximately 25% of HIV+ persons and 50-90% of HIV+ injection drug users (IDU) are infected with HCV. The effects of HIV on HCV treatment are well documented, yet there are limited studies on the effects of HCV on HIV-related clinical outcomes. The purpose of this analysis was to identify potential differences in clinical outcomes among HIV only and HIV-HCV co-infected persons in Washington, DC.

Methods: Surveillance data from the Hepatitis surveillance registry and the enhanced HIV/AIDS Reporting System (eHARS) were extracted and matched among cases diagnosed with HIV between 2003 and 2012. HIV and HCV cases were matched by first and last name, and date of birth. Bivariate analysis was performed to identify differences by demographics, HIV disease stage at diagnosis and stage in 2013, entry into and retention in HIV care, and HIV viral suppression and mortality. Logistic regression

was performed to identify any association between HIV/HCV co-infection and viral suppression and mortality.

Results: Between 2003 and 2012, there were 10,248 diagnosed cases of HIV, of which 954 HCV matches were identified. Nearly a third of matched cases were concurrently diagnosed with HIV and HCV (32.5%), 44.6% had an HIV diagnosis prior to the HCV diagnosis and 23% had HCV before their HIV diagnosis.

In comparison to cases with only HIV, HCV-HIV co-infected cases had a higher proportion of cases that were ≥ 40 years of age at HIV diagnosis (80.7% vs 44.0% $p < .0001$), were Black (85.8% vs 74.9%, $p < .0001$), had IDU as a mode of transmission (31.2% vs 8.8% $p < .0001$), were at stage 3 disease at HIV diagnosis (37.1% vs 31.7% $p < .0001$), were linked to care ≥ 3 months after HIV diagnosis (31.0% vs 26.8% $p = .0051$), and had no evidence of retention in HIV care in 2013 (46.9% vs 42.8% $p < .0001$). Median CD4 count at diagnosis and in 2013 differed among HIV-only and co-infected cases (median CD4 at diagnosis: 348 cells/ μL vs. 297 cells/ μL , $p = 0.02$; median CD4 in 2013: 493 cells/ μL vs. 447 cells/ μL , $p = 0.0069$). Although a statistically significant difference in viral suppression was not documented in multivariate models, analysis indicated an increased odds of death among HIV/HCV co-infected cases compared to HIV-only cases (aOR 1.48; 95% CI 1.16-1.87).

Conclusions/Implications: This analysis demonstrates that HIV cases co-infected with HCV differ from cases diagnosed with HIV only. HCV co-infection was associated with suboptimal HIV clinical outcomes including more advanced disease stage of HIV disease at diagnosis lower median CD4 counts and increased mortality. Prevention and care programs should be tailored to ensure increased HIV and HCV testing, linkage to care, and treatment adherence.

Abstract 2462 - Viral Suppression among Individuals Co-Infected with HIV and Sexually Transmitted Infections in Utah, 2009 – 2013

Author(s): *Kristina Larson, Matthew Mietchen, Allyn Nakashima*

Background: Sexually transmitted infections (STIs) diagnosed among HIV-infected individuals are common and may affect the health and/or treatment outcomes of these individuals. Co-infections are an indicator of continued engagement in high-risk behaviors and HIV-infected individuals with an STI diagnosis are at increased risk of transmitting HIV. The “Treatment as Prevention” model, being adopted nation-wide, focuses on linking and retaining those infected with HIV to care and achieving viral suppression. Evidence has suggested that suppressing viral loads (VL) reduces transmission of HIV. The objective of this analysis was to assess the retention to HIV care and viral suppression among those infected with HIV who acquire an STI.

Methods: HIV surveillance data were obtained from Utah’s enhanced HIV/AIDS Reporting System (eHARS). STI data were obtained from Utah’s NEDSS-compatible reporting system, TriSano. STIs included all reported cases of chlamydia, gonorrhea, and syphilis (all stages) between 2009 and 2013. Electronic record linkage, using deterministic and probabilistic matching, was utilized to obtain HIV-positive individuals with an STI diagnosed and reported in Utah during the five-year timeframe. The study population included those co-infected individuals with an STI diagnosis 90 days or more after their HIV diagnosis. The following definitions were used: “linked-to-care” = CD4 or VL result within 3 months of

HIV diagnosis; "currently-in-care" = CD4 or VL result either 6 months before or after STI diagnosis; and "viral suppression" = a VL of <200 copies/ml that is closest to the STI event within the 6-month timeframe.

Results: From 2009 to 2013, there were 334 HIV-positive individuals who became infected with an STI 90 days or more after their HIV diagnosis. Cross-tabulation of the co-infected population by risk category revealed that 68% were Men who have Sex with Men (MSM) and 25% were MSM/IDU (Injection Drug Use). In addition, the co-infected population was primarily White, non-Hispanic (76%) followed by Hispanic (16%) and the majority were male (97%). Further analysis found that 26% (85/334) of co-infected persons were linked-to-care within 3 months of HIV diagnosis; however, 81% (271 co-infections) were currently-in-care at the time of their STI event. Furthermore, only 36% (98/271 co-infections) of those currently-in-care had documented evidence of viral suppression surrounding their STI event. A previous analysis found that in 2013, overall, 59% (1,694/2,872) were considered currently-in-care and among those currently-in-care, 84% (1,420/1,694) had achieved viral suppression.

Conclusions/Implications: The results suggest that high-risk individuals infected with HIV who later become infected with an STI are not being linked-to-care. While the majority of individuals were currently-in-care at the time of their STI event, a high percentage had not achieved viral suppression, which is an interesting finding when compared to the entire HIV population in Utah that had a lower percentage currently-in-care and a higher percentage achieving viral suppression. This suggests that the co-infected population is at increased risk of transmitting HIV due to the low number of patients achieving viral suppression. Further data collection is needed to better determine why those co-infected with HIV and STIs that are currently-in-care are not achieving viral suppression.

Track B

Session B14 - Using Technology to Improve Prevention, Care and Health Communications

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 1204 - Multi-Platform Strategies to Address HIV/AIDS in Public Health Communications Campaigns

Author(s): *Diane Hansen, Lyell Collins*

Issue: The Centers for Disease Control and Prevention (CDC) outlines a wide variety of tools to develop health communication and social marketing campaigns and programs in its Gateway to Health Communication and Social Marketing Practice. The Nevada Division of Public and Behavioral Health (DPBH), Office of HIV/AIDS Prevention and Care, recognized a gap in public health communications and the lack of centralized tools that conformed to CDCs communications recommendations and took steps to remedy the issue.

Setting: DPBH Office of HIV/AIDS Prevention and Care houses the state HIV/AIDS prevention program, as well as the Ryan White care program, which work together to prevent HIV, identify positive cases, and integrate resources for prevention and care.

Project: BetOnThis NV has an online tool kit, social media integration, two mobile applications, health education tools, and information on Ryan White program eligibility, free condom locations, and testing locations throughout Nevada. The goal of BetOnThis NV is to 1) reach high-risk men who have sex with men (MSM) via the Internet and mobile applications, 2) coach sub-grantees on social media usage, 3) collaborate with sub-grantees to deliver a unified message, 4) approach MSM populations, 18-34, using the platforms they find convenient, to make information as easy to get as possible, 5) help improve communications across all platforms using health literacy tools available through the CDC.

Results: DPBH worked with the Nevada Coalition for Safe Sex and The Gay and Lesbian Center in Las Vegas to develop and launch an online tool kit and two apps. The campaign was structured around survey results from MSM persons living with HIV/AIDS within 400% Federal Poverty Level (FPL) showing 68.6% access the Internet at least once a day, with 50% of those using a cell phone to access the Internet. 87.5% access Facebook, 71.8% watch videos on YouTube, 68.7% search actively for new apps to download, and 56.3% report visiting health provider web sites on their mobile device.

BetOnThisNV.org contains comprehensive resources and is updated regularly to reflect community needs and trends. The NV SexSafe app is a sexual health education toy which allows the user to assess HIV and STI risk factors of randomized activity, resources for free condoms and HIV testing. NV SelfCare is a calendar app which allows users to track health indicators and send summary journals to care providers. Both apps allow Nevadans to ask questions and receive personal responses from providers. (Google Play/Apple AppStore)

Lessons Learned: There are positive benefits to using multi-platform strategies to address HIV/AIDS in public health communications campaigns. Geotargeted to Nevada, campaign advertising on Grindr resulted in the 235 downloads of the iOS version of NV SexSafe and 86 downloads of the Android version. Since the initial date they were downloaded, more than 60% of these apps remain installed and in use. Subgrantees continue to utilize the BetOnThisNV.org web site as a tool with their clients and 500 decks of NV SexSafe Playing Cards have been distributed in outreach efforts. 100 requests for information have been received through the tool kit and apps combined.

Abstract 1961 - Trending Topics: Effectively Maintaining an Online Intervention for High-Risk and HIV+ Young Black MSM and Transgendered Women

Author(s): *Karina Soni, Helene Kirschke-Schwartz, Emily Pike, Lisa Hightow-Weidman, Kate Muessig, Sara LeGrand*

Issue: Although young black men who have sex with men (YBMSM) are disproportionately affected by the HIV epidemic, there are few relevant prevention strategies tailored for this population. Despite enthusiasm surrounding the use of internet-enabled mobile interventions, little is known about how to facilitate and measure user engagement. Providing routine content updates is not likely to be sufficient to maintain user interest over the full intervention duration. Competition for user's attention from sexual and social networking sites, video sharing sites and games requires researchers to think critically about ways to prevent intervention drop-off.

Setting: healthMpowerment(HMP) is a state-wide randomized controlled trial for YBMSM/TW between the ages of 18-30, conducted in North Carolina. The intervention aims to lower self-reported risky sexual behavior via engagement with the website's interactive features which include informational articles, quizzes, Ask the Dr. feature, risk screeners and decision making tools. A unique and central feature of HMP is its focus on user-created content around trending topics and issues of relevance to YBMSM/TW.

Project: The intervention is non-directive, incorporates interactive features, and utilizes a point reward system, all designed to increase user engagement. Site activity has grown exponentially in the past year due to (1)tailored site updates that cater to popular features and posts based on participant use, (2)monthly contests that focus on different aspects of the HMP website (3)SMS reminders to use the website or engage with a particular feature, and (4)an increase in the number of "super users" or participants who are significantly more active on and engaged with the website and its social features.

Results: A toolbox of strategies is being used to create a relevant website for YBMSM/TW. Compared to control group participants, the intervention group has used the site significantly more: from 12/1/13 to 7/1/14, 59% of intervention participants versus 30% of control participants used the website after their initial log-on. Site usage has also increased over time, suggesting the effectiveness of the increasingly tailored site promotions. Of participants enrolled in the intervention group from 1/1/15 to 3/1/15, 45% logged on to HMP multiple times within three months of their initial enrollment. This is a substantial increase from the same time period in 2014, where only 32% of new participants logged in more than once within their three months of enrollment.

Monthly contests and weekend promotions are used to increase participant activity on the website, as well as encourage usage on specific pages. In March 2015, there was a 33.8% increase in usage compared to the previous month. During a weekend promotion of the educational quiz feature of HMP, there was a 17-fold increase in usage in the section versus the previous weekend.

Lessons Learned: There are benefits to creating a user-centric, engaging web-based intervention for YBMSM/TW. By fine-tuning updates and maintaining interest, participant activity increased significantly. This also may mean that social networking interventions need to reach a "critical mass" before participants feel comfortable engaging with other members of the community. This increase indicates more opportunities for participants to have exposure to health and wellness materials on HMP.

Abstract 2052 - TaSHA (Tablet-based Sexual Health Assessment): Barriers to Integrating Health Information Technology into Existing HIV Care Systems

Author(s): Ashley Scarborough, Carlos Romero, Linda Creegan

Issue: Previous research suggests that a sexual history is not routinely obtained among gay, bisexual and other men who have sex with men (MSM). For sexually-active HIV + MSM, appropriate STD screening is a necessary element of quality care in the HIV clinical setting. A tablet-based sexual health assessment (TaSHA) was developed to reduce barriers to routine sexual history collection and to provide clinical decision support based on CDC-recommended STD screening. TaSHA was piloted in 4 HIV private provider clinics, and despite provider buy-in and support from clinic champions, many barriers were encountered which prevented its integration into clinical systems.

Setting: The California Prevention Training Center (CA PTC) is a CDC funded training center charged with improving routine sexual history collection and appropriate STD screening in HIV+ MSM. CA PTC partnered with 2 HIV care settings in Northern California and 2 HIV care settings in Hawaii to implement TaSHA.

Project: TaSHA has 2 main components that facilitate both appropriate STD screening, and communication about sexual risk between patients and providers. First, TaSHA's sexual risk assessment elicits patient information about sexual history that informs STD screening done at that clinic visit. Second, TaSHA generates a report for the provider that summarizes patient responses, tailors STD screening recommendations, and highlights suggested messages to encourage risk reduction strategies. While buy-in was relatively simple to garner, we identified various obstacles at three key stages in the implementation process: 1.) baseline STD screening data was needed for quality improvement purposes was difficult for clinics to obtain 2.) patient privacy and data security 3.) equipment issues and integrating TaSHA into clinic flow. This presentation will highlight the process evaluation outcomes and these particular barriers to integrating TaSHA into clinical systems.

Results: From January 2012 through April 2015, the CA PTC reached various stages of integration in 4 HIV care centers. Three clinics struggled to assess baseline percentage of patients screened for STD. Two clinics encountered major barriers related to patient privacy and data security requirements. Although TaSHA meets HIPAA compliance standards and legal precedents allow vendors to maintain patient data, large agencies had difficulty fitting TaSHA into their strict data security parameters. One clinic experienced significant barriers with equipment and integration into clinic flow. As of April 17, 2015, 2 out of the 4 clinic sites have successfully integrated TaSHA into routine clinical care.

Lessons Learned: While technological tools may offer exciting potential for addressing gaps in clinical care, integration into existing clinical systems presents complex challenges. Smaller care organizations adapted more easily to accommodate the use of TaSHA than did larger agencies. Pre-integration of a health information technology tool, prepare to communicate in depth about legality and protection of patient data. Work-around plans to integrate these tools into existing clinic systems may also be beneficial in some settings.

Abstract 2548 - REACH: Increasing Rural African American Women's Access to Evidenced-Based HIV Interventions

Author(s): *Kristina Hood*

Background: African American (AA) women account for 71.5% of HIV/AIDS diagnoses among women in the South (CDC, 2013). Mississippi ranked 7th nationally in HIV case rates, with a rate of 20.7 per 100,000 persons in 2011 (CDC, 2012). In 2012, African Americans accounted for 75% of all new HIV infections in Mississippi, and those 13-24 had the highest reported rate of infection (32 per 100,000 persons)(MSDH, 2013). Notably, 43% of new HIV diagnoses are occurring in rural areas of Mississippi (Reif et al., 2014). Thus, rural AA women are at increased risk. The primary risk factor for HIV transmission among rural African Americans in the South is unprotected sex (Montgomery et al., 2012; Montgomery et al., 2014). Evidence-based behavioral interventions that emphasize consistent condom

use have demonstrated efficacy in reducing HIV risk. One way to increase access to HIV prevention programming, regardless of geographical location is to use internet-based media technology. The proposed project used social media tools to recruit and implement a single session, evidence-based HIV intervention (VOICES) for AA heterosexual women.

Methods: In order to assess the feasibility of using social media as an implementation tool for AA women, preliminary data was collected from August to December 2013 from 93 AA women (Mage = 18.77 SD = .90) residing in Mississippi. After completing baseline assessments, participants were randomly assigned to one of three groups: (1) VOICES conducted face to face, adapted VOICES-conducted online using the Google+ Hangout, or waitlist control. Participants completed a 60 minute intervention session, which includes a video on safer sex behaviors and a group discussion. All participants completed follow-up assessments at 3 months.

Results: It was found that women who participated in the VOICES online group had more positive attitudes towards using condoms $F(2, 92) = 118.39$ $p = .001$ and greater condom use intentions $F(2, 92) = 89.61$, $p = .001$ at 3 month than the waitlist control group. There were no significant differences between the face to face VOICES group and the online VOICES group.

Conclusions/Implications: Social media is a cost-effective tool for targeted health promotion campaigns (Hsu et al., 2013; Young, 2013), however, it is underutilized as an implementation tool. Delivering interventions in this way can help agencies reach more people with limited resources. It also can aid in sustainability and fidelity; online interventions are easily accessible for monitoring and require fewer resources for community partners than delivering face to face interventions. The results of this project demonstrated the use of social media as a wide reaching, cost-effective method to implement evidence-based, group-level HIV interventions for individuals with limited access to prevention services.

Session B17 - Stigma as a Cause of Risk and Morbidity in Populations Affected by HIV

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1215 - Vulnerability and Protective Factors Associated with Resilience among Women living with HIV

Author(s): *Monique Brown, Julianne Serovich, Jinxiang Hu, Judy Kimberly*

Background: Women comprise 20% of new HIV infections in the US. One factor that may help women living with HIV to cope better with living with the disease is resilience, which is defined as the process of positive adaptation in spite of adversity and stressors. The motivation, management, and mastery theoretical model may be used to understand resilience in the context of living with HIV. However, research exploring social and psychological factors associated with resilience among women living with HIV is scant. The aim of this study was to determine the vulnerability and protective factors associated with resilience among women living with HIV.

Methods: Data were obtained from 127 women living with HIV as part of a disclosure research study. The resilience scale had a Cronbach's alpha of 0.81 in the current study. Resilience was dichotomized at the 66th percentile of the overall resilience score with high resilience defined as the upper 33.3% versus

low resilience defined as the lower 66.6%. Logistic regression models were used to determine associations between vulnerability factors (stigma, depression, anxiety loneliness) and protective factors (openness and self-esteem), and resilience.

Results: Approximately 31% of participants were classified as having high levels of resilience. After adjusting for age and level of education, negative associations were seen between depression (OR: 0.93; 95% CI: 0.90 – 0.96), anxiety (OR: 0.95; 95% CI: 0.91 – 0.99), and loneliness (OR: 0.83; 95% CI: 0.76 – 0.90), and resilience. Overall stigma (OR: 0.98; 95% CI: 0.96 – 0.99) and negative image stigma (OR: 0.87; 95% CI: 0.82 – 0.93) were negatively associated with resilience. Personalized stigma (OR: 0.97; 95% CI: 0.93 – 1.00), disclosure stigma (OR: 0.94; 95% CI: 0.88 – 1.00), and public attitudes stigma (OR: 0.96; 95% CI: 0.93 – 1.00) were also negatively associated with resilience but showed borderline statistical significance. There was no statistically significant association seen between openness, self-esteem and resilience.

Conclusions/Implications: The motivation, management, and mastery theoretical model suggests that improving psychological health may improve perceptions of resilience through achieving desired health outcomes and advocacy. Intervention programs geared towards promoting resilience among women living with HIV should also address depression, anxiety, loneliness and HIV stigma. Providing resources that may improve social support for women living with HIV may also help to improve their psychological and emotional well-being.

Abstract 1436 - Understanding the Correlations Between Violence, Stigma and HIV Risk among MSM

Author(s): *Rob Stephenson, Catherine Finneran*

Background: It is only recently that of intimate partner violence (IPV) and its known adverse health effects have been recognized as prevalent among gay, bisexual, and other men who have sex with men (MSM).

Methods: We examined the correlates of IPV among MSM using a venue-recruited sample (n=1,053).

Results: Overall, 48.2% of respondents indicated that they had experienced at least one form of IPV in the past year from a male partner, including reports of emotional IPV (28.3%), physical/sexual IPV (23.6%), and monitoring IPV (21.6%). Similarly, perpetration of emotional IPV was the most commonly reported form of IPV perpetration (18.4%), followed by monitoring IPV (17.5%) and physical/sexual IPV (13.3%). Approximately one in three respondents indicated that they had perpetrated IPV against one of their male partners in the past 12 months (33.6%). Over half the sample (55.1%) reported unprotected anal intercourse (UAI) at last sex. In logistic regression, men who reported more experiences of minority stress (racist discrimination, homophobic discrimination, and internalized homophobia) were significantly ($p < 0.05$) more likely to report both perpetration and receipt of multiple forms of IPV (physical/sexual, controlling, monitoring, emotional, and HIV-related). Likewise, men who reported receipt or perpetration of IPV were significantly more likely to report unprotected anal intercourse at last anal sex.

Conclusions/Implications: These findings suggest an IPV framework for MSM in which minority stressors are associated with IPV, which in turn may modify sexual risk-taking and risk for HIV/STIs.

Abstract 2403 - "Because The Bible Says So": Religiosity and Stigma in a Sample of Latino HIV-Positive Men Who Have Sex with Men

Author(s): *Jose Martinez-Velez, Ricardo Vargas-Molina, Gerardo Jovet-Toledo, Edda Santiago-Rodriguez, Carlos Rodriguez-Diaz*

Background: HIV continues to disproportionately affect men who have sex with men (MSM). In Puerto Rico (PR), the HIV incidence among MSM has increased 126% in the last 12 years. As in many other Latin American and Caribbean countries, religion accounts for many of our socially-learned behaviors and has promoted a heterocentric ideology regarding sexuality and reproduction, in which, non-heterosexual identities and homoerotic sexual practices are condemned and stigmatized. PR also has a Judeo-Christian-based culture, with 45% of the population identified as catholic, 40% as protestant, and 15% as non-believers. Religiosity may be an important factor that highlights HIV and gay-related stigma among MSM. Considering this context, the objective of this analysis is to explore the role of religiosity in the experiences of HIV+ MSM as they pertain to gay-related and HIV felt stigma.

Methods: Using an explanatory sequential mixed methods approach, 149 structured interviews and 18 life history interviews were conducted in Spanish with HIV+ MSM in PR. Structured interviews included culturally-appropriate measures of religiosity and stigma (Gay stigma and HIV felt stigma). Descriptive and multivariate analyses were completed using SPSS. Qualitative data was analyzed using content and discourse analyses and a grounded theory approach supported by the use of NVivo for data management.

Results: The majority of the participants (n=149) reported being affiliated to a religion (69.1%), primarily Catholicism (38.9%) and Protestantism (30.2%). Most considered religion as important (25.5%) or very important (36.2%) in their lives, and nearly half (46.3%) reported to participate in religious events at least several times a month. Self-identifying as catholic or protestant was strongly associated with higher levels of religiosity ($p < 0.001$). High levels of gay-related and HIV felt stigma were reported across the sample. After multinomial analyses, those men who self-reported to be protestant also presented higher rates of hidden stigma than men who reported no religion (OR=1.126; 95% CI: 1.021-1.241). In life history interviews, participants (n=18) expressed being exposed to religious practices throughout their lives, mainly during childhood. Some participants expressed a negative moral judgment and self-condemnation regarding same-sex sexual practices and desires based on their religious beliefs, which were also associated with lack of social support, suppression of sexual activity, concealing of sexual identity, feelings of social inadequacy, substance use during sex, and depression.

Conclusions/Implications: Religion is a culturally grounded factor that influences health-related practices of HIV+ MSM. In this sample, high levels of gay-related and HIV felt stigma were reported. This may have impacted the relationship between religiosity and stigma. Nonetheless, data evidenced that higher levels of religiosity among those self-identified as protestant are associated with hidden gay stigma. Similarly, qualitative data analysis supports the notion of religion as a culturally-grounded experience for these participants. The stigmas grounded in their religious experiences have negatively

influenced their support networks. It is recommended to continue the study of the impact of religion in health-related practices, particularly among those groups otherwise made vulnerable due to their sexual practices or health status.

Abstract 2409 - Suicidal Behavior and Stigma: Consequences for the Mental Health and Quality of Life of HIV-Positive Men Who Have Sex with Men

Author(s): *Carlos Rodríguez-Díaz, Ricardo Vargas-Molina, Edda Santiago-Rodríguez, Edgardo Ortiz-Sánchez*

Background: Worldwide rates of suicide death have been consistently increasing. Currently, over 800,000 people die by suicide each year; the equivalent of one suicide death every 40 seconds. In the United States, approximately 40,000 people die by suicide each year. Additionally, 8.3 million and 2.2 million adults reported suicidal thoughts and plans, respectively. Furthermore, it is estimated that 25 suicide attempts occur for every suicide death. Researchers have suggested that the HIV+ population is among the most underestimated groups regarding suicide risk. This may be in part due to the experience of stigma. The objective of this study is to assess the prevalence of suicidal behavior and its association to demographic and mental health indicators of HIV-positive men who have sex with men (HIV+MSM) in Puerto Rico (PR).

Methods: We examined data from an ongoing health promotion study being conducted in community organizations that offers HIV-related services in PR. The study, enclosed to HIV+MSM, consists of the participation in a survey interview that includes domains of suicidal behavior, mental health, stigma and quality of life, among others. Using SPSS v.20, chi-square, one-way ANOVA and multinomial regression analyses were used to measure association.

Results: The mean age of the sample (N=149) was 38.8 and, in average, had been living with HIV for a decade. Almost half of the sample (43.0%) reported having a history of suicidal behavior; 40.6% reported a history of suicidal ideation (no attempt) and 59.4% had attempted suicide at least once during their lifetime. Statistically significant differences were observed for the number of years living with HIV (participants with a history of suicide attempt reported a larger number of years living with HIV), as well as depression and anxiety symptomatology. Likewise, most of the quality of life aspects explored (overall function, life satisfaction, and health and disclosure worries, among others) resulted in statistically significant differences. A multinomial regression analysis using the participants with no reported history of suicidal behavior as the reference category was conducted. Participants who reported suicidal ideation were over four times more likely to have depression and anxiety symptomatology and had significantly lower aspects of quality of life (overall function, life satisfaction, and health and medicine worries). Similarly, participants who reported attempting suicide were over two times more likely to have depression symptomatology and had significantly lower life satisfaction and sexual function. Although higher rates of stigma, drug use and poor adherence were observed in participants who reported a history of suicidal ideation, no statistically significant differences between these and the participants with no reported suicidal behavior were observed.

Conclusions/Implications: High rates of stigma were reported among participants and this may have contributed to the absence of association with suicidal behavior. Nonetheless, these findings suggest the

need to develop individual and structural interventions that reduce stigma and its consequences. Future research should focus on the specific mental health needs of HIV+MSM, particularly those with a history of suicidal ideation. Protective factors associated with suicidal behavior, such as resiliency and social support should be explored.

Session B21 - The Messages4Men Study: Testing Brief Messages on New HIV Prevention Information among HIV-Infected and Uninfected African American/Black and Latino MSM in Three U.S. Cities

Room: Embassy E/F (Hyatt Regency Atlanta)

Abstract 1387 - Testing HIV Prevention Messages about antiretroviral Pre-Exposure Prophylaxis (PrEP) and condom effectiveness for Anal Sex among HIV Uninfected and Infected African American/Black and Latino MSM

Author(s): *gordon mansergh, jeffrey herbst, nicole pitts, damian denson, matthew mimiaga, jeremy holman*

Background: PrEP is an efficacious HIV prevention option MSM at high risk for HIV acquisition. However, many MSM are still not aware of or take advantage of this important biomedical intervention – especially racial/ethnic minority MSM. Recent research found estimates of condom effectiveness during anal sex among MSM to be lower than effectiveness found in prior research on intercourse among heterosexual samples. Other research has raised concerns that MSM might stop using condoms when taking daily PrEP. In this study, we developed and tested brief messages about PrEP and condom effectiveness for black and Latino MSM. There were three messages for HIV-uninfected MSM (one single and two multiple-topic), one single message for HIV-infected MSM, and one condom effectiveness message for both subsamples.

Methods: The analysis included n=605 HIV-uninfected and n=330 HIV-infected black and Latino MSM. Individual messages tested with the HIV-uninfected subsample included (paraphrased): (1) taking a pill once a day (and rarely missing a dose) can reduce risk for HIV infection by 73%; (2) always using a condom during anal sex with an HIV-positive person can reduce risk for HIV infection by 70%; (3) a multiple topic message that combines #1 and #2; and (4) a multiple topic messages that presents three PrEP efficacy estimates based on differing adherence levels: 44%, 73%, and 95%. Individual messages tested with the HIV-infected subsample included #1 and #2 above. Analyses consisted of bivariate chi-square comparisons and multivariable logistic regression of demographic and behavioral factors associated with intent to use PrEP and condoms after hearing the messages, and believability and newness of the message information.

Results: After hearing message #1 (i.e., 73% PrEP efficacy), HIV-uninfected black (vs. Latino) MSM were more likely to say they would take PrEP in the future (81% vs. 70% respectively, $p<.05$), and there was no difference by race/ethnicity for intent to use condoms (69% vs. 73%, $p>.05$). Multivariate results indicated men with more education and who reported recent condomless sex were less likely to intend to use condoms. This message was largely new (67% vs. 60%, $p>.05$) and believable (82% vs. 77%, $p>.05$) for both black and Latino MSM. After hearing message #2 (i.e., 70% condom effectiveness), men reporting recent condomless sex (vs. not; 87% vs. 92%, $p<.05$) were less likely to intend to use a condom. These bivariate findings remained significant in multivariable regression analysis, and more

education was associated with less intent to use condoms. The condom effectiveness message was generally not new (20% vs. 17%, $p > .05$) but was highly believable (95% vs. 90%, $p > .05$) among both black and Latino MSM. Results for multiple topic messages for HIV-uninfected and single messages for HIV-infected participants were generally similar, with some exceptions to be described.

Conclusions/Implications: Racial/ethnic minority MSM continue to be unaware of PrEP and its benefits, although this information is largely believable once informed. A majority of MSM indicated they would use condoms in the future after hearing a PrEP message, which does not support concerns of risk compensation.

Abstract 1402 - Racial/Ethnic and Other Demographic Differences in Responses to Prevention Messages on Benefits of Antiretrovirals for HIV Treatment among African American/Black and Latino MSM

Author(s): *Jeffrey Herbst, Gordon Mansergh, Damian Denson, Nicole Pitts, Matthew J Mimiaga, Jeremy Holman*

Background: Black and Latino MSM experience higher rates of HIV than white MSM. Antiretroviral therapy (ART) and male latex condoms are proven interventions that significantly reduce HIV transmission and acquisition risk among MSM. This study examined racial/ethnic and other demographic differences in responses to prevention messages regarding the benefits of ART for HIV treatment among black and Latino MSM.

Methods: Data were collected as part of the Messages4Men study; a cross-sectional investigation of brief HIV prevention messages among black (166 HIV-positive, 296 HIV-negative) and Latino (164 HIV-positive, 309 HIV-negative) MSM. Men were recruited by community-based organizations in Chicago, Ft Lauderdale, and Kansas City. Web-based survey was used to deliver novel HIV prevention messages; questions regarding novelty, believability and behavior change intentions immediately after message exposure; and an assessment that included demographics, condom use history, and risk behavior (condomless anal sex, prior 3 months). The message for HIV-negative men was: "If your partner has HIV and takes all his HIV medications as prescribed, your risk of getting HIV will be much lower. A recent study was done of couples where one partner had HIV and the other did not. In the study, if the partner with HIV took HIV medications every day, the other partner's chance of getting HIV was reduced by 96%." Messages for HIV-positive men were (paraphrased): people with HIV who took HIV medications every day lived longer and were healthier (self-benefit), and if the partner with HIV took HIV medications every day, the uninfected partner's chance of getting HIV was reduced by 96% (partner benefit). Chi-square tests compared responses on message novelty, believability, likely future ART use (among HIV-positives), likely future condom use, and likely discussion of ART use with HIV-positive partner. Multivariable models controlled for demographics and were stratified according to race/ethnicity.

Results: Greater percentages of Latino MSM were older and college-educated than black MSM ($p < .0001$). Among HIV-positives, greater percentages of black MSM (vs. Latino MSM) reported likely condom use after exposure to single and combined prevention messages describing ART self and partner benefits ($p < .05$). Among HIV-negatives, a greater percentage of Latino MSM (vs. black MSM) reported likely discussion about ART with HIV-positive partners (91% vs. 85%, $p = 0.03$). There were no

significant racial/ethnic differences in novelty, believability or intentions for future ART use. In a multivariable model among HIV-positive black men, those reporting high-risk behavior were nearly 5 times as likely to report the ART self-benefit message was new compared to men not reporting high risk behavior (Adjusted Odds Ratio [AOR]=4.8; 95% Confidence Interval [CI]=1.3-18.3). Among HIV-positive Latino men, those reporting undetectable viral load were 5 times as likely to report the ART self-benefit message was new compared to men not reporting undetectable viral load (AOR=5.0; 95% CI=1.5-16.7).

Conclusions/Implications: Black and Latino MSM provide similar reactions to prevention messages regarding adherence, and knowledge and believability of ART benefits. However, HIV-positive black MSM have a preference for condom use relative to their Latino counterparts. Implications of findings for HIV prevention programs will be discussed.

Abstract 1404 - Effects of Brief Messaging about Undiagnosed Infections Detected through HIV Testing among African American/Black and Latino MSM

Author(s): *Paige Miller, Gordon Mansergh, Jeffrey Herbst, Nicole Pitts, Damian Denson, Matthew Mimiaga, Jeremy Holman*

Background: Persons unaware of their HIV infection are more likely to transmit the disease and account for the majority of new infections in the United States. African American/black and Latino men who have sex with men (MSM) are over-represented in the percentage of undiagnosed HIV infections. In this analysis, we tested the effects of a brief, plain-language message about results from a recent study that found high rates of undiagnosed infections among black and Latino MSM.

Methods: The analytic sample from the Messages4Men Study included HIV-uninfected black (n=296) and Latino (n=309) MSM. The brief, plain-language message tested was: It is important to get tested for HIV. Some people have HIV and do not know it. A recent study of black gay and bisexual men found that about 1 in 10 of them had HIV and did not know it. After reading the message, we assessed intentions to get an HIV test and to use condoms in the future; we also assessed newness and believability of the message. Participants then completed a computer-based assessment of demographic information and sexual behavior. Analyses included bivariate and multivariable logistic regression models to determine demographic and risk behavior associations with message outcomes and novelty.

Results: Most men were more likely to intend to be tested (89%) and use condoms (87%) after reading the message. Latino MSM were more likely to want a test today (40% Latino vs. 30% black, $p < .05$) and less likely to pay for a test (41% Latino vs. 58% black, $p < .05$). The message had invariably high believability among all demographic groups (98%, overall) and was not new information for two out of three men (67% overall). In multivariate models, including recent risk behavior, race/ethnicity, age, education, and city, young (18-29 year old) MSM were more likely to intend to be tested (Adjusted Odds Ratio [AOR]=2.386, 95% Confidence Interval [CI]=1.215-4.687), more educated (\geq college degree) MSM were less likely to intend to be tested (AOR=0.314, 95% CI=0.148-0.666) or use condoms (AOR=0.373, 95% CI=0.193-0.718), and those who reported recent risk behavior were less likely to intend to use condoms (AOR=0.352, 95% CI=0.207-0.598). Additionally, men in Kansas City (AOR=2.171, 95% CI=1.310-

3.597) and Latino men (AOR=2.248, 95% CI=1.137-3.837) were more likely to report this information in the message as new information.

Conclusions/Implications: A brief message regarding undiagnosed HIV infection was associated with increased intent to be tested and to use condoms with future partners. However, responses differed depending on demographic variables and risk behavior, especially for higher education and high-risk MSM, underscoring the importance of targeted HIV prevention efforts among black and Latino MSM.

Abstract 1423 - Effects of Brief Messaging about “Negotiated Safety” with Primary Partners for Reducing HIV and Other STI Risk among Black and Latino MSM

Author(s): *Veronica Mahathre, gordon mansergh, jeffrey herbst, nicole pitts, damian denson, matthew mimiaga, jeremy holman*

Background: “Negotiated Safety” is a potential, albeit challenging to implement, behavioral HIV risk-reduction approach for HIV-negative MSM in an HIV-seroconcordant primary partnership. Negotiated Safety is based on an agreement between primary partners that they can have condomless sex together under stringent conditions of HIV testing, communication, and ongoing condom use outside the relationship to reduce risk of acquiring HIV and STIs. For HIV-positive MSM, “HIV serosorting” is also an HIV transmission risk-reduction strategy wherein HIV-positive MSM only have sex without a condom with other HIV-positive men. The purpose of this study is to test the effects of a common Negotiated Safety message for HIV-negative and HIV-positive MSM on likelihood of using condoms in the future.

Methods: Messages were tested among HIV-positive (n=330) and HIV-negative (n=605) black and Latino MSM, including HIV-negative MSM who did (i.e., higher risk, n=318) and did not (i.e., lower risk, n=287) have condomless anal sex in the prior three months. Negotiated Safety for HIV-negative men was defined as stated above. For HIV-positive men, the definition was the same minus the HIV-testing component, thus making condomless sex specific to a primary partnership and thus more focused than “HIV serosorting”. After reading the message, intent to use condoms, newness and believability of the message, were assessed and analyzed with bivariate and multivariate logistic regression.

Results: In bivariate analysis, after hearing the Negotiated Safety message, most men in each of the groups still intended to use a condom in an HIV-seroconcordant primary relationship, including HIV-positive, and higher-risk and especially lower-risk HIV-negative men (69%, 60%, 79% respectively, $p<.05$); similarly, a majority of each group intended to use a condom outside of a primary partnership (86%, 86%, 94%, $p<.05$), particularly the lower risk HIV-negative men. This information was new to less than 25% of the sample overall, and a majority of HIV-positive and higher-risk (especially) and lower-risk HIV-negative men believed the information (78%, 95%, 88%, $p<.05$). In multivariate analysis among HIV-negative men, higher- (vs. lower-) risk men were less likely to intend to use a condom in an HIV-seroconcordant primary relationship (Adjusted Odds Ratio [AOR]=0.40, 95% Confidence Interval [CI]=0.28-0.59), as were men with some post-high school training (AOR=0.50, 95% CI=0.31-0.82) and a 4-year college degree or more education (AOR=0.39, 95% CI=0.24-0.63), vs. a high school diploma or less, after hearing the message. Also among HIV-negative men, higher- (vs. lower-) risk men were less likely (AOR=0.39, 95% CI=0.22-0.70) and men age 18-29 (vs. 40+) were more likely (AOR=2.13, 95% CI=1.09-

4.17) to intend to use condoms outside of the primary partnership. HIV-negative men with more education were less likely to say the information was new and more likely to believe it.

Conclusions/Implications: Negotiated Safety is not a message that resonates strongly with black and Latino MSM in this study, although it is largely believable and not novel to these men. Though more research is needed, the nuanced differences by risk and education levels would suggest opportunities for targeted prevention messaging.

Abstract 1510 - Qualitative Research Findings in Developing Brief Health Communication Messages of Emerging HIV Prevention Options that Represent the Opinions of African American/Black and Latino MSM

Author(s): *Matthew Mimiaga, Shanice Battle, Jeffrey Herbst, Damian Denson, Nicole Pltts, Jeremy Holman, Gordon Mansergh*

Background: Black and Latino MSM are disproportionately affected by HIV in the US. Existing approaches to HIV prevention have been, alone, insufficient in reducing HIV incidence in these communities. However, over the past few years, results from large-scale trials of antiretrovirals for treatment (i.e., ART) and prevention (e.g., PrEP) have emerged as new biomedical prevention modalities, but behavioral factors are closely tied with efficacy. Given the recency of these trials, the current study developed a variety of brief, easy-to-understand HIV prevention messages that provide salient information succinctly and have the potential to influence health behavior change from the perspective of black and Latino MSM.

Methods: The current qualitative study was conducted in 2013 to collect formative data to lay the groundwork for the Messages4Men study: an investigation of brief HIV prevention messages for black and Latino MSM. For this phase, 90 MSM of mixed HIV serostatus and sexual risk were recruited by community-based organizations in three US cities—Chicago (n=19 black and 11 Latino MSM), Fort Lauderdale (n=30 Latino MSM), and Kansas City (n=29 black and 1 Latino MSM)—to participate in either a semi-structured individual qualitative interview (n=43 total) or a focus group discussion (n=47 total) exploring messages of PrEP, ART, condom efficacy, HIV serosorting, negotiated safety, and HIV testing with respect to comprehension of information/health literacy, believability, increase in knowledge, and potential to influence attitudes and motivate behavior change. Through an iterative approach, the messages were further refined and finalized. Interviews and focus group data were recorded, transcribed and analyzed using a qualitative descriptive approach.

Results: Participants ranged in age from 19 to 61 years; 57 and 33 participants across the three cities were HIV-negative and HIV-positive, respectively. Across HIV serostatus, level of risk behavior and racial/ethnic group, there were varied responses with respect to comprehension, believability, prior knowledge, and potential to influence attitudes and motivate behavior change. Qualitative analysis addressed four emergent thematic messaging areas: 1) PrEP: low levels of awareness, message content (44% vs. 95% effective) understandable, general fear of behavioral disinhibition related to provision of PrEP; 2) ART for Treatment as Prevention: findings from HPTN 052 regarding a 96% reduced transmission probability were believable; 3) Condom Efficacy: low levels of actual efficacy awareness, some disbelief for 70% condom efficacy; and 4) HIV Serosorting, Negotiated Safety, and HIV Testing:

messages were clear, all viable options after hearing current prevalence statistics of HIV in their community. Men across all literacy levels understood most of the messages though higher literacy men could articulate their thoughts about the messages more clearly.

Conclusions/Implications: These findings provide useful information, similarly expressed across black and Latino MSM, for message refinement and finalization. There was skepticism about condom efficacy level and fear that PrEP messages would lead to risk compensation. Providing clear and simple framing was critical to comprehension of prevention information. This process resulted with a series of brief health communication messages of HIV prevention modalities that are to be tested quantitatively, and subsequently applied in real world settings.

Session B25 - Taking it to the People: Providing PrEP in Diverse Clinical Settings

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1715 - Pre-Exposure Prophylaxis Implementation to Prevent HIV Infection at a Public Sexually Transmitted Diseases Clinic in the Deep South

Author(s): *Laura Beauchamps, Philip Chan, Amy Nunn, Frederick Page, Kenneth Mayer, June Gipson, Leandro Mena*

Issue: Public sexually transmitted diseases (STD) clinics often reach individuals at high risk for HIV infection and, therefore, may be ideal places for implementation of HIV pre-exposure prophylaxis programs.

Setting: Crossroads Clinic is a publicly-funded STD clinic in Jackson, Mississippi (MS) that offers free STD/HIV testing to a community with among the highest rates of HIV and STDs in the country. It serves over 1,500 men who have sex with men (MSM) per year, 90% of whom are African-American. Open Arms Healthcare Center (OAHCC) is a community based primary care clinic that focuses on health needs of the lesbian, gay, bisexual, transgender (LGBT) population and communities of color. Collaboration was established between these two clinics in January 2014 to implement a PrEP program.

Project: A PrEP patient education and referral program was initiated at Crossroads Clinic for all HIV negative MSM, transgender women, and high risk heterosexuals attending the clinic for STD/HIV screening services. Clinicians, nurses, case managers and disease intervention specialists were educated about PrEP and trained on how to present and counsel patients. Staff referred interested patients to OAHCC for further care. At OAHCC, all patients were offered a more comprehensive educational session about PrEP and MSM completed a validated Centers for Disease Control and Prevention (CDC) risk stratification tool followed by a brief survey on PrEP knowledge and beliefs. MSM were then offered a clinical appointment to actually be prescribed PrEP. A health educator provided PrEP education and assisted with coordinating appointments, enrollment in the drug assistance program (DAP), and prior authorizations.

Results: A total of 130 MSM interested in PrEP presented to OAHCC and completed the post-education survey. Of these, 78% were African American, and 86% reported they would use PrEP if it were prescribed that same day. While 76% of MSM were stratified in a group with highest risk of HIV

infection, only 26% perceived themselves at risk, and 18% were not interested in a clinical appointment for PrEP. The main reasons for this included: low perceived risk (50%), not interested (19%), not currently sexually active (13%) and preferring to discuss with partner first (8%). Among those who expressed initial interest in making an appointment, 65% didn't follow up. Main concerns expressed about PrEP of this group were side-effects (53%), paying for it (58%), apprehension about taking daily medication (17%), and interaction with alcohol/drugs/medication (26%). Overall 73 patients completed an initial provider visit and received a prescription for PrEP.

Lessons Learned: A large proportion of high-risk MSM are unaware of their vulnerability for HIV infection, this consequently leads to a failure in follow up with first PrEP clinical visits. Public STD clinics provide opportunities to educate high-risk populations about PrEP and collaborate with local providers for referrals. Based on our experience we recommend developing a patient navigator assistance program in STD clinics to incorporate PrEP education and overcome this common barrier to scaling PrEP programs.

Abstract 1727 - Connecting Resources for Urban Sexual Health (The CRUSH Project): Establishing a Sexual Health Clinic for Young MSM in Oakland, California

Author(s): *Ifeoma Udoh, Mi-Suk Kang-Dafour, Michael D'Arata, Kristin Kennedy, Kim Koester, Janet Myers, Robert Grant, Jeffrey Burack*

Issue: Young men who have sex with men (YMSM), particularly YMSM of color, are the only group in the United States with increasing HIV infection rates. In Oakland during 2010-2012, 73% of all newly diagnosed HIV cases were among MSM. In 2013, the California HIV/AIDS Research Program awarded Alta Bates Summit Medical Center a demonstration project entitled Connecting Resources for Urban Sexual Health (CRUSH). The goal of CRUSH is to expand services at an existing HIV care clinic to provide and integrate sexual health services, including PrEP, for YMSM.

Setting: The CRUSH Project is located in the East Bay AIDS Center, an outpatient HIV primary care clinic in Oakland CA. CRUSH eligibility includes 18-29 year old MSM and transgendered persons, with a particular focus on persons of color.

Project: The CRUSH Project aims to evaluate the effectiveness of a tailored package of HIV care, treatment and prevention by integrating routine sexual health services into an existing HIV clinic - including STI screening and treatment, and PrEP and PEP access, for a local community which does not have access to such care. Patients can come in for scheduled or drop-in clinic visits, be assessed for and access STI treatment, PrEP, PEP, and specialized HIV testing, and receive adherence support and counseling. Community partners can also conduct 'warm hand offs' for youths who may need support in accessing services.

Results: Since February 2014, CRUSH has enrolled a total of 208 participants. 115 of these are currently receiving Truvada® PrEP. Nearly 60% are African American or Latino. The average age of participants is 25 years. At the time of writing, adherence monitoring drug levels were available for 80 individuals. All tests had detectable levels of tenofovir (TFV), and 80.1% demonstrated levels consistent with at least 4

doses per week. More than a third of participants seeking PrEP have been determined by a provider to need nPEP upon intake, because of a recent high risk sexual exposure.

Lessons Learned: Young MSM accessing Truvada® PrEP can adhere at levels consistent with a high degree of protection against HIV infection. Offering and covering costs for STI treatment is a critical service needed for integrating PrEP into an existing HIV primary care setting targeting YMSM. The addition of a retention coordinator/navigator can greatly support adherence and ease of access in a clinic setting for youth patients. Developing appropriate sexual health messaging for providers, clinic staff and community members can help support increased knowledge of PrEP as a prevention tool in urban communities such as Oakland.

Abstract 1728 - Adding Pre-Exposure Prophylaxis (PrEP) to the Care of People Who Inject Drugs

Author(s): *Aaron Fox*

Issue: Persons who inject drugs remain at high risk for HIV infection. Harm reduction activities, including sterile syringe exchange, and expanded access to opioid addiction treatment, have decreased rates of new HIV infections among people who inject drugs; however, with rates of opioid addiction increasing over the past decade and a more recent resurgence of heroin use across the United States, continued vigilance and new HIV prevention interventions are necessary for this population. Nearly all persons who inject drugs report heroin use, therefore opioid addiction treatment settings are also ideal for these HIV prevention interventions, such as pre-exposure prophylaxis (PrEP). Buprenorphine maintenance treatment (BMT) is safe and effective for opioid addiction and has been integrated into primary care and HIV treatment settings. This presentation will discuss strategies for reducing HIV risk in persons who inject drugs by implementing BMT into primary care and HIV treatment settings and routinely offering PrEP as a component of treatment.

Setting: We implemented office-based buprenorphine treatment in a Federally Qualified Health Center (FQHC) in the Bronx, NY in 2004. This FQHC is affiliated with a university hospital and serves a low income community with among the highest rates of opioid addiction and HIV-infection in New York City. We have also collaborated with two large New York City harm reduction agencies that provide sterile syringe exchange and diverse social services to people who inject drugs. Staff at these harm reduction agencies have received training regarding BMT and referral of clients with opioid addiction to the FQHC for treatment.

Project: Since 2014, we have offered PrEP to patients receiving BMT at the FQHC. This presentation will describe our collaboration with harm reduction agencies; strategies for implementing office-based buprenorphine treatment within primary care; aspects of patient-centered care delivery models for persons who inject drugs; potential barriers to PrEP use among BMT patients; and strategies to support PrEP use for BMT patients.

Results: N/A

Lessons Learned: 1. The people who inject drugs who are at highest risk for HIV are those who are not engaged in opioid addiction treatment. Working with harm reduction agencies or community-based organizations that serve people who inject drugs is necessary for outreach to high risk populations. 2. Despite compelling data demonstrating the safety and efficacy of BMT, many medical providers remain reluctant to prescribe BMT or lack the institutional support to offer BMT. Within FQHCs, having a physician champion, a buprenorphine coordinator, and a system for communicating with insurance companies can support BMT program. 3. Many people who inject drugs do not seek medical care because of stigma or fear of discrimination. 4. In order to optimize PrEP use in people who inject drugs, we first must adapt the medical care delivery system so that is acceptable to people who inject drugs.

Abstract 1955 - PrEParing Practices for PrEP: Real World Lessons from a Community Health Center
Author(s): *Helena Kwakwa, Donielle Sturgis, Natasha Mvula, Sophia Bessias*

Issue: HIV pre-exposure prophylaxis has been shown to be an effective prevention method for men who have sex with men, heterosexual adults, and people who inject drugs. Yet even as its use increases in the United States, questions remain about how best to deliver it in the real world to populations standing to benefit the most from it. We present valuable lessons learned from a PrEP delivery program and implementation study in North Philadelphia.

Setting: The Strawberry Mansion Health Center (SMHC) is a publicly funded community health center operated by the Philadelphia Department of Public Health. A FQHC look-alike facility, the SMHC houses an HIV clinic and a robust HIV rapid testing program as one of a full array of primary care services. It is staffed by 8 primary care and 2 HIV specialist physicians, and is located in a service area with a population that is largely African American and mostly poor.

Project: The Sustainable Health Center Implementation PrEP Pilot (SHIPP) Study is a multi-site 3-year project designed to evaluate the process of implementing PrEP delivery in community health centers. The SMHC is one of four participating sites nationwide. The PrEP delivery model at this site is primary care provider-driven, with HIV specialty staff mostly in a training and support role. Candidates for PrEP are drawn largely from the existing health center patient population, and identified primarily through a risk assessment process during routine HIV rapid testing.

Results: In the first 8 months of the study, of the 384 individuals who were referred, 87 were screened for, and 39 initiated PrEP. Of the 384 referrals, 82.9% were referred from on-site HIV rapid testers, and 3.9% from external sources. Of the referred, 44.7% were female, and a third (32.4%) of those started on PrEP were female. Four individuals discontinued medication, three because of changing risk circumstances, and one due to reduction in renal function. One participant seroconverted 4 weeks after cessation of PrEP. All but 2 clinicians participated in PrEP delivery.

Lessons Learned: Securing the support of institutional leadership was essential to the success of the program. Training was necessary but insufficient for individual clinicians to incorporate PrEP delivery into practice, and assistance with each clinician's first PrEP patient was useful. Having general clinicians incorporating PrEP into the care of their patients, with HIV specialty physicians in a support role, was

effective and is a viable model with potential for success in different settings. Routine HIV risk assessment of patients offered a standardized mechanism for identifying potential PrEP candidates. This was achieved by incorporating it into the HIV rapid testing process, but could be systematized in other ways. Patient follow up rates were higher the sooner they were scheduled for PrEP medical visits following risk screening. Institutional permission to utilize walk-in and other appointment slots for this purpose was helpful in expediting visits.

Session B31 - Sexual Risk and Seroadaptive Behaviors Among MSM

Room: A706 (Atlanta Marriott Marquis)

Abstract 5054 - Purposely Adopted Seroadaptive Behaviors and their Association with HIV and Sexually Transmitted Infections (STI) among Men Who Have Sex with Men (MSM)

Author(s): *Christine Khosropour, Julia Dombrowski, David Katz, Roxanne Kerani, Lindley Barbee, Matthew Golden*

Background: Seroadaptive behaviors are common among MSM. Most studies have defined seroadaptive behaviors based on men's sexual behavior history, regardless of whether those behaviors reflect purposely adopted risk-mitigation strategies. The association between purposely-adopted seroadaptive behaviors and HIV/STI risk is unknown.

Methods: This study enrolled HIV-negative MSM aged >18 years attending an STD clinic in Seattle, Washington, 2013-2015. A computer-based survey queried MSM about the seroadaptive behaviors they purposely employed in the past 12 months. HIV/STI testing was performed per routine care. We examined 5 behaviors: pure serosorting (chose to have sex with HIV-negative partners and avoid sex with HIV-positive/unknown-status partners); condom serosorting (chose to use condoms with HIV-positive/unknown-status partners but not HIV-negative partners); seropositioning (chose to only have insertive anal sex with HIV-positive/unknown-status but not HIV-negative partners); condom seropositioning (chose to use condoms for receptive anal sex with HIV-positive/unknown-status but not HIV-negative partners); and consistent condom use with all partners regardless of serostatus. We compared proportions with Fisher's exact tests.

Results: We enrolled self-reported HIV-negative MSM at 3,018 (55%) of 5,535 eligible clinic visits; 1.5% (38 of 2,463 tested) tested newly HIV positive. Men reported the following behaviors: pure serosorting (60%), condom serosorting (11%), seropositioning (2%), condom seropositioning (6%), consistent condom use (17%), no seroadaptive behavior (32%). The risk of HIV was lower for pure serosorters than other men (0.9% vs. 2.4%; $P=0.006$), as was rectal gonorrhea/chlamydia (GC/CT) (21% vs. 25%; $P=0.03$) and urethral GC/CT (15% vs. 19%; $P=0.08$) but not syphilis (2.4% vs 2.9% $P=0.46$). Among the 54% of men with HIV positive/unknown-status partners, men reporting no seroadaptive behavior were at higher risk for HIV (2.8%) than those reporting consistent condom use (0.5%; $P=.02$), seropositioning (0.0%; $P=0.63$), condom serosorting (1.2%; $P=0.22$), and condom seropositioning (0.8%; $P=0.34$). Rectal GC/CT test positivity was 22.6% overall and was lowest among condom seropositioners (15%) and consistent condom users (10%); urethral GC/CT test positivity was 16.4% overall and was highest among seropositioners (28%).

Conclusions/Implications: When purposely adopted, pure serosorting was protective from HIV and some STIs. The protective effect of other seroadaptive behaviors was variable.

Abstract 5064 - Parent Communication about Sex Predicts Sexual Risk Behavior among Young Black Men who have Sex with Men

Author(s): *David Huebner, Brian Thoma, Lance Pollack, Greg Rebchook, John Peterson, Susan Kegeles*

Background: Young, Black men who have sex with men (YBMSM) are at high risk for HIV infection. Parents of adolescents and young adults are powerful sources of socialization regarding sexuality, and their impact on sexual behaviors among heterosexual youth is well documented. However, we know virtually nothing about how parents communicate about sex with YBMSM and how this affects their HIV-related risks.

Methods: In a multi-year evaluation of a community-level HIV prevention intervention, we collected cross-sectional data annually from YBMSM (ages 18-29) in Houston and Dallas via venue-based sampling. In 2014, 641 YBMSM reported how much their parents/caregivers engaged in various types of sexual communication (SC): punitive SC (e.g., forbidding sex), distressed SC (being upset during conversations), open SC (being open about sexual topics), and condom-related SC. Men also reported on HIV-related psychosocial variables (e.g., self-efficacy) and sexual risk behaviors.

Results: YBMSM reported varied styles of parental SC. One common approach appeared to be to say little or nothing: 52.5% indicated their parents never or rarely spoke openly about sex in general, and 25.6% said their parents never spoke to them about condoms. Punitive SC was experienced by a significant minority of YBMSM: 29.6% indicated their parents told them either very or fairly often that having sex was a sin, 26.0% were told either very or fairly often that they were not allowed to have sex, and 30.0% indicated their parents regularly suggested that gay sex would lead to HIV. However, similar proportions of YBMSM indicated positive things about their parents' SC: 28.8% said their parents spoke openly about sex fairly or very often, and 39.5% said their parents spoke about condoms either very much or a great deal. In multivariate models adjusting for age and socioeconomic status, SC was associated with a number of HIV-related risk variables. Both punitive and distressed parental SC were associated with lower condom-use self-efficacy, more negative attitudes about condoms, having sex more frequently in difficult sexual situations (e.g., while drunk or high), and feeling more HIV-related stigma. In contrast, greater condom-related SC from parents was associated with higher self-efficacy and engaging less frequently in difficult situations. Finally, men who reported more condom-related SC and less distressed SC were less likely to have engaged in condomless anal intercourse with a casual, non-monogamous, or sero-discordant partner in the past 2 months (all p 's < .05).

Conclusions/Implications: Many parents/caregivers of YBMSM talk about sex with their sons, and what gets said (or left unsaid) predicts men's HIV-related attitudes, skills, and sexual risk behaviors. This suggests parents might be important targets for family interventions to improve SC and reduce these young men's sexual risks. Moreover, epidemiologic data indicates many YBMSM are infected with HIV during their teenage years, well before they are likely to come into contact with most forms of community-based HIV prevention (that often utilize adult venues for advertising or outreach). Given

parents' regular contact with this otherwise hard-to-access population, they have particularly strong potential to be partners in HIV prevention focusing on adolescent YBMSM.

Abstract 5130 - Seroadaptive Behaviors and HIV Prevention Strategies Used by Sexually Active San Francisco MSM in HIV Care

Author(s): *Alison Hughes, Susan Scheer*

Background: New HIV prevention tools have recently emerged, including treatment as prevention (TasP) and pre-exposure prophylaxis (PrEP). However, observational data describing the use of these tools and other seroadaptive behaviors and prevention strategies among men-who-have-sex-with-men (MSM) is limited.

Methods: The Medical Monitoring Project is an annual survey that assesses health care utilization, clinical outcomes and HIV-related risk behaviors among HIV-infected persons receiving care in San Francisco (SF). Interviews were conducted from August 2014-April 2015. Men who reported anal sex with ≥ 1 male partner in the 12 months prior to interview were included in this analysis; each participant could report up to 5 most recent sexual partners. Only male-male anal sex partnerships are included in this analysis. Prevention strategies were characterized using self-reported information from the participant on their perceived viral load, condom use during anal sex in the past 12 months, the HIV status of their sexual partners, and PrEP use among their HIV-negative partners. We used this information to categorize the following non-mutually exclusive seroadaptive and prevention strategies: serosorting (sex with an HIV-positive partner), TasP (participant reported being virally suppressed), HIV-negative partner using PrEP (PrEP), and condom use. If a participant reported a serosorting partnership, we categorized the prevention strategy as serosorting only, even when the participant was virally suppressed (i.e. not both TasP and serosorting).

Results: There were 121 sexually active MSM in our sample. The median age of participants was 50 years (range: 24-70). Most were white (62%) or Latino (25%), diagnosed with HIV ten or more years prior to interview (72%), had an education greater than high school (92%), reported current antiretroviral treatment (ART) (98%) and reported viral suppression (83%). These 121 MSM had 380 male-male sexual partnerships involving anal sex. Of the 380 partnerships, 2% used no prevention method, 68% used one prevention method, 29% used two methods and <1% used three methods. Serosorting was the most common prevention strategy, used in 52% of partnerships, followed by TasP (42%), condoms (26%) and PrEP (8%). Of the 380 partnerships, 185 used serosorting only; 72 used condoms and TasP; 60 used TasP only; 24 used TasP and PrEP; 12 used serosorting and condoms; 12 used condoms only; 2 used condoms, TasP and PrEP; 2 used PrEP and condoms; 2 used PrEP only; and 9 used none. Additionally, 66% of participants either agreed or strongly agreed to the statement "If my partner tells me he or she is HIV positive, I am more likely to have unprotected sex with him or her," and 60% either agreed or strongly agreed to the statement "If I have an undetectable HIV viral load, I am more likely to have unprotected sex."

Conclusions/Implications: We found high use of seroadaptive behaviors and HIV prevention strategies among sexually active HIV-infected MSM in SF. In only nine partnerships was there no evidence of any

prevention strategy. During a period of rapid PrEP uptake in SF, PrEP was used as a prevention strategy, but most often in conjunction with other strategies.

Track C

Session C02 - eHealth Interventions for HIV Prevention and Care: Lessons from Innovative Programs on Maximizing Recruitment, Engagement, and Impact with Diverse Men who have Sex with Men

Room: A705 (Atlanta Marriott Marquis)

Abstract 1820 - Program Acceptability of a Text-Messaged Based HIV Prevention Program for Gay, Bisexual, and Queer Adolescent Males

Author(s): Michele Ybarra, Tonya Prescott, Gregory Philipps II, Jeffrey Parsons, Sheana Bull, Brian Mustanski

Background: Adolescent gay, bisexual, queer, (AGBM) bear a disproportionate HIV incidence burden, accounting for 72% of new HIV infections among young people. AGBM are also one of the few risks groups to show a significant increase in new infections – up 22% from 2008 to 2010. Yet, few validated prevention programs are available for AGBM, and none are available for adolescents under the age of 16 years. Programs that are developmentally appropriate and salient for this vulnerable population and the unique experiences they face are urgently needed.

To that end, we developed and tested Guy2Guy, a HIV prevention program for AGBM between 14-18 years of age. Content was crafted based upon the Information-Motivation-Behavioral Skills (IMB) Model of HIV prevention.

Methods: Guy2Guy was evaluated in a RCT. Participants were recruited online from advertisements placed on Facebook. Eligible candidates were contacted by staff to confirm participant eligibility, review consent/assent form, and enroll in the study. Participants were randomly assigned to either the intervention or control group, while balancing on youth's sexual experience and sexual identity. Intervention messages were dyadic and included interactive program components: Text Buddy (another participant one was matched with to discuss the program content) and G2Genie (automated, on-demand question and answers about sexual health-related topics). The attention-matched control group received healthy lifestyle messaging that discussed basic HIV prevention information, coping with bullying, and self-esteem. All participants received messages for five weeks and then followed by a one-week booster delivered six weeks after the core program. Quantitative and qualitative program acceptability data were collected online at three-month post-intervention follow-up.

Results: Of the 340 individuals screened via phone, 321 (94.4%) were eligible and assented / consented to participate in the RCT. Of the 321 participants who were sent the baseline survey, 302 (88.8%) completed the survey and were randomized. Two hundred and seventy-five (91.1%) participants (143 control and 132 intervention participants) provided acceptability data in the three-month follow-up survey. Across both study groups, participants overwhelmingly rated the program positively: 93.2% of intervention participants and 95.8% of control participants said they "liked the G2G program"; 92.4% of intervention participants and 95.1% of control participants felt they "learned things in G2G that will help

them make decisions that will keep them safer from HIV and other STDs". Interestingly, the only statistically significant difference between the two groups was noted for condoms: 22% of intervention participants compared to 7% control participants felt that "G2G talked too much about condoms" ($p < 0.001$). Intervention program components were also well-received: 70% of intervention participants agreed or strongly agreed that they liked G2Genie and 60% agreed or strongly agreed they liked having a Text Buddy.

Conclusions/Implications: Program acceptability data suggests that an HIV prevention program delivered via text messaging, a mode widely endorsed by youth, is engaging and can give youth the confidence to engage in HIV preventive behaviors. The attention-matched control group, which appears to have been successfully blinded, also appears to be well received. Future programs may consider combining healthy sexuality with other important youth health topics, including self-esteem and bullying.

Abstract 1916 - Reducing HIV Transmission Risk among Men who have Sex with Men through Innovative Technology-based ART Adherence Interventions

Author(s): *Keith Horvath, Thu Danh, Bobbi Gass, Gunna Kilian*

Background: Currently, our most effective HIV prevention tools include targeting high-risk groups with biomedical approaches such as the provision of antiretroviral therapy (ART) for sexually active HIV-positive persons. The benefit of this approach - called "Treatment as Prevention" (TasP) - is directly correlated with high and sustained oral medication adherence. However, only one quarter of people with HIV in the US are on ART and virologically suppressed, suggesting that novel HIV medication adherence approaches are needed. In this presentation, 2 technology-enabled ART adherence intervention approaches for HIV-positive men who have sex with men (MSM), at different stages of development and testing, are described. Particular focus is given to intervention development, recruitment, and feasibility and acceptability.

Methods: The first intervention is an online and mobile peer-to-peer social support intervention, called "Thrive with Me" (TWM), that leverages social networking, ART self-monitoring and targeted HIV information to improve ART adherence. The second intervention is an ART adherence smartphone app intervention, called "APP+," for stimulant-using HIV+ MSM (SU-HIV+ MSM) that incorporates ART self-monitoring, medication adherence information, and engaging storylines to improve medication adherence.

Results: TWM was piloted with among US HIV-positive gay or bisexually-identified MSM who self-reported imperfect ART adherence in the past 30 days and were randomized to a no treatment control ($n=57$) or the eight-week TWM intervention ($n=67$). TWM participants were recruited mostly through a variety of online venues: 42% of participants from a prior online survey were contacted via e-mail and rescreened for inclusion in the current study; 21% were recruited using online banner ads on HIV-related websites; 11% were recruited using online banner ads placed on websites that target the gay/bisexual MSM community; and 1% via Facebook. Nearly one-quarter (24%) of the sample came through other sources, such as word-of-mouth or hearing about the study at their clinic. Follow-up assessment completion rate was 90%. Participants rated (1 to 7 scale) the intervention high in

information and system quality, and were satisfied with the intervention (Means>5.0). The APP+ intervention was informed by a series of focus groups with SU-HIV+ MSM in San Francisco, CA and Minneapolis, MN to explore preferred features and functions of a mobile app to improve ART adherence and overall wellbeing. Next, a 2-day consultation meeting was held that included community representatives and experts in interventions addressing ART adherence with drug-using populations to determine intervention content. Afterward, an Agile development process was implemented to build the APP+ intervention, which will be piloted to assess the feasibility and acceptability of this approach among US-based SU-HIV+ MSM.

Conclusions/Implications: These studies demonstrate potential ways technology may be leveraged to reach and improve ART adherence outcomes among HIV-positive MSM. As biomedical approaches increasingly rely on optimizing adherence outcomes to reduce possible transmission risk, these approaches may be adapted and modified across a variety of prevention approaches (e.g., both TasP and PrEP interventions) and for a variety of populations. The successes and continuing challenges of using eHealth technologies to improve treatment outcomes and reduce transmission risk among persons with HIV will be discussed.

Abstract 2135 - Keep It Up! (KIU!): Lessons on Maximizing Recruitment, Engagement, and Impact with Diverse Men Who Have Sex with Men

Author(s): *Brian Mustanski, Krystal Madkins, George Greene, Jeffrey Parsons, Patrick Sullivan*

Issue: Young men who have sex with men (YMSM) account for almost 70% of HIV diagnoses among all young people in the US. However, there are few effective behavioral interventions tailored to YMSM.

Setting: Keep It Up! (KIU!) is an online, multimedia HIV prevention program designed for YMSM. Formative mixed methods research with racially diverse YMSM (18-24 years old), with input from key informants in community-based organizations (CBOs), guided KIU! content and delivery. The intervention is based on the information-motivation-behavioral skills model of HIV risk behavior change and delivers developmentally- and culturally-appropriate content highlighting sexual risk situations relevant to YMSM.

Project: There have been three iterations of KIU! The first, KIU!1.0, was a pilot randomized controlled trial (RCT) that compared the intervention to a didactic HIV knowledge condition. The second, KIU!1.5, was a community implementation evaluation (pretest/posttest) of the intervention at a CBO site. Lastly, KIU!2.0 is currently being conducted as a multisite RCT in Atlanta, Chicago, and New York City. Similar to previous implementations of KIU!, YMSM who test HIV negative are recruited at local CBO sites in each city. For KIU!2.0, YMSM are also recruited through social networking websites and smartphone applications. In KIU!2.0, prevalence of sexually transmitted infections (STIs) is a new outcome. Participants complete distance self-testing for urethral and rectal chlamydia and gonorrhea at baseline and the final follow-up (12-months). Participants with positive STI results at baseline also test at 3- and 6-months.

Results: Both KIU!1.0 and KIU!1.5 produced significant effects on condomless anal sex (CAS). Specifically, KIU!1.0 participants in the intervention arm reported a 44% reduction in CAS when

compared to the control arm at follow-up ($p < 0.05$). KIU!1.5 participants had a decrease in CAS with casual partners at 3-month follow-up ($p < 0.05$). In KIU!2.0, 707 participants have been enrolled to date (94% toward initial goal of 750). The sample is diverse: 21% Latino, 17% Black, and 17% other. To further increase sample diversity, the enrollment goal was increased to 900 with enrollment restricted to Black and Latino participants. The larger sample also allows for greater power to assess demographic and risk behavior differences between participants recruited online and those recruited from CBOs. Currently, there are no differences in CAS between the recruitment venue (online vs. offline); however, more White YMSM were recruited online than from CBO sites ($p < 0.001$). Similar to STI rates among YMSM in other research, rectal STI prevalence was more than triple that of urethral STIs (13% vs. 4%) in KIU!2.0 participants at baseline.

Lessons Learned: Results from KIU!1.0 and KIU!1.5 suggest that eHealth interventions can engage racial minorities who are traditionally underrepresented in research and promote health behavior change in YMSM. Preliminary KIU!2.0 data highlight the need for clinical rectal STI screening among YMSM. Taken together, KIU! is an effective intervention that can be translated for community-based implementation, as well as for online delivery to include distance HIV and STI testing.

Abstract 2255 - HealthMindr: Development and Evaluation of a Comprehensive HIV Prevention Mobile App for US MSM

Author(s): *Patrick Sullivan, Tamar Goldenberg, Joanne Stekler, Sarah McDougal, Rob Stephenson*

Background: Epidemic models estimate that reducing HIV incidence among US MSM will require high levels of coverage of multiple prevention services (e.g., HIV testing, condom use, pre-exposure prophylaxis [PrEP], non-occupational prophylaxis [nPEP]). Given low levels of PrEP use, nPEP use and awareness of HIV positivity among US MSM, there is a need to bring efficacious prevention services to scale among MSM. This may be especially challenging for rural MSM, who report levels of HIV testing, STI testing, and receipt of prevention interventions at lower rates than do urban MSM. Mobile smartphone applications (“apps”) hold promise to provide assessment and referral to services at scale, with minimal cost of delivery.

Methods: We undertook an iterative process of key informant interviews, qualitative data collection focus group discussions and app development. Our goal was to determine which HIV prevention services MSM were interested in receiving through a mobile app, and to understand the characteristics of a mobile app that would make it valuable to non-client stakeholders, such as health department staff and counselors in community-based organizations (CBOs). We theater tested a beta version of the app with groups of MSM in Seattle and Atlanta.

Results: MSM expressed interest in having an app that was adaptable to their personal circumstances, and that would allow them to select the types of information and referrals that they received. Further, men expressed willingness to provide detailed information about their risk behaviors through in-app behavioral surveys if that information would lead to tailored recommendations for relevant prevention services. Health department and CBO staff felt that an app could compliment their current HIV prevention efforts, and were willing to use an app to distribute commodities (e.g., condoms, at-home self HIV test kits) purchased by their organizations through the app. Major components of the final app

included creating an HIV testing plan, reminders for HIV testing, PrEP eligibility screening and referral, nPEP eligibility screening and referral, condom and at-home self HIV test kit ordering, and referral to HIV care locations. Features considered but not included based on focus groups included a sex diary and an HIV prevention “feed” (timeline of major events, such as testing or risk). Men in theater testing reported high interest in using some or all of the app components.

Conclusions/Implications: MSM and diverse prevention stakeholders had substantial agreement on the value of an app to promote multiple HIV prevention services. Through the use of key informant interviews, qualitative data collections with MSM and iterative app development, we produced an app that was acceptable to MSM in two cities. Next steps include field testing to determine acceptability and use of the app from May-October 2015 in Seattle and Atlanta.

Session C21 - Working with Incarcerated/Recently Released PLWH and affected Women Partners

Room: A707 (Atlanta Marriott Marquis)

Abstract 1249 - Continuity of HIV Medical Care: Treatment as Prevention (Linkage to Care from Corrections to Community)

Author(s): *Cody Poerio*

Issue: According to the Center for Disease Control and Prevention, “an estimated 1 in 7 persons living with HIV will pass through a correctional facility in their life time”. Inmates in jails and prisons across the United States are disproportionately affected by multiple health problems including HIV.

Setting: In Philadelphia, there is a strong correlation between incarceration, low income individuals and HIV transmission. It was in recognition of this that in 1991 ActionAIDS expanded their care services into the Philadelphia Prison System and founded The Philadelphia Linkage Program. The primary goal of the Philadelphia Linkage Program has been to ensure the linkage of HIV positive inmates to medical and social services as they transition back into the community. These services are initiated, while the individual is incarcerated, building the development of a supportive relationship to increase engagement post release. Under AIDS United’s Social Innovation Fund, the Philadelphia Linkage Program has expanded its prison programming with the development and Implementation of a Care Coach Collaborative Model.

Project: The Care Coach Collaborative Model targets those HIV positive members of the incarcerated population identified as being most at risk for becoming lost to care and disengaging from vital care services. Interrelated factors that increase this likelihood have been associated with, untreated mental health diagnosis, drug and alcohol dependency, and sub-standard housing and homelessness. Our intervention integrates collaborative provider organizations designated in each of these specialized areas, to ensure individuals have increased access to assessment and treatment where applicable. The two primary goals of this long term case management model, are to provide increased contact and support to clients to assist in their engagement and retention in medical care, and to improve viral load suppression among participants.

Results: From March 1, 2013 through February 28, 2015, a total of 73 individuals enrolled in our program. Of those enrolled, 93% (68) were successfully linked to medical care, and 84% (57) have been retained in care with a minimum of two medical appointments within a twelve month period of time. Our data analysis indicates that each participant is seen on a minimum average twice a month for 48 unique encounters per year. Since the inception of this intervention, we have realized viral load suppression for 70% of participants, a 42.3% increase from baseline data.

Lessons Learned: There are positive benefits to initiating care services for HIV positive incarcerated individuals during their incarceration period and throughout their reentry into independent living. In addition, an extended period of supportive care service delivery, and intensive contacts has the plausible outcome of increased medical linkage and retention as well as improved health outcomes such as viral load suppression.

Abstract 1582 - Gender Responsive and High Impact Prevention Programs for Women Partners of Incarcerated or Recently Released Men: Cross-site Evaluation Results, 2012-2014

Author(s): *Katie Kramer, Sharon McDonnell, Megan Comfort, Barry Zack*

Issue: While increasing emphasis is placed on HIV prevention programs for incarcerated men, women in relationships with these men are often overlooked. Research indicates that these women, who are primarily low-income women of color, are at increased risk of HIV and STI infection since the couple's separation increases her likelihood of concurrent partners and financial and psychological stresses increase her risk for sexual and drug using behaviors. Post-incarceration, couples may engage in unprotected sex to demonstrate loyalty, reestablish intimacy, or conceive children.

Setting: The U.S. Department of Health and Human Services, Office on Women's Health funded 8 agencies across the country to provide HIV/AIDS Prevention and Support Service Programs for Women Partners of Incarcerated/Recently Released Men. These sites are a combination of urban and rural areas with large communities of women of color, particularly African American women.

Project: The Women Partners program sites integrated a core of common characteristics into their programs, including: 1) recruiting women with currently incarcerated or recently released male partners; 2) utilizing similar core HIV/STI prevention education; 3) providing condoms (male and female); 4) onsite HIV testing or testing referral; 5) optional gender-responsive program content such as domestic violence, nutrition, parenting, or other women's health issues.

A collaborative cross-site evaluation study was conducted to improve our understanding of HIV and other health risks unique to women partners of incarcerated men and examine the effectiveness of implementing a gender-specific intervention.

Results: From February 2013 through December 2013, 388 women across all eight program sites completed questionnaires at pre-intervention, post-intervention and 30 days follow-up. Qualitative data was also collected from 39 women who participated in focus groups at all sites. Results demonstrated that participants showed a significant increase in knowledge regarding transmission, testing and prevention ($p < 0.0001$) and in gender-specific knowledge regarding condom use ($p < 0.0001$)

between baseline and post program. There was also a significant increase in participants who reported having ever used a female condom between baseline and follow-up surveys ($p < 0.0001$). As well, participants demonstrated a significant increase in sense of social support networks ($p < 0.0001$). Finally, 81% of participants identifying that they had never been tested for HIV were tested for the first time during or after the program. While partner testing was not a required program component, women reported that 29% of their partners tested during the program and 28% of partners tested after the program.

Lessons Learned: There is a major gap in information addressing the unique context of HIV and other health risks for women with incarcerated partners and in understanding the usefulness and effectiveness of interventions that address this population. This evaluation demonstrated that developing programs to meet the specific health risks and needs of women partners is feasible. A gender responsive high impact prevention intervention is significantly effective in helping to increase testing, knowledge of personal risk, condom use (especially female condoms) and positive social support networks. These results help provide a context for policy considerations and add greatly needed information to fill the void in knowledge about this community of vulnerable and underserved women.

Abstract 1837 - CHARLI: An Effective Intervention for Increasing Linkage and Retention in Medical Care for Recently-Released Incarcerated Persons Living with HIV

Author(s): *Susan Carr*

Issue: Each year, an estimated one in seven persons living with HIV/AIDS (PLWHA) pass through a correctional facility in the US. Most of them acquired HIV in the community, not while incarcerated. Compared with those who have not been incarcerated, incarcerated populations have more risk factors that are associated with HIV, including injection drug and other drug use, commercial sex work, untreated mental illness, and lower socioeconomic status. HIV-positive individuals recently released from incarceration without case management assistance often revert to pre-incarceration behaviors; they stop taking their medication, fall out of care, and return to incarceration.

Setting: The Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) program was developed as the Virginia Department of Health's response to high numbers of recently-released inmates lost to care after discharge from correctional facilities. This presentation will focus on Virginia's efforts to provide its offender population living with HIV services both in and out of jails and prisons, and promote retention in care and medication adherence within a holistic comprehensive prevention program.

Project: CHARLI services are available to the Virginia Department of Corrections' state correctional facilities, and regional, city, and local correctional facilities. The CHARLI program provides a continuum of services for inmates that includes HIV/STI education and HIV testing 60 to 90 days pre-release; discharge planning; and post-release case management/patient navigation for 18 months. The pre and post-release services are far reaching: our contractors provide linkage to medical providers, medication access, transportation assistance, assistance in applications for social services, linkage to employment services, assistance in locating and securing housing, and interventions and strategies for PLWHA.

Currently, there are four community-based organizations and one health system funded to provide CHARLI services.

Results: This presentation will present data from Virginia's Care Markers Database (a repository that collects data from eHARS, Virginia Client Reporting System, and AIDS Drug Assistance Program databases) and contractor's quarterly reports that support evidence that when HIV-positive members of the offender population are provided CHARLI services to assist them in assimilating back into the community setting, they are less likely to return to incarceration and are more likely to maintain adherence to their medical treatment. Outcomes for 128 offenders living with HIV who participated in CHARLI included a significant reduction in recidivism, an 80.5% medical adherence rate, and 69.5% viral load suppression.

Lessons Learned: The CHARLI intervention addresses the needs of both the offender and the PLWHA through addressing social determinants of health (employment, housing, access to medical care) and coordination of their care needs in a holistic approach tailored to each individual offender through intensive case management. The success of this program benefits both the public health and criminal justice systems.

Abstract 2538 - Medical Students Support HIV Prevention Program in Local Jails

Author(s): *Elyse Schultz, Dana Rice, Sarah Atkinson, Caleb Vanderveen*

Issue: Incarcerated populations are particularly vulnerable to HIV. Though the incarcerated population demands significant attention, medical students have little experience working with such a specialized group. Further, few are familiar with career opportunities that would allow them to serve high-risk populations. To dually address both the unique health needs of incarcerated groups and the need for practitioners who are interested and skilled in working with high-risk populations it is important for medical schools to create partnerships and opportunities that provide students early exposure to public health settings.

Setting: Faculty in the Department of Family Medicine and Public Health Sciences (DFMPHS) at Wayne State University School of Medicine (WSUSOM) provide HIV prevention services in the Wayne County Jails (WCJ), offering a unique opportunity for medical student learning in a public health setting. Through the Co-Curricular Service Learning Program at WSUSOM, first- and second-year medical students in the STI/HIV Initiative student organization are offered credit for completing a two-year volunteer commitment by providing education and awareness for STI/HIV prevention in metro-Detroit.

Project: The Michigan Department of Community Health (MDCH) certified students in HIV prevention, training typically restricted to employees of local health departments and AIDS service organizations. Among those certified, select students volunteered with the DFMPHS's jail prevention program. In coordination with Wayne County Sheriff's Department and full-time WSUSOM jail staff, students completed orientation to the jail setting, jail medical service delivery and public health policies and procedures. Each student committed to work a minimum of 2-4 hours per month in partnership with the WSUSOM jail staff. Students shadowed staff at least three times before they could counsel and test

independently. Medical students screened, counseled, and tested inmates based on standard program criteria.

Results: Since 2012, 21 of the 76 certified medical students volunteered in the WSUSOM jail HIV prevention program. Between 2013 and April 2015, students provided 178 prevention counseling sessions and tested 119 of those individuals. Select students provided qualitative assessments and reviews of their experiences.

Lessons Learned: To ensure that student volunteers are comfortable in the setting, proficient in their skills and reliable implementation of programmatic structures are recommended. Protocols such as: 1) limiting the number of certified students volunteering in the jail; 2) providing an orientation to students in the public health setting; 3) providing additional on-site training with the HIV prevention staff, and; 4) providing a consistent volunteer schedule, builds sustainability and confidence among partners. Qualitative data assessing all students change in knowledge, attitudes, and skills in HIV prevention and in public health settings should be collected throughout the volunteer period to assess the experience and impact on jail service delivery. One limitation to replication of this program at other medical schools is that most academic institutions lack HIV prevention partnerships with local correctional facilities. Thus, schools may have some difficulty creating partnerships like the one that exists at the WSUSOM. However, academic-correctional partnerships provide opportunities for enhancing medical student exposure to public health settings early in their training and create a beneficial support to HIV prevention at the community level.

Session C30 - Condom Distribution

Room: A708 (Atlanta Marriott Marquis)

Abstract 1947 - Taking Condom Distribution to the Next Level: An Innovative Expansion to the Traditional Condom Distribution Program

Author(s): *Tanya Myers, Margo Rosner, Ravikiran Muvva, Carolyn Nganga-Good, Hilda Ndirangu, Sophie Sembajwe, Nathan Fields*

Issue: HIV is an ongoing concern in Baltimore City. In 2012, there were 1,466 (469 in Baltimore city) adult/adolescent HIV positive persons (age 13+) diagnosed in Maryland. About 35.7% of the new cases occurred amongst the men who have sex with men (MSM) community.

Setting: The Baltimore City Health Department (BCHD): STD/HIV Prevention Program is located in Baltimore City. Our program's mission is to improve the sexual health and well-being of all Baltimore City residents.

Project: The BCHD STD/HIV Prevention Program decided to expand the existing condom distribution program by adding a condom home delivery component. The first phase would specifically target LGBT youth for home delivery of condoms and later expand to other high-risk populations. Our STD Program researched successful condom distribution programs in 5 US cities in order to determine which condom distribution strategies to adopt. We also conducted surveys and focus groups to determine the need, condoms of choice and challenges with a home delivery system. From our research of various programs,

we developed two phases for our program. The first phase was a home delivery system that targeted the young black LGBT population while the second phase will be to distribute condoms in areas of high morbidity and transmission. The plan for the second phase is to distribute through barber shops, beauty salons, laundry mats, etc. to make condoms more accessible to the general public in high morbidity and transmission areas. The launch of the first phase, "B'More Protected Condom Distribution Program" was at the 2014 BCHD sponsored "Know your Status Ball"; an annual event that is popular with the target population. The Ball patrons had the opportunity to sign up for condom home delivery services during the Ball.

Results: The first shipment of condoms was mailed on March 3, 2015 to 43 individuals who signed up at the Ball. Each shipment contained 5 Trojan Magnums, 5 assorted condoms (including flavored condoms) and 5 packets of lube. The mailed packages also contained a post card with information on the Baltimore City STD Clinics and the services they offer. In April, we sent out 51 condom packages; an increase of 18.6% in 30 days. We anticipate that this number will increase as the program gains momentum.

Lessons Learned: Although the service is new, we have received great feedback and learned valuable lessons. The main lesson is that we will need an online component to manage and grow the program. Our STD Program is in the process of developing an online system for individuals to order condoms through the Baltimore Status Update webpage; a BCHD supported website that provides health and event information targeting the LGBT community. As this program expands, we are anticipating increased expenditures. Currently, we are in the process of identifying additional funding to sustain the program.

Abstract 2064 - Universal Condom Work Group: How to Make The Female Condom a Star in Hollywood, California

Author(s): *R Lewis*

Issue: In combination with biomedical interventions, the CDC has recognized the importance of condom distribution programs in reducing HIV and STI transmission rates. The Universal Condom Work Group was created to increase provider knowledge about female condoms (FC). Providers have historically been viewed as the gate keepers to community health. However in Los Angeles many healthcare professionals have little to no knowledge about female condoms and how they can be incorporated into the prevention spectrum. It was reported in 2011 only 600 female condoms were distributed, while 60,000 male condoms were distributed during the same time frame. With 10,500 individuals living in Los Angeles County unaware of their HIV status, there is a need for scaling up comprehensive prevention activities.

Setting: Universal Condom Work Group Los Angeles serves to train healthcare providers in Los Angeles County. Though the Universal Condom Work Group is based in Los Angeles, we collaborate with the National Female Condom Coalition and its affiliates. Our local members include Community Based Organizations, the Los Angeles Department of HIV/ STD Programs (DHSP). Los Angeles counties expansive size makes disseminating resources and efforts complicated and collaborations have been integral to the work group's activities.

Project: The Universal Condom Work Group's mission is to increase awareness and access to Female Condoms to all women, men, and youth who wish to use them. Studies indicate that female condoms can prevent STI at comparable rates of male condoms. However in Los Angeles only one of the two Health Department coordinated condom distribution programs distributes female condoms to patients and providers. Our group began meeting in 2010 at the behest of the Female Health Company. In 2012 we enacted an initiative for all clinics/ agencies who distribute FC to attend training. Upon reviewing data from the first training evaluations, it quickly became evident providers needed more access to up to date FC information. In 2013 the work group began to implement an educational effort targeting healthcare providers called "boot camps". These boot camps provide materials, resources and information to increase the provider's knowledge regarding FC.

Results: The first boot camp was conducted in April 2013 at Planned Parenthood Los Angeles. Since beginning the boot camps we have trained 81 providers. Providers knowledge has increased on average 40% from pre test to post test. These providers then return to their facilities and train other staff and share the information with patients. The work group is also working with the DHSP to increase FC access in all of their campaigns and clinics.

Lessons Learned: Research shows that providers attitudes and prejudices can impact a client's willingness to engage in certain behaviors. We have found a deficiency in providers in Los Angeles county who have the level of knowledge to accurately provide female condom information. About 73% of participants from the January 2015 boot camp report believing there is a chance the FC could get "lost or stuck inside of a woman's body". These findings underscore the need for increased provider education and training.

Abstract 2120 - Bridging Condom Distribution as a Structural Intervention and Evidence-Based Interventions/Public Health Strategies: Leveraging Interventions and Strategies for High Impact Prevention

Author(s): *Miguel Chion, Patricia Abshier, Oscar Marquez, Jennifer Medina Matsuki, Sapna Mysoor*

Issue: The Centers for Disease Control and Prevention (CDC) recommends the implementation of High Impact Prevention (HIP) through the integration or combination of cost-effective appropriate interventions and strategies to reach the prioritized target population. Agencies face the challenge of implementing condom distribution as a structural intervention combined with other existing interventions. Often, agencies struggle to maintain the structural nature of condom distribution in lieu of a standalone distribution program. In addition, there is a gap on documenting successful experiences integrating this type of structural interventions that can be used as a reference for future prevention programs.

Setting: The capacity building workgroup for Condom Distribution (CD) as a Structural Intervention (CDSI) is formed by three capacity building assistance (CBA) providers* funded by the CDC. Its mission, to increase the capacity of the HIV service providers in the U.S. and territories to implement Condom Distribution as Structural Intervention (CDSI). The CD workgroup gathered several experiences and lessons learned on integrating CDSI with other interventions and strategies. This presentation, of the

data, will inform new HIV prevention programs (such as PS 15-1502) on integrating CD with other Evidence Based Interventions (EBI) and Public Health Strategies (PHS) without losing its structural nature.

Project: The CD workgroup developed a strategic plan to build the capacity of HIV providers to implement CDSI. An important activity in the strategic plan is conducting an inventory of existing resources that HIV prevention programs can use to inform and build their capacity to implement CDSI. The CD workgroup is gathering experiences from the field, on integrating CD with other EBIs and PHS. This information is being formally documented, formatted and placed in a repository to support current and future prevention programs. These resources will be shared in various easy-to-use formats and media such as online repository, oral presentations, and printed materials.

Results: The CD workgroup is gathering information, from the last 5 years, from their own and other organizations' experiences focused on bridging CDSI with the EBIs and PHS. Preliminary results showed successful integration/combinations of condom distribution with three prevention EBIs (Mpowerment, Community PROMISE, and Personalized Cognitive Counseling); with social support services (food bank services, case management, home health services, among others); and through social networks, online platforms, and health departments. These results convey successful experiences integrating CD targeting people at high risk and people living with HIV. These successes provide a roadmap for advancing HIV via CDSI.

Note: If approved presenters will invite CDC to share their experience and perspective.

Lessons Learned: Numerous positive experiences exist, demonstrating the integration of EBIs/PHS and CDSI, that many stakeholders are unaware of; unless they are directly involved in these interventions or strategies. Enhanced awareness of those experiences, from CBO and HD peers, help build the capacity of HIV prevention providers in implementing CDSI in combination with other services without losing intervention fidelity. These intervention-bridging and integration lessons learned will impact, short and long term, how grantees implement new FOAs such as PS15-1502.

Abstract 2223 - What's in a Brand? Evaluating the Impact of Quality and Availability on Use of Municipally Branded Condoms

Author(s): *Nana Mensah, Kathleen Scanlin, Christine Borges, Zoe Edelstein, Jennifer Matsuki*

Background: In 2013, the New York City Health Department (NYC DOHMH) distributed over 25 million municipally-branded condoms. 'NYC Condoms' are distributed at over 3,500 venues, including all NYC DOHMH Sexually Transmitted Disease (STD) clinics, and in over 95% of bars/clubs frequented by men who have sex with men (MSM). We conducted an evaluation of the NYC Condom program, examining use, and perceived quality and accessibility of the NYC Condom.

Methods: Surveys were conducted July-September, 2013 at nine NYC STD Clinics and ten street-intercept locations. For both survey locations, eligible respondents were NYC residents, aged 18-64, who reported being sexually active in the past 6 months. The survey measured recent NYC Condom use (past 12 months). Respondents reported quality by rating the Condom on a 4-point scale from "very high quality" to "very low quality" and accessibility by rating ease of finding free Condoms on a 4-point scale

from “very difficult” to “very easy.” Associations with recent Condom use were examined using multivariable logistic regression. Initial multivariable models included survey location and one other demographic factor (age, race/ethnicity, education, sexual orientation) or NYC Condom rating (quality or accessibility). The final multivariable model was constructed wherein all variables were considered using backwards stepwise selection (cutoff $p < 0.2$).

Results: We surveyed 412 respondents, 51.9% via street-intercept ($n=214$) and 48.1% at STD clinics ($n=198$). Overall, 62.3% were male ($n/N=251/408$); 12.2% identified as white/non-Hispanic ($n/N=50/409$), 43.3% black/non-Hispanic ($n/N=177/409$), 35.9% Hispanic ($n/N=147/409$), and 8.6% other race ($n/N=35/409$); mean age was 31.9 (median age =29.0); 83% identified as heterosexual ($n/N=336/404$), and 29.2% had a high school education or less ($n/N=118/404$).

A total of 69.9% of respondents reported ever using a NYC Condom, and 56.1% reported recent NYC Condom use. Recent use varied by location (62.6% among STD clinic respondents vs. 50.0% among street-intercept respondents, $p=.001$). Among those who had ever used the Condom, 54.7% rated the condom as high/very high quality, and 88.5% indicated that it was accessible. Quality did not differ by survey location, but accessibility did (92.1% among STD clinic respondents and 84.4% among street-intercept respondents, $p=.04$.)

In models only controlling for survey location, recent NYC Condom use was associated with LGBT identity (odds ratio (OR)=2.1, 95% confidence interval (CI): 1.5 – 3.7), and rating the Condom as high/very high quality (OR=3.5, 95% CI: 2.0-6.2) and accessible (OR= 4.0, 95% CI: 2.3-6.9). In the final multivariable model, recent use remained associated with ratings of high/very high quality (OR=3.1, 95% CI: 1.7-5.6) and accessibility (OR=2.2, 95% CI: 1.0-4.9).

Conclusions/Implications: In this evaluation, NYC Condom use was widespread, and respondents identifying as LGBT, a target population for the program, were more likely to have used the Condom. Most respondents rated the Condom as easily accessible, though only half of respondents rated it as high quality. Both accessibility and quality were associated with recent NYC Condom use. Results of this evaluation have informed the launch of a comprehensive marketing campaign to promote the NYC Condom while improving perceptions of quality and normalizing its use.

Session C35 - Engagement and Interventions for Homeless Populations

Room: A601 (Atlanta Marriott Marquis)

Abstract 2206 - Understanding and Addressing the Multiple Dimensions of Stigma to Promote Engagement in HIV Care for Homeless Populations

Author(s): *Serena Rajabiun, Manisha Maskay, Kate Franza, Ruthanne Marcus*

Issue: Several studies have documented the role of stigma in both delaying HIV testing, and failure to enter or initiate care and poorer adherence to HIV care and treatment. For persons living with HIV who are homeless or unstably housed additional factors such as substance use and mental illness may also compound stigma and affect access to and receipt of quality of care. The presentation will review study methodology and initial data related to measuring stigma and the types of stigma experienced by HIV homeless unstably housed individuals, diagnosed with mental health and/or substance use disorders. It

will also address strategies that may be used to help address stigma at the individual, community and systems level.

Setting: Nine clinic and community-based organizations across the US and one multisite coordinating center are funded by The Health Resources & Services Administration, HIV/AIDS Bureau through its Special Programs for National Significance (SPNS) as part of a national initiative focused on building medical homes for multiply diagnosed HIV-positive homeless/unstably housed populations.

Project: The demonstration projects implement and evaluate service delivery models aimed at achieving two main outcomes: 1) increase engagement and retention in HIV care and treatment; and 2) improve housing stability for multiply diagnosed HIV-positive homeless/unstably housed populations. A key service delivery strategy is the use of patient navigators/care coordinators to engage and retain HIV homeless/unstably housed individuals in care and assist with multiple stigmas. This presentation will describe strategies used by the initiative to measure stigma, review initial results and describe some strategies that can be used to help clients in addressing stigma and building resilience.

Results: As part of a national multisite evaluation of engaging and retaining HIV homeless in care and treatment, a multidimensional measure of individual and provider level stigma addressing homelessness, substance use, mental illness and HIV was adapted and developed across six sites. The presentation will share preliminary baseline findings and discuss strategies to address stigma at the individual, community and systems level to promote linkage and engagement in HIV care.

Lessons Learned: Stigma is often cited as the reason why individuals resist getting HIV tests as well as accessing and/or treatment for HIV and mental health/substance abuse disorders. The multiple facets of stigma are however poorly understood and defined, thus making it difficult to address it at the individual, community or systems level. Learning about how to measure stigma, understanding the dimensions and determining effective strategies to help individuals to address stigma and build resilience is an important facet of enabling them to become engaged in care and treatment.

Abstract 2421 - Using the PDSA Cycle to Improve Linkage and Retention in HIV Care among Homeless HIV+ Individuals with Mental Health and Substance Use Disorders

Author(s): *Nicole Chisolm, Manisha Maskay*

Issue: Quality Improvement (QI) is the use of a deliberate and defined improvement process to ensure a continuous and ongoing effort to achieve measurable program improvements. QI processes must be conducted on a continuous basis in order to enhance the care of clients in real-time. The PDSA Cycle- Plan, Do, Study, and Act Cycle- is one method that has been applied in healthcare settings to improve the quality of services and ultimately the quality of health of the community.

Setting: Health Hope & Recovery, a program of AIDS Arms, Inc. in Dallas, TX provides intensive care coordination and seeks to create a medical home for HIV+ individuals diagnosed with mental health and/or substance use disorders and are homeless. The program utilizes regular process evaluation to systematically assess client encounters, fidelity to defined interventions and other associated processes.

Project: Plan - The process evaluation for Health, Hope & Recovery is intended to: 1) assess the use of and fidelity to principles of cognitive behavioral therapy (CBT), harm reduction, solution based therapy (SBT), and strengths based case management (SBCM) techniques; 2) ensure acuity driven standards of contact; 3) ensure appropriate referrals and follow up are provided; and 4) provide feedback for ongoing program improvement. The process is not associated with performance reviews nor are findings used to impose punitive actions.

Do - The process evaluation is facilitated through the use of a peer review checklist, supervisor care plan review checklist, and supervisor observation of motivational interviewing. The process evaluation activities are conducted on a quarterly basis.

Study - All individual level findings are reviewed with staff during supervision in order to address individual needs. Data is compiled and summarized for aggregate reporting then summarized in a quarterly process evaluation staff report. Results of the current review period are compared to prior period findings in order to evaluate changes over time. Quarterly staff reports are reviewed with program staff for discussion among implementation staff and program managers.

Act –The findings, presented as staff process evaluation reports, are used to identify QI priorities, to highlight and reinforce program strengths, and to facilitate collaborative strategy development for program improvements.

Results: Review of process evaluation data from year 2 and year 3 of program implementation indicate improvements in fidelity to the program principles across all measurement categories. Documentation of client encounters improved significantly over the review period. Review of findings resulted in the development of yearly biannual training goals in order to directly address areas of deficit. Strengths identified in the evaluation are reviewed in depth in order to standardize and formalize service approaches among direct service staff.

Lessons Learned: Use of the PDSA cycle is an effective method of ensuring continuous improvement for HIV intensive care coordination. It is imperative that such QI activities are not conducted in association with performance evaluation in order to ensure staff buy-in and encourage open sharing of views and practices.

Abstract 2478 - Access to HIV Prevention Services among Chronically Homeless Persons Entering Permanent Supportive Housing

Author(s): *Hsun-Ta Hsu, Suzanne Wenzel, Taylor Harris, Harmony Rhoades, Hailey Winetrobe, Eric Rice, Ben Henwood*

Background: Permanent supportive housing is an empirical solution for reintegrating homeless populations by providing basic needs for housing and ongoing supportive services. Integrated health care is a hallmark of permanent supportive housing (PSH) for chronically homeless persons. There has been minimal attention paid to pre-exposure prophylaxis (PrEP) and other HIV/STI prevention services in PSH despite documented risky sexual activity. Using a mixed methods approach, we investigated availability and access to these services from the perspectives of both homeless persons entering PSH and providers of PSH.

Methods: Structured interviews were conducted with 216 chronically homeless respondents in Los Angeles upon acceptance into PSH and 3 months following move-in. Assessments focused on PrEP, HIV/STI testing, and prevention education. Semi-structured qualitative interviews regarding availability and barriers in providing HIV services were conducted with 34 PSH providers across agencies into which homeless respondents were being housed.

Results: 67.6% of homeless respondents reported testing for HIV and 47.7% for other STIs including Syphilis, Gonorrhea, Hepatitis B, Hepatitis C, Human Papillomavirus, and Chlamydia in the past year. Only 43.1% of respondents reported a healthcare provider speaking to them about HIV/STI prevention in the past year and 0.53% had ever been prescribed PrEP. 36.15% of respondents reported being sexually active at baseline. Of those who were sexually active, 74.03% reported having unprotected sex and 26% reported multiple sex partners in the last 3 months. While 60.85% said it was likely they will use a condom if they have sex in next 3 months at baseline, at follow-up 63.27% were having unprotected sex and 32.66% had multiple sex partners of those who were sexually active (47.12% of sample at follow-up). PSH provider interviews suggested barriers to prevention and HIV service delivery include: lack of clarity regarding which individuals and agencies should be responsible for delivering HIV services, limited awareness of PrEP and guidelines for use, and concerns about limited agency and staff resources to support access to PrEP and medication adherence.

Conclusions/Implications: To the extent that PrEP and other HIV services are poorly accessed among homeless respondents entering housing and not provided as part of integrated health care in PSH suggests a need for a multi-pronged effort. Future efforts to enhance availability and provide education throughout the provider network for both homeless and formerly homeless persons in PSH are warranted.

Session C36 - Drug User Health

Room: A602 (Atlanta Marriott Marquis)

Abstract 1857 - Prospects for “Ending the HIV Epidemics” among Persons Who Inject Drugs in a High Resource Setting (NYC) and a Resource-Limited Setting (Haiphong, Viet Nam)

Author(s): *Don Des Jarlais, Kamyar Arasteh, Courtney McKnight, Duong Thi Huong, Pham Minh Khue, Khuat Thi Hai Oahn, Hoang Thi Giang, Le Bach Duong, Didier Laureillard, Nicolas Nagot*

Background: “Combined prevention,” large-scale implementation of multiple interventions, has led to dramatic reductions in HIV transmission among persons who inject drugs (PWID) in multiple high resource settings, including New York City (NYC). We compared “combined prevention” and “ending the HIV epidemic” among PWID in NYC and Haiphong, (HP) Viet Nam.

Methods: We reviewed the history of implementation of combined prevention in the two cities. Serial cross sectional and cohort studies were used to trace trends in HIV prevalence and estimate HIV incidence and community viral load in the two cities. There were 3511 study participants in NYC and 603 in HP. “Ending the HIV epidemic” was operationalized as an estimated incidence >0.5/100 person-years.

Results: Combined prevention including needle/syringe programs, opiate substitution treatment and antiretroviral treatment (ART) have been implemented in both sites, though ART is available for all HIV seropositive persons in NYC and only HIV seropositives with CD4 cell counts <350 cell/mm³ in HP. Needle/syringe distribution occurs primarily through syringe exchange programs in NYC and through pharmacy sales in HP. Coverage of HIV testing is <98% in NYC and 65% in HP. HIV prevalence among PWID in NYC has declined from 50% in 1990 to 6% currently, and 76% of HIV seropositive PWID are currently on ART. HIV prevalence among PWID in HP has declined from 66% in 2006 to 25% currently, and 34% of HIV seropositive PWID are currently on ART. Estimated HIV incidence is 0.1/100 person-years in NYC and 2/100 person-years in HP.

Conclusions/Implications: HIV among PWID in NYC has reached an “end of the epidemic” low incidence stage. The decline in HIV among PWID in HP is approximately 10 to 15 years behind the decline in NYC. Intensification of prevention efforts, particularly increasing the numbers of HIV seropositive PWID who are on ART, is needed to accelerate the decline of the HIV epidemic among PWID in Haiphong.

Abstract 1877 - Drug User Health: Mobilizing Community to Accomplish Effective Prevention and Care Responses

Author(s): *Barry Callis*

Issue: Efforts to reduce transmission of new HIV in Massachusetts have been successful among injection drug users. This is evidenced by an 84% decrease from 2000 to 2013 in the number of cases diagnosed among IDUs. As in many states across the country, Massachusetts is facing an epidemic of opioid addiction and overdose deaths. In 2013, there were 908 confirmed opioid-related deaths, up nearly 200 from 2012. Opioid addiction, particularly among younger injection drug users has resulted in a disproportionate impact of hepatitis C infection and increased risk for hepatitis A and B. Between 2010 and 2012, the average annual number of reported HCV cases in people under the age of 30 was 2,146. These indicators and the social and behavioral factors that contribute to risk require strategic responses to reduce HIV and HCV co-morbidities.

Key Points: An assessment of HIV, HCV, and STD surveillance data and direct service investments was conducted to assess the sufficiency of public health response to drug users. A literature review and consultations with those working in the field informed an approach to the health of drug users that focuses on a combination of prevention, intervention, access to treatments, and recovery supports. Activating public health partnerships and applying lessons from the field promotes access to health promotion and disease prevention services.

Implications: This roundtable session will describe efforts to mobilize community and public health stakeholders to promote the health of drug users. A set of core services were prioritized to address transmission and treatments for HIV, HCV and STDs, overdose, and substance use. They include: access to sterile drug preparation equipment, biomedical prevention services (PEP/PrEP), risk education and reduction, integrated testing and treatments, overdose education and Naloxone distribution, linkage to behavioral health, opioid substitution therapies, primary care, and novel case management services. Combining forces across service areas and disciplines improves health outcomes.

Abstract 1973 - Participation in HIV Testing among Drug Users on Probation Recruited from Community Settings

Author(s): *Jennifer Lorvick, Megan Comfort, Christopher Krebs, Alex Kral*

Background: People in the criminal justice (CJ) system are at disproportionately high risk for HIV infection. Jails and prisons have been identified as key settings for implementing the systematic provision of HIV testing. However, HIV testing is not routinely available through community supervision (e.g., probation, parole). Probation is the most common form of CJ system involvement, and may offer an opportunity to provide HIV testing and counseling to CJ-involved people engaging in risk behavior in community settings. The objective of this study is to describe HIV risk and participation in HIV testing by people on probation.

Methods: Cross-sectional, community-based research was conducted with people who inject drugs or use crack cocaine in Oakland, CA from 2011-2013 (N=2,094) as part of the NIH-funded "Seek Test Treat and Retain" initiative. Participants were recruited using targeted sampling and underwent a quantitative survey data regarding HIV risk behavior, CJ system involvement and past participation in HIV testing. This analysis is restricted to participants who reported being on probation in the 6 months prior to interview (n=573). We calculated simple frequencies and proportions, and used the chi square test to examine the relationship between HIV risk and HIV testing.

Results: Unprotected sex with =>2 partners in the past 6 months was reported by 34% of probationers. Among those who injected drugs (n=181), 30% reported sharing syringes in the past 6 months. Only 23% of probationers (134) reported having an HIV test in the past 6 months. There was no correlation between having engaged in risk behavior in the past six months and having participated in HIV testing. The most common venues for HIV testing were community agencies (39/134), hospitals (23/134) and health clinics (21/124). No one reported testing at a probation office. Only 21/134 reported testing in jail during the past six months, even though 41% of probationers in this sample had been incarcerated at some point during this time frame.

Conclusions/Implications: People on probation are a large and crucial segment of the CJ involved population. In this sample, levels of HIV risk behavior among people on probation were substantial. Increased efforts to provide HIV testing both in jail and in probation settings are needed. Concurrently, the role of community agencies in reaching this high-risk population should be recognized and enhanced, as they can reach probationers who are either avoiding (absconding) or not required to formally report to probation systems. HIV testing for probationers should include population-specific counseling about risk behaviors and risk reduction strategies for people with CJ involvement, such as navigating safer sex while incarcerated or accessing sterile injecting materials in community settings in ways that minimize risk of arrest.

Abstract 1987 - Community-Based HIV Test and Treat Initiative: Treating and preventing HIV infection among drug users in Newark, NJ

Author(s): *Liliane Windsor, Corey DeStefano, Shariff Hall*

Issue: Health disparities in the United States are well documented and result in a significant health threat to the nation. For example, the per capita rate of new HIV cases is 8 times higher for Blacks than it is for Whites. Kaiser Permanente launched the Community-Based HIV Test and Treat Initiative (TTI) to improve early identification of new HIV cases and to increase the HIV care acquisition and maintenance of newly diagnosed individuals in minority communities disproportionately affected by the HIV epidemic.

Setting: Essex County, NJ has the highest concentration of people living with HIV in New Jersey (N=23,152). Of these, 76% are Black and 15% are Hispanic. This area is disproportionately impoverished and has higher HIV/AIDS related death rates when compared to the State of New Jersey. This may reflect poor access to quality HIV prevention and care services in the area. The leading mode of transmission is injection drug use (40%), followed by heterosexual contact (34%), and male-to-male sexual contact (13%).

Project: The North Jersey Community Research Initiative (NJCRI) received funding from Kaiser Permanent to implement and evaluate the Modelo de Intervención Psicomédica (MIP) in Newark, NJ. MIP is a holistic behavioral intervention based on motivational interviewing to reduce HIV risk among intravenous drug users (IDUs). MIP combines counseling and case management. The project is expected to test substance using individuals at risk for HIV infection through targeted outreach, link them to care, and evaluate MIP using a quasi- experimental design. All HIV+ individuals identified will be linked to care either as part of the experimental or comparison group (N=120). Those in the experimental group will receive MIP and those in the comparison group will receive standard care at another community agency (medical, clinical and case management). Participants are interviewed at baseline, 3 and 6 months follow-ups about their behaviors, services used, and medical outcomes. This presentation will describe our outreach strategies, the implementation of MIP, and preliminary findings from the evaluation.

Results: From June, 2014 through April 2015, a total of 1,631 substance using individuals at risk for HIV infection were tested. Of these, 19 HIV positive individuals have been identified and engaged in the experimental group and 33 HIV positive individuals have been identified and engaged in the comparison group. All individuals in the intervention remain engaged in treatment while one individual from the control group died and two have dropped out. All 52 participants are Black, HIV+, low-income, and using drugs at baseline. Preliminary analyses indicate that transportation and navigation services are key to linking and retaining intervention patients into care.

Lessons Learned: Thus far, MIP seems to be an appropriate best practice program to engage HIV positive drug users in minority communities disproportionately affected by the HIV epidemic. However, we had to enhance MIP with transportation and navigation services to keep participants in HIV care, meeting all their medical and case management appointments along with their substance abuse and mental health service appointments.

Track D

Session D06 - Telling Your Story: HIV Testaments of Prevention and Care

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1182 - CDC's HIV Treatment Works Social Marketing Campaign Targeting Persons Living with HIV/AIDS (PLWH)

Author(s): *Kelly O'Neill, Laura McElroy, Sara Bresee, Jackie Rosenthal, Jessica Lacy, Nick DeLuca*

Issue: More than 1.2 million people in the United States are living with HIV infection, and nearly 1 in 7 (14%) are unaware of their infection, leaving them without the knowledge of a confirmatory diagnosis, potential access to medical care, and strategies to prevent transmission to partners. Of those infected, an estimated 86% are diagnosed with HIV, and 40% are engaged in HIV medical care. But only approximately 3 in 10 people living with HIV (PLWH) currently have their virus under control. Early linkage and retention in HIV care, and antiretroviral therapy (ART) adherence, are essential for optimal disease management, promotion of health, and receipt of secondary prevention messages to decrease onward transmission of HIV.

Setting: HIV Treatment Works, part of CDC's Act Against AIDS initiative, is a national social marketing campaign with the goal of encouraging PLWH to get in care, start taking HIV medications, remain in care, and adhere to treatment. This effort involves a national media campaign and grassroots community engagement initiatives.

Project: HIV Treatment Works focuses on how PLWH have overcome barriers to get in care and stay on treatment. The campaign provides access to information and resources, including personal stories, to help increase the proportion of PLWH who enter and remain in care. Key campaign messages to reach PLWH including those at greatest risk (MSM, African American men and women, and Latino men and women) are disseminated through 1) targeted print, cable, outdoor, and online media; 2) media relations; 3) educational website including relevant information and videos; 4) social media; 5) materials dissemination; 6) community engagement, including local ambassadors; and 7) partnerships with local and state health departments, national organizations and HIV care provider organizations. Process evaluation was conducted to assess exposure of the campaign to PLWH and whether the program was implemented as planned.

Results: From the launch of the campaign in September 2014 through December 2014, the campaign generated over 1 billion impressions in under four months. A total of 827,953,956 impressions were garnered using print media outlets, and 2.3 million impressions were garnered using online media, targeting key populations. By tailoring media with increased reach and frequency, the campaign was able to successfully reach PLWH where they live, work and seek care. Earned media impressions from wire, print, online and broadcast coverage totaled 1.1 million, including notable outlets AP, TIME magazine, Shape magazine, and BET. The educational website has had 39,174 hits, including 10,847 video views. Social media is an important channel for reaching PLWH, and the campaign hashtag was tweeted 940 times and the campaign was mentioned on Facebook 537 times. Over 35,000 materials have been distributed through a variety of channels with the majority (33,179) distributed through hospitals, clinics, churches, health departments and government organizations serving PLWH.

Lessons Learned: A diversified media strategy inclusive of multiple media channels and strategically targeted to the most at-risk populations for HIV was imperative to reach a broad PLWH audience. The

national media campaign was further enhanced by local advertisements, social media and materials dissemination.

Abstract 1340 - FLAS Novelas

Author(s): *Kimberly Palacios*

Issue: The purpose of the program FLAS Novelas is to provide culturally competent substance abuse and HIV prevention messages through social media to Latino gay men and Latina women who have sex with men. The messages are inculcated through prevention messages in a new transformed concept that is already part of the culture. These episodes are created and produced based on real life stories shared by participants willing to share their dark nightmare experiences to make them shine light to issues faced by many Latinos. Every message portrays their stories with the purpose to stop future generations from acquiring HIV/STD infections, domestic violence, substance abuse, and more. Each personal experience shared is transformed into a novela (soap opera) to deliver and teach the Latino community about these current issues. Dramatic stories reflecting many of life's challenges such as love, betrayal, drug use, HIV, domestic violence and much more. The traditional novela is usually based on the same plot but, this novela series grows off of the foundation used in various stories which will educate the community. The hardships that individuals face daily are projected through this form of art so that any member of the community can relate and share this experience in hopes of creating a better future for themselves.

Key Points: FLAS' strategy for delivering our purpose is short video episodes streamed through the most popular social media blocks, and websites. Every episode is based on a real life story shared by interviewed participants, and is categorized as domestic violence, drug abuse, and sexual transmitted disease related. A community board and the FLAS Novelas Team will review and approve the stories prior to be sent out to the screenwriter. The most used social media sites for diffusing the videos are Facebook, Twitter, Instagram, and Tumblr amongst others. The strategic method for exposing this educational material is through soap operas because they are part of the Latino culture. Novelas is such a strong technique to transmit a message, making it easy to be adopted quickly by a large population, especially in the Latino community. This concept brought to live FLASNovelas to showcase HIV/STD's prevention messages and break taboos and stigma in the Latino culture.

Implications: FLASNovelas has reached thousands of viewers showing initiative and interests in this project. It has been such a positive impact that the audience reaches out to FLAS to share their stories to be part of the change. FLASNovelas has given them initiative and courage to speak of the unspoken resulting in families free of fear and stigma. The new method for transmitting prevention messages has definitely taught viewers basic HIV knowledge and substance abuse consequences. FLASNovelas has reached other cities surrounding Houston creating a positive impact for transmitting educational material based on these delicate subjects to their communities. The city of Austin has published the #FLASNovelas in their various social sites to spread and teach prevention in their city. As well international with the interview from the major TV network Univision. The show "Primer Impacto" came to visit FLAS to interview the FLAS Novelas Team. The public has engaged in the new informative medium to learn about issues that affect principally the Latino community, taking in consideration statistical data showing Latinos and African Americans on top of the HIV/STD's infection transmissions.

Locally, the greater Houston Southwest area has become highly populated by Latino immigrants mostly originally Central America and Mexico.

As a result of the program FLAS Novelas has been seen by thousands of people which have learned something new from the prevention messages. Many of whom have reached out to FLAS to get tested for HIV and also helped others by referring relatives to the other programs. FLAS strives to continue with the this new type of way of educating the community with the topics people rarely speak of in their household. It is time for the Latino community break down the silence of the many issues they face on a daily basis. This will allow viewers to understand the importance of breaking negative culture barriers and taboos that are affecting their community to achieve a healthy community. The community in Houston has come together to share their stories to shine light on the behaviors and attitudes that can harm others. The stories have taught the community to seek for help if they feel in danger. Others have come with the courage to share their story so help the program FLAS Novelas. The program is breaking walls and joining unheard voices together as a united tight community.

Abstract 1597 - Positive Spin: Digital Storytelling across the HIV Care Continuum

Author(s): *Michelle Samplin-Salgado, Miguel Gomez, Cathy Thomas, Ken Williams, Patrick Ingram, Guy Anthony, Uriah Bell, Paul Glass, Aisha Moore, Pavni Guharoy*

Issue: According to the CDC, 25% of people living with HIV (PLWH) in the U.S. have achieved viral suppression. Among racial and ethnic groups, African Americans are the least likely to be in ongoing care or to have their HIV virus under control.

The HIV Care Continuum is a model to track health-related outcomes of PLWH. It identifies opportunities to improve the delivery of services to PLWH so they ultimately achieve viral suppression.

Setting: As a program of the US Department of Health and Human Services, AIDS.gov works to extend the reach of HIV programs to communities at greatest risk by increasing the use of new media tools by government, minority, and community partners online.

Project: Positive Spin is a project that uses the power of digital storytelling to raise awareness of the HIV Care Continuum and the steps PLWH can take to live longer, healthier lives and reduce their risk of passing HIV to others. As a comprehensive digital educational tool, it includes video narrative and evidence-based health information. The project, developed by AIDS.gov with input from federal agencies, health care professionals, PLWH and community-based HIV organizations, is available at <https://positivespin.hiv.gov>.

Results: The project team initially selected four men from diverse backgrounds who were virally suppressed and comfortable sharing their stories publicly and online. We received feedback to include someone who had experienced mental health issues. Subsequently, we identified a fifth man who has a mental health diagnosis to share his story.

As a result, Positive Spin features the personal experiences of five HIV-positive, gay black men who have successfully navigated the care continuum, from diagnosis to treatment and, ultimately, to viral suppression.

The videos leverage the power of their compelling stories to counter the misconceptions, stigma, and discrimination that continue to create significant barriers to HIV testing and treatment for all populations.

Launched on March 25, 2015, Positive Spin received nearly 5,000 page views and more than 1,500 video views within the first two weeks.

Lessons Learned: HIV affects each individual differently, and everyone’s story of living with HIV is unique. While Positive Spin represent five individuals’ experiences and are not intended to cover the entire range of possible outcomes, by sharing these stories, AIDS.gov hopes to inspire more people with HIV to get tested, get connected with care, start HIV treatment, and stay in care..

It provides educational support to community advocates and service providers as they work to improve linkages to and retention in care.

A key goal of the project is to promote and demonstrate digital storytelling as a tool for HIV outreach. It supports the Federal HIV/AIDS workforce and state/local HIV service providers in their ongoing efforts to respond more effectively to the HIV epidemic in communities at greatest risk.

Ultimately, we hope that Positive Spin will reinforce efforts by the HIV community—Federal, state, and local—to engage new audiences and counter the misconceptions, stigma, and discrimination that continue to create significant barriers to HIV testing and treatment for all populations.

Session D09 - Reaching Young People Where They Are: School and non-School Based Education and Prevention

Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1774 - Promoting Adoption of a Comprehensive Sexual Health Policy and Curriculum Through School-Community Partnership

Author(s): *Candace Lacey*

Issue: Nationally, youth ages 13 to 29 account for 39% of all new HIV cases. About 1 in 4 new HIV infections occur for youth ages 13 to 24. Between 2012 and 2014, 548 new HIV infections were reported in Florida for youth between 13-19 years. Broward County currently has over 17,500 people living with HIV/AIDS. Broward is one of the top two counties in Florida with the highest HIV/AIDS rates.

Over 100 studies have demonstrated that students equipped with medically accurate information are more likely to remain abstinent and more likely to use protection when they do become sexually active, helping to prevent pregnancy and STIs such as HIV. Unfortunately, according to district YRBS data 13% of

students said they were never taught about HIV/AIDS in school. Florida has no uniform sexual health curriculum policy. School districts teach the type of curriculum they deem appropriate.

Lacking a uniform state policy, and supported by local survey findings indicating that 74% of parents wanted schools to offer sex education that includes information about contraception and condoms, Broward Schools began the process of developing and implementing a groundbreaking comprehensive sexual health policy.

Setting: Broward County Schools is the sixth largest public school district in the nation with over 260,000 students in more than 310 schools. The District serves 30 Florida cities including Fort Lauderdale, which has one of the highest HIV/AIDS rates in the country.

Project: To address the alarming trend in HIV/AIDS infections, District staff collaborated with community and school stakeholders to develop the LGBTQ Critical Support Guide and corresponding video. School leaders, teachers, staff, and parents participated in trainings on the new guide. Following the training, focus groups and surveys were conducted with those who participated. Data indicated that all of these groups expressed an urgent need to replace the current sexual health curriculum with one that would be inclusive, honest, relevant, and engaging for the students. Participants also recommended content including topics such as healthy relationships, peer pressure, sexual bullying, and condom demonstrations. The findings from these data along with support from the medical community, community agencies, parents, and students were instrumental in the two year process that led to the development of The Family Life and Human Sexuality policy.

Results: On May 6, 2014, the District's School Board took less than one minute to unanimously approve The Family Life and Human Sexuality policy. The policy ensures that all students grades K to 12 receive developmentally appropriate sexual health education that will hopefully reverse the trend in HIV and AIDS cases in the county. Additionally, as a result of the data gathered for this project, the district was awarded a Promoting Adolescent Health grant. Over the next four years, stakeholders will benefit from the resources that will continue to be developed because of this funding.

Lessons Learned: Through this project we have learned the tremendous power of collecting and leveraging data, the importance of bringing all stakeholders to the table, and the impact of advocacy in the creation of groundbreaking policy and curriculum adoption.

Abstract 1821 - Bringing the Health Department Services to At-Risk LGBT Youth and Young Adults

Author(s): *Keith Holt, Tanya Myers, Carolyn Nganga-Good, Ravikiran Muvva*

Issue: HIV/AIDS is an ongoing concern in Baltimore City. In 2011, CDC ranked the Baltimore Metropolitan Area sixth highest in new HIV diagnoses. The majority of new cases of HIV are occurring among African American lesbian, gay, bisexual, and transgender (LGBT) youth. Many focus groups showed that members of the LGBT community were unaware of services since the closing of several key community organizations that served the African-American LGBT community. Baltimore City Health Department (BCHD) responded by developing partnerships with community stakeholders, local club owners, and the underground ballroom community to brainstorm on innovative ways that youth and

particularly LGBT youths can access health and social service resources and assist with filling the void left by the closing of several LGBT organizations.

Setting: Baltimore City is surrounded by major cities such as Philadelphia, New York, and DC which have high proportions of LGBT communities. The city attracts many visitors each year which may also draw unsafe sexual practices due to its geographical location. BCHD has found many HIV positives who were visiting Baltimore while maintaining a permanent residence in other states.

Project: The Know Your Status free ball and conference has become the most successful annual event developed by BCHD. The Free Ball invites community partners to come and promote their services at no cost and allow many LGBT youth to attend and compete in various categories. The attendees get a wide variety of information from community partners on issues ranging from health to social services including career development. In addition, BCHD partnered with MICA to develop a social marketing campaign – Status Update. The campaign featured an easy to navigate website offering information on testing sites, condom distribution, and various events. Local members of the LGBT community were featured in the advertisements used to promote HIV awareness. Outreach for the ball was also done using social media.

Results: In 2014, we tested 121 people at the Free Ball and 23 were positive (19% positivity rate). 2014 was the first year that we enrolled individuals in the affordable care act and had the Baltimore Police Department doing LGBT police recruitment. The Baltimore Free Ball was voted by the National Ballroom Alliance as “Ball of the year” at the New York Awards Ball. The Status Update campaign has been featured in bars and clubs all around Baltimore. BCHD has also allowed the Baltimore Ballroom Coalition to use BCHD meetings space to conduct meetings and has become a trusted source for information.

Lessons Learned: We found that the best way to reach the LGBT community is by meeting them on their terms. The BCHD-sponsored LGBT events provide a safe and enjoyable environment. Other organizations have allowed BCHD to provide testing and linkage/re-engagement to care services in their facilities with the goal of streamlining services to areas with the greatest need and building a rapport with the community. Building these relationships did not happen overnight but the progress thus far is revolutionary and can be adopted by other health departments.

Abstract 1908 - Developing a Comprehensive Sexual Health Policy and Education Program

Author(s): *Amalio Nieves, Candace Lacey*

Issue: Nationally, youth ages 13 to 29 account for 39% of all new HIV cases. About 1 in 4 new HIV infections occur for youth ages 13 to 24. Between 2012 and 2014, 548 new HIV infections were reported in Florida for youth between 13-19 years. Broward County currently has over 17,500 people living with HIV/AIDS. Broward is one of the top two counties in Florida with the highest HIV/AIDS rates.

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Lessons Learned: Through this project we have learned the tremendous power of collecting and leveraging data, the importance of bringing all stakeholders to the table, and the impact of advocacy in the creation of groundbreaking policy and curriculum adoption.

Abstract 1917 - Addressing the Social Determinants of Health: A New Model for HIV Prevention among At-risk Youth in Albuquerque High Schools

Author(s): *Antonio Quintana, Jamie Finkelstein, Zachary Bosshardt, Wilma John, Ali Moore*

Issue: The CDC recommends agencies provide effective school and community based interventions to make available the necessary education and resources to ensure that all youth can get tested for HIV and can receive necessary healthcare and prevention services. The HIV infection rate among youth has risen in recent years, partly as a result of barriers to prevention such as lack of insurance, lack of access to services, concerns about confidentiality, lack of HIV awareness, and stigma.

The Truman School Based Health Initiative (TSBHI) is a multi-disciplinary team approach designed to create opportunities for addressing unmet needs, and improving access to health promotion, disease prevention and resources for at-risk youth in the high schools.

Setting: UNM Truman Health Services (UNM THS) has added full-time health education, case management, mental health, and substance use services to the School Based Health Centers (SBHC) in two high schools in Albuquerque, New Mexico.

Project: In addition to offering full-time HIV testing, education, and prevention services on-site in the high schools, the TSBHI aims to decrease students' HIV risk by addressing the social determinants of health. In addition to HIV risk reduction and general health education, the initiative includes: access to health services, identification and elimination of socio-economic barriers, and diagnostic and therapeutic behavioral health services.

The health educators provide on-site rapid HIV counseling and testing, linkage to care, health education, condom distribution, and make referrals directly to appropriate services. Additionally, health educators conduct presentations, workshops, health fairs, awareness campaigns, and student groups addressing health literacy, stigma, and access to services.

The additional case management and behavioral health services create a comprehensive multidisciplinary team that works to ensure that all students' needs are met on-site, and that the initiative is able to effectively address the social determinants affecting HIV risk including access to health services, housing, and food insecurities.

Results: The initiative has effectively addressed the social determinants of health by increasing access to health related services for over 2,000 students. Based on the existing program in the public schools, all students reached by the initiative have additional supports which reduced risk and are more educated based on the services and counseling received.

During the first six months of the initiative, the health educators conducted 151 rapid HIV tests, 783 one-on-one health education sessions, and made 224 referrals connecting at-risk youth with appropriate services including behavioral health, case management, additional STI testing, primary care, and other health and wellness services.

Lessons Learned: The TSBHI is an effective model which makes health promotion and disease prevention services easily accessible to at-risk youth. In the first six months, the initiative reached over 2,000 students through the various health education and associated programs implemented through this initiative.

Session D14 - Capacity Building Assistance Network

Room: A703 (Atlanta Marriott Marquis)

Abstract 5058 - The CBA Provider Network: THE Source for Training and Technical Assistance in HIV Prevention Services

Author(s): Laurie Krom, Jacki Witt, Erin Hobbs, Adam Viera, Deena Murphy, Maria Alvarez, Patricia Patrick, Mari Brown

Background: The workforce employed by the nation's health departments (HDs), community-based organizations (CBOs), and healthcare organizations (HCOs), bears a heavy burden to provide HIV prevention services with limited resources. Community High-Impact Prevention (CHIP) brings focused attention to providing effective HIV prevention services to the populations disproportionately affected by HIV/AIDS. Research shows, however, that simply disseminating or spreading the word about innovative or effective prevention practices does not lead to their use in the field. Capacity building assistance (CBA), which is culturally and linguistically competent training, technical assistance, and information, is a key strategy for the promotion, delivery, and sustainability of CHIP. CBA assists HDs, CBOs, and HCOs in bridging the gap between knowledge and practice to implement CHIP. It is critical that the HIV prevention workforce knows and understands how CBA can support organizations in providing effective strategies to serve the populations with the highest needs.

Description of Program to Be Discussed: The CBA Provider Network (CPN) is comprised of 20 CBA Providers and a National Resource Center and is overseen by CDC's Capacity Building Branch's Partnerships Team. Collectively, the CPN increases the ability of HDs, CBOs and HCOs to provide effective HIV prevention services with a particular focus on the following CBA Components: HIV testing, condom distribution, prevention with HIV-positive persons and high-risk HIV negative persons, organizational development and management, and policy.

Summary of Panel Topics: The NHPC provides a unique opportunity to showcase the CPN, CDC's flagship program for high-impact HIV prevention CBA. The CPN Resource Center (CRC) will facilitate a panel presentation that will include three oral presentations -- one for each of the target audiences of the CBA Providers (HDs, CBOs, and HCOs). The CRC will frame the panel by opening with an overview of CPN-wide resources (e.g., CPN website and CBA Provider Directory) and closing with a focus on case studies that address how accessing CBA improved the ability of organizations to meet critical needs. The panel will be followed by an interactive question and answer session.

Significance of Presenting These as a Unified Panel: Every member of target populations for high-impact HIV prevention services lives in a community; the prevention track is blending with the treatment track and CBA can address this across the workforce; navigation services are becoming increasingly critical; and newly funded CBOs under CDC's 15-1502 award will be required to enhance existing and establish new collaborative partnerships with HIV medical care providers. The CPN is here to help in each of these areas, but in order to help, HDs, CBOs and HCOs need to know about the CPN and how to request CBA from CBA Providers. CDC has the ability to maximize the impact of the Agency's scarce resources by providing a forum to showcase the CPN through the NHPC.

Abstract 5075 - Capacity Building Assistance for Health Departments: Working with the Nation's Health Departments to Achieve Their HIV Care Continuum Goals

Author(s): Erin Hobbs

Issue: The Nation's health departments meet a critical need in achieving the goals set in the HIV Care Continuum. Providing funding to health departments has long been a central component of CDC's HIV prevention strategy, and is CDC's single largest investment in HIV prevention (CDC, 2012). In 2012, CDC continued this effort through the current HD funding mechanism, PS12-1201: Comprehensive Human Immunodeficiency Virus (HIV) Prevention Programs for Health Departments. However, even with this continued CDC funding and support of HIP services, health departments are under increasing demands to do more with less.

Setting: For decades, the Centers for Disease Control and Prevention's (CDC) Division of HIV/AIDS Prevention (DHAP) has funded a variety of organizations to provide capacity building assistance (CBA) services to health departments, healthcare organizations, or community-based organizations to support them in their HIV prevention efforts. They continued this priority with the 21 current organizations funded under PS14-1403.

Project: DHAP has funded CBA for state, tribal, local and territorial health departments (HDs) since the 1980s. Half of the current eight CBA providers in this CBA for HD Community of Practice (HD CoP) have previously received DHAP funding. This ongoing focus on CBA for HDs recognizes the critical role HDs play in the HIV care continuum.

There continues to be a high-demand for CBA for HDs services. A total of 947 CRIS requests were submitted in the first year of PS14-1403. Of those, 270, or 28.5%, were directed towards CBA for HDs. These requests covered six component areas: Prevention with HIV-Positive Persons, 95(35.2%); HIV Testing, 66(24.4%); Organizational Development and Management, 50(18.5%); Policy, 28(10.4%); Prevention with High-Risk HIV-Negative Persons, 24(8.9%); Condom Distribution, 7(2.6%).

Results: In the spring of 2015, the CPN's CBA for HDs undertook a collective strategic planning process. As a result, the CBA for HDs will leverage their expertise to strengthen the capacity of the HIV prevention workforce, capitalizing on their CBA strengths and building enhanced relationships between CBAs as a foundation for improved learning, collaboration and coordination to provide high quality services to HDs. In this way, CBA for HDs can proactively provide CBA that increases the effectiveness of HDs, thereby improving HD resiliency to fulfill their missions, to address issues of social justice, to build a continuous leadership pipeline, and to ensure HDs have the skills needed to be responsive to the dynamics of the health care and HIV prevention landscape.

Lessons Learned: CBA for HDs will focus on scalable activities that will have maximum impact, and effectively coordinate, communicate, and collaborate to promote our high quality CBA services. This will build increased awareness and trust within the HD network of how this the CPN can support HDs and meet their shared goals of effecting change and ending this epidemic.

The session will be part of a larger panel, followed by an interactive question and answer session. Throughout the Special Session the CRC will incorporate opportunities to encourage participants to visit the CBA Providers in the exhibit hall (at least fourteen CBA Providers will be exhibiting at this conference).

Abstract 5078 - Capacity Building Assistance for Community-Based Organizations: Working in Partnership to Support Organizations in Their HIV Prevention Efforts

Author(s): *Adam Viera*

Issue: High-Impact HIV Prevention (HIP) programs can address disparities and improve outcomes along each step of the HIV prevention and care continuum.

Many community-based organizations (CBOs) lack the capacity to successfully implement HIP. A 2015 report by the Black AIDS Institute found the HIV science and treatment knowledge base of the HIV prevention workforce to be surprisingly low while a 2013 report from Capacity for Health identified organizational barriers to implementing healthcare-related services, including lack of financial services (90%), lack of expertise (69%), concerns about sustainability (37.5%), and lack of human resources (37.5%). These results indicate significant gaps in individual and institutional capacity to support HIP implementation.

Setting: For decades, the CDC's Division of HIV/AIDS Prevention has funded organizations to provide capacity building assistance (CBA) services to support HIV prevention efforts. The 21 programs currently funded are all national in scope; eleven provide services to CBOs.

Project: CBOs remain the number one consumer of CDC's free CBA services. Of the 947 requests submitted in the first year, over half (565 or 59.7%) were from community-based organizations. These requests are categorized into five component areas: Organizational Development and Management, 244 requests, (43.2%); Prevention with HIV-Positive Persons, 153 requests (27.1%); HIV Testing, 82 requests (14.5%); Prevention with High-Risk HIV-Negative Persons, 79 requests (14.0%); Condom Distribution, 7 requests (1.2%).

Results: In the spring of 2015, the CPN's CBA for CBOs Community of Practice undertook a collective strategic planning process, identifying 10 strategic priorities:

1. Identify the social and structural issues impacting HIV services.
2. Identify CBO needs for implementing condom distribution as a structural intervention.
3. Identify CBO needs around third-party billing.
4. Identify systems to support PrEP in CBOs.
5. Identify strategies for CBOs to increase HIV case finding.
6. Identify CBO needs around the implementation and adaptation of ARTAS for linkage to care.
7. Identify resources needs related to patient navigation.
8. Build the capacity of CBA Providers to provide services around organizational development and management.
9. Expand services for transgender women.
10. Identify strategies to support organizational development and management in CBOs.

Lessons Learned: As a result, the CBA Providers serving CBOs will leverage their expertise to strengthen the capacity of the HIV prevention workforce, capitalizing on their CBA strengths and building enhanced relationships between CBAs as a foundation for improved learning, collaboration and coordination to provide high quality services to CBOs. In this way, CBA Providers working with CBOs can proactively provide CBA that increases the effectiveness of CBOs, thereby improving CBO sustainability to fulfill their

missions, to address issues of social justice, to build a continuous leadership pipeline, and to ensure CBOs have the skills needed to be responsive to the dynamics of the health care and HIV prevention landscape.

This session will be part of a larger panel, followed by an interactive question and answer session. Throughout the Special Session the National CBA Provider Network Resource Center will incorporate opportunities to encourage participants to visit the CBA Providers in the exhibit hall (at least fourteen CBA Providers will be exhibiting at this conference).

Abstract 5091 - “Capacity Building Assistance for Health Care Organizations: A Collaborative Effort to Support Organizations in Achieving Their HIV Prevention and Care Goals”

Author(s): *Deena Murphy*

Issue: High-impact HIV prevention (HIP) programs and the accompanying approaches that support and increase effectiveness and/or efficiency can assist with public health problems by addressing disparities and improving outcomes along each step of the HIV prevention and care continuum. Despite this, many healthcare organizations (HCOs) lack the capacity to successfully implement HIP. As HCOs struggle with the complexities in operationalizing the Affordable Care Act (ACA) and juggle multiple priorities (e.g. cancers, diabetes, smoking-related illnesses, and obesity), the task of implementing systems-level change in the HIV arena, such as universal HIV screening, culturally competent care for men having sex with men (MSM), integrating services in electronic medical records, and HIV linkage/retention/re-engagement programs, can be both difficult and daunting without assistance.

Setting: To better align the provision of CBA services and to support the public health priorities of increasing diagnosis of, and reducing transmission from, persons living with HIV, as well as reducing HIV transmission to persons at high-risk of infection, the CPN extends FREE assistance – in the form of training, consultation, facilitation of peer-to-peer mentoring, and information dissemination – to healthcare organizations (HCOs), health departments (HDs), and community-based organizations (CBOs).

Project: This is the first time the CDC Division of HIV/AIDS Prevention (DHAP) has funded CBA for healthcare organizations (HCOs). This increased attention to CBA need in HCOs is due to science-driven recognition of the importance of HIV prevention modalities in biomedical and healthcare settings. The use of post- and pre-exposure prophylaxis (PEP and PrEP), the implementation of routine HIV screening, and increased treatment retention and adherence have all demonstrated a significant impact on reducing HIV infections across the United States and its territories. This newly supported focus on CBA for HCOs recognizes the critical role HCOs play in the HIV care continuum.

As a newly funded category with three current HCO CBA Providers, awareness of free CBA services for HCOs is growing and HCO CRIS requests now represent 9% (85) of the 947 total requests submitted in the first year of funding. These requests are categorized into four component areas: Prevention with HIV-Positive Persons, 36 requests (42%); Prevention with High-Risk HIV-Negative Persons, 26 requests (31%); HIV Testing, 22 requests (26%); Perinatal HIV Prevention, 1 request (1%).

Results: In the spring of 2015, the CPN's CBA for HCOs Community of Practice undertook a collective strategic planning process and identified a total of 7 strategic priorities (SPs) that it plans to address with the larger CBA Provider Network (CPN). These SPs focus on working collaboratively to build the capacity of HCOs to engage in HIV prevention efforts and address: Social Determinants of Health, Condom Distribution as a Structural Intervention, Billing, PrEP, Universal HIV Testing, Engagement and Retention in Care, and Organizational Development and Management.

Lessons Learned: CBA Providers working with HCOs can proactively provide CBA that increases the effectiveness of HCOs, thereby improving HCO resiliency to fulfill their missions, to address issues of social justice, and to ensure HCOs have the skills needed to be responsive to the dynamics of the health care and HIV prevention landscape.

Track B

Session BR08 - High(er) Impact Prevention: Understanding the Impact of Social Determinants of Health

Room: Techwood (Hyatt Regency Atlanta)

Abstract 2325 - High(er) Impact Prevention: Understanding the Impact of Social Determinants of Health

Author(s): *Linda DeSantis, Tim Vincent, Alice Gandelman*

Issue: Despite many advances having been achieved in High Impact Prevention (HIP) with newer biomedical interventions, we are not adequately reducing health disparities, a goal outlined in the National HIV/AIDS strategy (NHAS). Health disparities are influenced by social determinants of health (SDH), the social, economic, political, or structural factors such as poverty, racism, stigma, homophobia and transphobia that often prevent those at greatest need from accessing and maintaining HIV prevention and care services. Increasing the understanding of SDH and the influence on HIV is necessary for assisting HIV prevention and care providers in addressing the broader factors that affect communities most impacted by HIV. Addressing these broader factors requires individual, social and structural changes.

Key Points: The Centers for Disease Control and Prevention (CDC) surveillance data indicate African Americans account for 44% of all new HIV infections yet only represent 12% of the US population. Data continues to inform us that AA continue to be at higher risk of acquiring HIV, less likely to know their status and therefore less likely to be linked to or retained in care. With the hopeful outcomes of biomedical interventions, the influence of SDH cannot be discounted. As evidenced in the newly released CDC RFA PS15 -1506,1509, and 1510 funding announcement series addressing disparities among men who have sex with men (MSM) of color, the larger factors are becoming a required focus nationally. The California Prevention Training Center (CA PTC) has been leading efforts in addressing the impact of SDH in HIV prevention via training and technical assistance. In recent years, we developed 2-day training titled: Social Determinants of Health and HIV: Expanding HIV Prevention. The facilitators will share best practices learned from participants and organizations regarding different levels and types of interventions needed to help decrease HIV disparities and begin to address SDH.

Implications: We can no longer ignore the larger social factors that influence risk and create barriers to prevention and care to those most impacted by HIV. Understanding and addressing these larger factors will ultimately improve engagement along the different stages of the prevention and care continuum and help decrease disparities. Addressing challenges associated with recruitment and retention efforts, linkage to and retention in care, can medication adherence often requires shifting the focus of prevention from an individual focus to the larger social determinants. If we are to achieve the third goal of NHAS we must begin with increasing provider awareness of the impact these factors have on

health outcomes and help to develop strategies to address SDH at all stages of the prevention and care continuum. We must strategize ways to internalize understanding at the provider level and operationalize the values at the organizational, community and societal levels.

Session BR09 - Linkage to Care Among A Sample of African American and Latina Women in Los Angeles: the Ladies of Diversity Project (LODi)

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1725 - Linkage to Care Among A Sample of African American and Latina Women in Los Angeles: the Ladies of Diversity Project (LODi)

Author(s): *Christopher Hucks-Ortiz, Krystal Griffith, Tina Henderson, Sandra Valdivia, Sergio Avina*

Issue: Homeless and fragilely housed individuals have been found to be disproportionately at risk for serious health consequences. Physical and mental chronic diseases run rampant among this vulnerable population because of difficulty navigating the health care system and misconceptions about their health vulnerabilities. Many mortality studies have shown that HIV/ AIDS is the leading cause of death among the homeless, particularly among homeless women. Among the new HIV cases experienced by U.S. women in 2011, 63% were Black/ African-Americans, and 17% were Hispanic/ Latina (U.S. Department of Health and Human Services, 2013). Therefore, being a homeless/marginally housed Black/African-American or Hispanic/Latina woman puts this population at a greater risk of contracting HIV/ AIDS.

Key Points: The Ladies of Diversity (LODi)/ Diversidad de Mujeres (DiMu) program was a HRSA/SPNS as part of the Women of Color initiative. The program's primary goal was to provide assertive case management, skill building, and network support to HIV- positive homeless or fragilely housed women of color who reside in Los Angeles. Women were eligible to participate in LODi/ DiMu if they were HIV- positive and identified as Black/ African- American or Hispanic/ Latina, new to care, in sporadic care, lost to care, in need of additional care or resources, and agreed to four in-person follow-up interviews after baseline at months 3, 6, 12, 18 respectively as part of the multi-site evaluation. An additional instrument was administered at each of these time-points and at 9 & 15 months post-enrollment as part of the local evaluation. During interviews, participants provided self-reported information on sexual and substance abuse risk behaviors, overall mental health, viral load, CD4 count, and adherence to HARRT. Specific services offered to participants included, but were not limited to; financial resources, housing assistance, mental health care, substance abuse treatment, childcare referrals, interpersonal relationships, support groups, HIV treatment/ education, volunteer referring opportunities, and mobile case management. A total of 140 women of color participated in the LODi/DiMu program throughout a five-year period (2009-2014) with 70% retained in the study and 81% retention in HIV care at 18 months post-enrollment.

Implications: Through the LODi/ DiMu program we hope to better understand the services that homeless and/or fragilely housed women of color are in need of to better ensure continuity of HIV care, including social support and peer navigation. By better understanding the necessary resources that these women need to maintain adequate health, we hope to provide accurate and specific

recommendations to service providers across the nation so that they too can replicate the LODi/ DiMu service model in their communities.

Track C

Session CR04 - Meet Me at the Intersection of Life & The Medical Home

Room: University (Hyatt Regency Atlanta)

Abstract 1464 - Meet Me at the Intersection of Life & The Medical Home

Author(s): *Maura Riordan, Monique Tula*

Issue: Data related to the HIV care continuum tells us that in the US, far too many people living with HIV are not connected and retained in care. This has significant implications for both individual health outcomes, as well as an increased risk of failing to prevent the infection of others. As treatment and prevention options have flourished in the US, we must examine why PLWH are not fully embracing them. In a time of waging a response to the US epidemic with a robust medical model, we are seeing that a pill alone will not get us to the end of the US epidemic. The intersectional nature of people's lives (race, poverty and gender) must be understood, and interventions must be adapted to that understanding if we are to truly change to trajectory of the care continuum.

Key Points: * We will explore what an intersectional framework for understanding success vs. failure to achieve good health outcomes for PLWH looks like.

* We will examine some community best practices in supporting PLWH to access and stay in care, and reduce their risk for transmission.

* We will discuss how this framework for developing support and interventions can be successful in a time when much of the HIV field has shifted toward a medical model of serving PLWH.

Implications: Understanding how intersecting realities of race, poverty and gender impact individual decision-making around initiating and staying on treatment can lead to the development and implementation of support and intervention models that do a better job of addressing the competing needs of PLWH in the US.

Session CR13 - Providing Practical Information for Teens, Parents, Teachers and Clinicians Regarding the Use of PrEP and nPEP for Teenagers at High Risk of HIV Infection

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 2124 - Providing Practical Information for Teens, Parents, Teachers and Clinicians Regarding the Use of PrEP and nPEP for Teenagers at High Risk of HIV Infection

Author(s): *Lisa Barrios, Stephanie Zaza, Leah Robin*

Issue: HIV incidence is increasing among young (13-24) year old men who have sex with men (YMSM), especially Black/African American MSM. This is despite the fact that Black/African American MSM are more likely to use condoms and have fewer sex partners than white or Latino MSM. A new HIV prevention technology – pre-exposure prophylaxis (PrEP) – offers the potential to substantially reduce transmission among YMSM minors, especially those in high prevalence sexual networks. Current CDC clinical guidelines regarding the use of PrEP include consideration for adolescents, however FDA approval of PrEP medications is currently only for adults. Additionally, non-occupational post-exposure prophylaxis (nPEP) has had modest uptake in the past decade in which it has been recommended by the Department of Health and Human Services. Anticipating FDA approval for use of PrEP among adolescents in the future, CDC is beginning to consider how to develop practical forms of information materials for teenagers, parents, teachers, and clinicians regarding the potential use of PrEP and nPEP for high risk teens.

Key Points: If PrEP is approved for adolescents, consideration by clinicians and uptake among adolescents, even those who are at greatest risk of HIV infection, is expected to be initially low as it is with nPEP. Current clinical guidelines for assessing risk, counseling patients, prescribing PrEP and monitoring its use are complicated. The facilitators will summarize the current guidelines and lead a discussion about 1) issues that might affect adolescents' use of PrEP and nPEP that differ from those of adults (e.g., access, confidentiality, payment, or adherence); and 2) how the context of adolescents' use would affect the content of information materials for teens, parents, teachers, and clinicians about PrEP and nPEP.

Implications: PrEP and nPEP offer a unique primary prevention opportunity for high risk adolescents. Identifying and addressing key issues that will foster uptake and continued use of PrEP and nPEP will be critical to their effectiveness as prevention options in this population.

Session CR15 - Utilization of Process Improvement Methodologies in the HIV Continuum: Mapping for Linkage-to-Care and Support Services Quality and Results

Room: Spring (Hyatt Regency Atlanta)

Abstract 1684 - Utilization of Process Improvement Methodologies in the HIV Continuum: Mapping for Linkage-to-Care and Support Services Quality and Results

Author(s): *Jeff Blanchard, Gisele Pemberton*

Issue: The process of linking clients to HIV care and treatment is paramount in the HIV Care Continuum. Recent studies have shown that only 72 % of those with positive HIV test results have been linked to care within a four (4) month period and only an estimated 19% of HIV infected individuals are retained long enough to engage in the full spectrum of the HIV Treatment Cascade to achieve undetectable viral load suppression through ART (Antiretroviral Therapy). Many newly diagnosed HIV positive individuals have difficulty making it through the early stages of the treatment cascade including initial linkage to care. There are several factors that could impact linkage-to-care including: poorly constructed linkage models, inefficient linkage processes, poorly constructed medical service agreements and lack of adherence to linkage protocols. These factors can have a negative affect on patient outcomes. To address inefficiencies, utilization of process improvement methodologies can facilitate a systematic

analysis of linkage-to care systems. The effective application of tools and techniques, including process mapping can bring critical awareness to the strengths and weaknesses of a linkage model and lead to informed decisions on improvement.

Key Points: In a case study of newly installed HIV testing and linkage-to-care services for adolescents and young adults at Children’s National Medical Center, Washington, DC, process mapping was utilized to assess strengths and weaknesses in the linkage to care model to identify opportunities for improvement. A capacity building intervention was facilitated to assist Children's with installing a new HIV testing and linkage to care program. After testing activities commenced and an HIV positive person was identified, a process analysis was conducted to look at variables and effectiveness of the Linkage to Care protocol. In building organizational capacity to improve outcomes in the Linkage-to-Care component of the HIV Treatment Cascade, Process Mapping and other diagnostic methodologies can be used to identify opportunities for improvement. Process Mapping is a method of visual analysis of a linkage to care model and provides a pictorial reference to the coordination of collaborative partnership in the HIV Care Continuum. The Mapping process facilitates a systematic review of personnel, procedures, tasks, metrics, quality, standards and regulations.

Implications: Linkage-to-Care process assessment and improvement can have a far reaching affect in linkage and retention in HIV treatment. The implementation of Process Improvement initiatives can have an impact on closing the gap between those who drop out of care and those few who reach viral suppression. Process improvement strategies can help address delay in engaging in treatment, can affect quality of service, effectiveness of referral processes and partnerships for support services. For example, if housing can be assessed and achieved early in the linkage timeline, it may help the client focus on treatment. Providers can adopt and utilize process improvement methodologies like process mapping to visually identify processes, process groups, tasks and service integration entry points for systematic analysis. Improving the Linkage-to-Care process and support services can help clients move further down the Treatment Cascade, improve client outcomes, increase community viral suppression and reduce HIV transmission.

Session CR17 - The START Intervention and Its Role in Linking HIV+ Currently Incarcerated Individuals to Care

Room: Edgewood (Hyatt Regency Atlanta)

Abstract 1231 - The START Intervention and Its Role in Linking HIV+ Currently Incarcerated Individuals to Care

Author(s): *Nadia Molina*

Issue: In many cases individuals are released from a correctional facility with only a 10 day supply of medication, few resources, and little or no community support. They may engage in behaviors which increase their risk of acquiring or transmitting sexually transmitted infections and/or HIV. In addition, for most people being released from prison, health is not a priority. They are more concerned with finding housing, food, clothing, and meeting other more immediate needs. Depending on their history of substance use or prostitution, they may return to previous behaviors that led them to become

incarcerated. The START intervention focuses on addressing these high risk behaviors as well as linkage to care and services.

Key Points: According to the Texas Department of Criminal Justice Office of Public Health, as of February 2015 there are 2155 individuals with HIV/AIDS in the Texas Department of Criminal Justice (TDCJ) prison system and of these an average of 116 are released each month. Additionally, 221 offenders with HIV/AIDS enter the TDCJ system each month and an average of 32 new cases are diagnosed in the same period. The START intervention provides client centered education and counseling for people being released from a correctional facility to help them identify their risks, barriers to care and concerns about re-entering the community, and to develop a plan of action. A staff member meets with soon to be released HIV+ individuals approximately 30 days prior to release to discuss health, risk reduction and transitional needs. The staff member then connects with the client within 48 hours of release to continue working on risk reduction and linkage to care and resources. The round table facilitator will delve further into program details, discuss both successes and challenges, and lead a discussion on how the soon to be released and re-entry community can be better served. Free World Bound Plus (FWB+), a program of AIDS Arms, Inc. has provided the START intervention to incarcerated HIV+ individuals for 5 years. Because of the teams' relationship with TDCJ we have been able to access 25 different prisons and state jails within a 330 mile radius of Dallas, TX.

Implications: By connecting with HIV+ individuals while they are still incarcerated, staff is able to build a rapport and stronger relationship with potential clients thus making it easier to connect with them upon their release. When clients are engaged in the intervention, access to medical care, psychosocial and other support services and/or educational activities is facilitated, and engagement and retention is more likely. The FWB+ teams' relationship with the client, the prison system, and community partners has resulted in a retention rate of over 70% during the first 4 years of our program for clients released from prison.

Session CR19 - Peer Navigators in the Ryan White HIV/AIDS Program: Models, Successes and Challenges

Room: Lenox (Hyatt Regency Atlanta)

Abstract 1697 - Peer Navigators in the Ryan White HIV/AIDS Program: Models, Successes and Challenges

Author(s): *Rupali Doshi, Amelia Khalil, Tracey Gantt*

Issue: The purpose of this roundtable is to examine implementation models where HIV-infected peer navigators have become part of HIV care teams.

Key Points: Patient Navigators serve as a critical link in the health care service delivery system between prevention and care providers and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Navigators can increase the effectiveness of treatment and care and, in some instances, avert or circumvent potential obstacles. Lay health care workers have been used in a variety of capacities for chronic diseases, maternal-child health and infectious diseases, and they may provide a wide range of activities such as outreach, community education, counseling, support and advocacy. The use of patient navigation has been most prominent in

cancer screening, care and treatment programs, and race and language concordance has been found to result in improved outcomes.

Peer navigators are specially trained individuals with common personal experiences that are shared with patients and clients. They are able to leverage shared experience to foster trust, decrease stigma and create a sustainable forum for seeking help and sharing information about support resources and positive coping strategies. Through their roles, peer navigators build individual and community capacity by increasing health knowledge and self-sufficiency. Given some similarities between cancer and HIV (severity and complexity of illness, multiple medical tests that need to be done, side effects and complexity of treatment, and history of stigma associated with the disease), it has been postulated that HIV peer navigators could be used to strengthen HIV outcomes. However, the evidence base for HIV peer navigation programs has been limited, so programmatic experiences are needed to understand the models, successes and challenges to implementation.

Peer navigators could help to improve the health outcomes of people living with HIV. People living with HIV, which is a chronic infectious disease, may potentially benefit from involvement of peer navigators in their health care, in order to improve retention in care and viral load suppression.

This roundtable will describe a variety of models of implementation of peer navigators in Ryan White HIV/AIDS Program (RWHAP) funded health care settings, funding mechanisms, successes and challenges. Discussion leaders will examine the successes, including clinical and non-clinical outcomes, as well as challenges, such as training, certification, human resources development, and patient confidentiality. The discussion will also include preliminary experiences of navigators in the context of the Affordable Care Act. The discussion will be led by 3 authors who have overseen the implementation of peer navigation programs in RWHAP-funded programs, and they will be supported by representatives from the health care organizations that have implemented peer navigator programs. Audience members may participate by asking questions or sharing their experiences with peer navigation programs.

Implications: Audience members will have a unique opportunity to learn about peer navigation implementation, successes and challenges in the Ryan White HIV/AIDS Program, in order to enhance their efforts to improve retention in care and viral load suppression among people living with HIV.

Session CR20 - Utilizing a Community Agency's Non-Traditional Outreach Approach to Help You Stay Relevant in Changing Times and Effectively Recruit Latino MSM for High Impact Prevention Activities
Room: Kennesaw (Hyatt Regency Atlanta)

Abstract 1711 - Utilizing a Community Agency's Non-Traditional Outreach Approach to Help You Stay Relevant in Changing Times and Effectively Recruit Latino MSM for High Impact Prevention Activities
Author(s): *Tony Iniguez, Joaquin Gutierrez*

Issue: Over 65% of the 3,000 Latino men that tested negative for HIV through AltaMed's testing initiatives reported not practicing safer sex within the last twelve months. With the ever-changing landscape in HIV Prevention, a community assessment using real-time interviews with Latino community members, families, and providers were used to help determine the relevancy and utilization of High impact prevention methods. This led to greater insight on the beliefs,

understanding, and disconnect between community knowledge and practices around sex. AltaMed will share information on real-world challenges that lead to disconnect between knowledge and the Latino community sexual practices. AltaMed will share video documentation and insight from the community dialogue that can be used to help shape accurate, and on trend methods to be utilized for safe sex education within Latino MSM communities. AltaMed's new outreach approaches include street-based outreach, online, social media, and community events.

Key Points: AltaMed Health Services Corporation, the largest Latino HIV Provider in Southern California, has been providing HIV outreach and prevention services for over 20 years. As time has progressed, AltaMed has had to evolve their outreach approaches keeping pace with environmental and sociological changes and community trends. Although outreach strategies and approaches have changed, the main elements of human connection and empowerment have remained central to AltaMed's outreach team. AltaMed's outreach team will share their best practices for engaging Latino MSM into High Impact prevention services and provide a framework for developing and creating your own outreach plan.

Implications: The development of culturally competent and innovative forums that arose from this community assessment have helped address cultural and peer norms in Latino MSM communities and identify appropriate messaging and relevant tools for dealing with real life issues. Lessons learned from this process include how community engagement, rapport, and innovation are essential in creating a successful and strategic outreach plan and its effective implementation. Meeting clients where they are at, having a team of devoted and engaging Outreach workers, and staying up-to-date with community trends were key components of becoming a significant, trusted and innovative HIV organization in Los Angeles County.

Session CR22 - Core Competencies for Providing High Impact Services – Are You Ready to Deliver?

Room: Inman (Hyatt Regency Atlanta)

Abstract 2431 - Core Competencies for Providing High Impact Services – Are you ready to deliver?

Author(s): *Miguel Bujanda, Oscar Marquez*

Issue: Working with High Impact Prevention (HIP) programs such as Linkage to Care, Navigation services, and HIV testing, organizations must be capable of engaging clients and building strong relationships with them to provide effective services. Providers must continually work on their one-on-one skills to effectively engage clients into care; a challenge many are facing. Agencies have tried to address this gap in skills by requesting "Motivational Interviewing" (MI), an intervention to address a client's ambivalence. The techniques presented in MI are valuable, but they do not address all the competencies needed by a provider to appropriately engage a client in services. Furthermore, MI does not allow the skills building practice to address these other competencies, including; cultural proficiency, developing rapport between clients and providers, identifying barriers that prevent clients from engaging in services, and creating action plans to address barriers. In order to enhance the implementation of HIP, the HIV field needs more options (skills building trainings) to build the competencies of individual level service providers.

Key Points: Many organizations have depended on Motivational Interviewing (MI) trainings to help increase their staff's skills for providing individual level services. While MI is highly effective in some contexts such as mental health service, it does not always address all the components that can affect a client's engagement in HIV services. In 2014, AIDS Project Los Angeles (APLA) developed an interactive, skills-building training to increase the capacity of service providers who work individually with clients. The One-on-One Core Competencies training was designed to address cultural proficiency, creating rapport between client and the provider, identifying barriers for engaging in services and a plan of action to address those barriers.

Implications: APLA will provide an interactive and participatory workshop to review its innovative One-on-One Core Competencies training and skills building activities that address the four core competencies: Cultural Proficiency, Relationship Building, Client Readiness and Goal Setting. With these additional skills building activities, they will enhance a provider's ability to effectively engage a client. In addition to reviewing the curriculum, APLA will provide examples of how these core competencies skills building activities can benefit a program's capacity to provide enhanced HIV testing and care services (HIP programs) and increase providers' self-efficacy in providing individual level services.

Track D

Session DR16 - So You Want a New Website? From RFP to Launch: What You Need to Know

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1802 - So You Want a New Website? From RFP to Launch: What You Need to Know

Author(s): *Michelle Samplin-Salgado, Jennie Anderson, Meico Whitlock*

Issue: Websites have become an essential part of nearly every HIV organization's strategy to reach and engage their audiences from nonprofits to government agencies to businesses. Your website makes helps your organization be visible and accessible to your audience and is a key tool for sharing knowledge and information. Even with the rising using of social media such as Facebook and Twitter, websites are are a mainstay and can be a way to connect and engage people to social media and other communications platforms.

Key Points: To further the work of our HIV prevention work, in the last year, AIDS.gov, Kaiser Family Foundation's (KFF) Greater than AIDS, and the National Association of State and Territorial AIDS Directors (NASTAD) have each embarked on redesigning their websites. It's vital to include online communication as a key part of an HIV health communications strategy.

Specifically, we need to design websites and online communications that reach our audiences anytime, anywhere, wherever they are. This requires knowing who our audiences are (their information needs, how they are accessing/using our websites), creating a website with a mobile first mentality, and creating content that is timely, relevant, and easy-to-navigate, including topics such as the newest HIV prevention tools available such as PrEP and treatment as prevention. Successful websites have engaging content that includes images and videos of real people with real stories, multiple access points and integrate with social media (both connecting people to our own social platforms and enabling people to

share content on their own social platforms), website, and other communication channels, and involve thoughtful and thorough website planning, project management, maintenance, and monitoring and evaluation.

Metrics and analytics pulled from website traffic combined with an evaluation of website user interactions through usability testing are foundational elements to creating a website that meets user needs. With tools like Google Analytics, we can capture thousands of data points regarding the interactions that take place on our digital properties – websites, social media channels, email, and other digital tools.

Implications: During this roundtable discussion, AIDS.gov, Kaiser Family Foundation’s Greater than AIDS, and NASTAD will talk about what we have looked for on our websites, beyond the numbers, to determine and capture user intent, test new ways of connecting users to critical health information, and build newly redesigned websites that capitalizes on these insights.

By sharing the range of experiences from AIDS.gov, Greater than AIDS, and NASTAD, HIV organizations will have a better understanding of how to conceptualize, execute, and implement a web redesign/modification that furthers their HIV prevention efforts.

Session DR18 - A Systematic Evaluation of Barriers to the Implementation of Widespread nPEP and PrEP Provision in Jacksonville, Florida

Room: Baker (Hyatt Regency Atlanta)

Abstract 2038 - A Systematic Evaluation of Barriers to the Implementation of Widespread nPEP and PrEP Provision in Jacksonville, Florida

Author(s): *Treva Davis, Irfran Kakezai, Maximillion Wilson, Aja Arrindell, Wideline Julien*

Issue: Florida is heavily impacted by HIV/AIDS, ranking second in the U.S. in new HIV infections and third in new AIDS cases. There are over 125,000 HIV-infected Floridians and almost 3,500 new infections per year. Of the Floridian’s living with HIV infection, 105,627 (84%) of them were diagnosed and of those, 85,051 (81%) were linked to care but only 66,868 (63%) were retained in care over time. Of those persons diagnosed with HIV, 61,986 (59%) were on antiretroviral treatment, and only 47,171 (45%) achieved viral suppression. Despite many recent journal publications and guidance from federal agencies (such as the Centers for Disease Control and Prevention), the provision of nPEP (Non-occupational Post Exposure) and PrEP (Pre-exposure) services to this large population of need remains very limited. Fifty providers/hospitals in Jacksonville, FL were surveyed to determine the level of PrEP and nPEP services at their facilities. Of the providers surveyed, only 2 are currently providing PrEP and nPEP services. There are a few providers that are only providing emergency services.

Key Points: Jacksonville, FL, a metropolitan city in Duval County located in the South, continues to experience high numbers of persons newly diagnosed with HIV in the urban core of the city. Annually, approximately 300 people are newly diagnosed with HIV. In addition, the diagnosis rate for HIV infection in the target area has steadily increased in the past five years, going from 33.7 in 2010 to 39.3 in 2014. Duval County is currently ranked in the top 7 counties within the state that have seen an increase in

newly diagnosed HIV infection cases from 2012 to 2014. This population is primarily Black or Hispanic, poor, and do not have access to medical insurance to pay for care. Additionally, they often suffer from co-morbidities including mental health issues, chronic illnesses such as hypertension and diabetes, and substance abuse. Consequently, this population does not access primary care on a regular, planned basis which results in poor health outcomes. In Jacksonville, 1875 HIV/AIDS positive persons, or 35% of those diagnosed, do not receive HIV specialty care. Some have been in the HIV healthcare system but have fallen out of care. Others will not come in for services, or wish to receive medical services in private primary care sites. Lastly, there are still many that have not been identified as HIV positive.

Project: This existing project intends to build on earlier findings and through a systematic survey of barriers to implementation of widespread nPEP and PrEP provision. A probability sample of providers will be interviewed to determine their willingness/readiness to implement PrEP and nPEP services.

Results: Results illustrate the patterns of readiness for change for Jacksonville providers. Barriers to change will also be explored. Variation in patterns of readiness among providers will be described.

Lessons Learned: Project lessons will be used to develop a regional nPEP and PrEP implementation plan, including provider trainings, marketing and other resources.

Session DR20 - The U.S. Virgin Islands: Will Stigma, Silence, and Working in Silos = the Death of Us in the Era of High Impact HIV Prevention?

Room: Marietta (Hyatt Regency Atlanta)

Abstract 2050 - The U.S. Virgin Islands: Will Stigma, Silence, and Working in Silos = the Death of us in the Era of High Impact HIV Prevention?

Author(s): *Gisele Pemberton, Ivy Moses*

Issue: The U.S. Virgin Islands (USVI) continues to face unique cultural, resource, and geographical challenges in its scale-up of high impact HIV prevention. With HIV testing and diagnosis, linkage and engagement in care, HIV treatment, adherence support, and viral suppression serving as the new benchmarks of HIV prevention success, HIV-related stigma and homophobia continue to threaten the territory's ability to build cross-sector partnerships and maximize the scope, reach, and impact of local HIV prevention efforts. HOPE Inc., a local health, medical and social service organization, has been on the forefront of the HIV/AIDS epidemic in the USVI since 2000, and has led the charge on anti-stigma efforts. In collaboration with PROCEED Inc., a U.S. based Centers for Disease Control and Prevention (CDC)-funded Capacity Building Assistance (CBA) Provider that has worked in the territory since 2001, the two initiate a frank dialogue about the impact of HIV-related stigma and homophobia on local HIV prevention efforts, and discuss strategies and action steps for advancing an agenda to address HIV-related stigma and homophobia in the USVI at the structural and community levels.

Key Points: HIV-related stigma and homophobia present barriers to HIV testing, medical care utilization, treatment initiation, adherence and retention in care in the USVI. A culture of silence, secrecy and shame surrounds an HIV diagnosis and disease management. The "brother's keeper" philosophy and community-centered values and that define island life and are regarded as "protective factors" for

health and social connectedness, simultaneously raises issues of confidentiality, access, and service utilization when considered in the context of the HIV prevention and care continuum. As such, value clarification in anti-stigma campaigns requires closer analysis and consideration.

Men who have sex with men (MSM) and gay men remain largely invisible in the local HIV/AIDS response. Concerns about backlash, stigma, and assumption about HIV status have caused many MSM and gay men to remain on the periphery of HIV prevention efforts; yet, gay men remain a "priority population" for HIV prevention. For persons living with HIV (PLWH), concerns about confidentiality, disclosure and care management have kept individuals from seeking and accessing care in a timely manner or remaining in care. In the USVI, PLWH often choose to wait until s/he is able to travel off-island before accessing care due to HIV-related stigma.

Implications: This roundtable "breaks the silence" and begins a process of acknowledging and addressing the deleterious impact of HIV-related stigma and homophobia on high impact HIV prevention efforts in the USVI. Conversation points will:

Examine Current Initiatives: Local efforts to address HIV-related stigma through social media, marketing campaigns, and radio "operas" that are culturally and linguistically appropriate will be discussed and input sought.

Present Exploratory Research: Findings from focus groups with local men who have sex with men (MSM) will be discussed to identify best strategies for and engaging this vulnerable group.

Plan for the Future: Explore structural and community level strategies to address stigma and homophobia in the USVI, and facilitate cross-sector collaboration and coordination of anti-stigma/homophobia efforts.

Session DR22 - Mental Health, HIV/AIDS, and the Continuum of Care: What are the Workforce Training Needs and Models for Cross-Disciplinary Collaborations?

Room: Roswell (Hyatt Regency Atlanta)

Abstract 2342 - Mental Health, HIV/AIDS, and the Continuum of Care: What are the Workforce Training Needs and Models for Cross-Disciplinary Collaborations?

Author(s): *Evelyn Tomaszewski, Erin Smith*

Issue: Increasingly, with effective treatment regimens and care management, HIV infection has become a chronic disease. More than 1.1 million people in the United States are living with HIV infection and many will live with the infection for decades. (CDC) Yet having HIV continues to present a host of biological, psychological and social challenges; often exacerbated by co-occurring mental disorders and addictions and the challenges of medication adherence. Changes in treatment protocols, prevention strategies, and movement towards holistic HIV/AIDS care management has served to highlight the critical need for a skilled workforce--psychologists, social workers, psychiatrists, substance abuse counselors and other front-line providers. Over the next decade, the combined forces of these providers will contribute to reshaping how mental and behavioral health services are delivered. Through

their participation in integrated care systems, mental health and behavioral health providers can reach and effectively serve the most vulnerable populations, including those with serious mental and substance use disorders. (NHAS,HRSA) Provider engagement must include providing care to those who are already know their HIV status, as well as ensuring that at-risk populations served in mental health services are encouraged to get tested, know their status and benefit from both prophylactic and treatments now available.

The mental health and behavioral health workforce has an essential role to play in creating the safe and affirming settings in which those who are coping with and at risk for HIV/AIDS and mental health and substance use disorders can access culturally-relevant mental health and behavioral health services.

Key Points: In 2014, a needs and gaps assessment was implemented by the Substance Abuse Mental Health Services Administration (SAMHSA), HIV/AIDS & Mental Health Training Resource Center. The findings will be highlighted, with reference to training evaluations from the previously funded HIV Mental Health Training Programs implanted by Resource Center partners: the American Psychological Association, the American Psychiatric Foundation, and the National Association of Social Workers. Roundtable participants will be asked to discuss these findings, and help identify building blocks for a cross-disciplinary HIV mental health collaboration that will support and enhance the goals of the National HIV/AIDS Strategy,

Key points include the workforce need for:

Implications: The goal of the SAMHSA's HIV/AIDS & Mental Health Training Resource Center is to: expand the knowledge and capacity of mental health care providers, particularly social work, psychology, psychiatry, and other direct care providers, to address the mental health and psychosocial needs of consumers impacted and affected by HIV.

In light of this goal, findings from the needs and gaps assessment suggest that there exists great opportunity to better prepare the mental health and behavioral health workforce to effectively meet the service needs of persons living with HIV or AIDS. This discussion will help to guide the Center toward developing new and innovative training materials and delivery systems for the workforce.

Session DR23 - Utilizing New Media & NASTAD's The R.A.W. Web-series as a Guide, Curriculum & Pathway to Meaningful Engagement for Black gay men/MSM

Room: Piedmont (Hyatt Regency Atlanta)

Abstract 2505 - Utilizing New Media & NASTAD's The R.A.W. Web-series as a Guide, Curriculum & Pathway to Meaningful Engagement for Black gay men/MSM

Author(s): *Justin Rush, Blake Rowley, Omoro Omoighe*

Issue: Black men who have sex with men (MSM) are disproportionately affected by HIV across all stages of the continuum of care. In an effort to gain a better understanding of how to leverage the internet and mobile technology to reach and engage Black gay men/MSM and other MSM around national health policy, advocacy and health promotion, the National Black gay Men's Advocacy Coalition (NBGMAC) constructed a Black MSM communications survey from March 2013 – June 2013. The findings of this survey provides the foundation for the concept of utilizing new media to engage Black gay men/MSM. NBGMAC discovered the following through their survey: 1) Black MSM are heavy utilizers of social media

(e.g., Facebook and Twitter. 2) Advocacy, policy and health information is primarily accessed by Black gay men/MSM through social networking venues. Due to these findings NASTAD has developed a series of web-based videos designed to increase health literacy, fill knowledge gaps, and offer diverse perspectives myriad challenges Black gay men/MSM face when navigating the healthcare landscape.

Key Points: The Center for Engaging Black MSM Across the Care Continuum (CEBACC), a health initiative funded by the Health Resources Services Administration, is an online resource center designed to address the health needs of Black MSM through trainings, knowledge transfer and dissemination of best practices for engagement into quality healthcare. NASTAD will leverage CEBACC to implement innovative communications and outreach strategies that strengthen Black gay men's ability to successfully navigate through the HIV care continuum. One such feature includes, R.A.W. (Real Authentic Words), a web-series that will serve as a vehicle for disseminating health and policy information as it pertains to Black gay men/MSM. The primary audience for The R.A.W includes Black gay men/MSM, with a target age of 18-34. Within the primary audience of Black gay men resides two groups; "connected" – individuals who currently navigate the healthcare delivery system with some fluency and possess a support network - and "disconnected" individuals, who lack a network of Black gay men/MSM and do not currently engage the healthcare delivery system at all. The R.A.W. includes key concepts from the Ecological Systems Theory, which identifies and organizes the environmental (health) systems which an individual (Black gay men) interacts. Institutions that immediately and directly impact the individual's development refers to the microsystem (providers). Interconnections between the microsystems comprises the mesosystem (health departments). The exosystem involves links between State, city and local health officials and the macrosystem describes the culture in which individuals live (the larger Black community). These are the groups, which comprises the primary and secondary audiences for the series.

Implications: The round table is a unique opportunity to provide additional support for health departments and other healthcare delivery professionals to ensure the constant construction of innovative modalities to disseminate pertinent health and policy information Black gay men/MSM, closing the information gaps that exists. The workshop will provide participants with an opportunity to engage health departments on how to create innovative outreach and engagement models for Black & Latino gay men/MSM.

Session DR24 - Jurisdictional HIV Planning and Meaningful Stakeholder Engagement: No One-Size-Fits-All

Room: Greenbriar (Hyatt Regency Atlanta)

Abstract 1978 - Jurisdictional HIV Planning and Meaningful Stakeholder Engagement: No One-Size-Fits-All

Author(s): *S Rivera, D Varsovczky*

Issue: HIV planning, through the Centers for Disease Control and Prevention (CDC) flagship health department funding process, remains an essential and critical component of developing, implementing, and monitoring local HIV prevention programs nationally. The process, through which health departments work in partnership with the community, ensures that programs are aligned with the goals

of the National HIV/AIDS Strategy (NHAS) while also engaging populations at greatest risk for HIV infection, are evidence-based, cost-effective and scalable.

As mandated in the CDC's 2012 HIV Planning Guidance, identification and engagement of community stakeholders are key steps in the planning process. Meaningful, results-oriented stakeholder engagement is defined in the Guidance as a "...collaborative and coordinated process that results in the seamless access to HIV prevention, care, and treatment services, for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities." Challenges in identifying, recruiting and continuously engaging key stakeholders have been recognized by many HIV planning groups. To address this challenge the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) has developed a peer-to-peer approach to support jurisdictions in HIV planning and has specifically supported activities that foster and strengthen meaningful stakeholder engagement throughout the planning process.

Key Points: Utilizing its unique government-community partnership and peer-to-peer learning model, UCHAPS has supported HIV planning in jurisdictions directly funded by CDC for HIV prevention since its founding in 1998. UCHAPS has and continues to strengthen HIV planning and stakeholder engagement in urban jurisdictions by utilizing in-person meetings, individualized technical assistance, development and dissemination of successful models and technology transfer. Specifically, health department HIV Program and HIV Planning Group (HPG) leadership work collaboratively to ensure that the local HIV planning process represents the diversity of HIV-infected populations and other key stakeholders in HIV prevention, care and related services as stated in the Guidance. Within the UCHAPS jurisdictions, HIV planning models differ in terms of the scope of integrated/collaborative planning; population and ex-officio representation; member and stakeholder roles; leadership structure; and meeting schedules and structure, based on local need and context. The roundtable facilitators will review various models employed by HPGs in UCHAPS member jurisdictions, provide rationale for their implementation and facilitate a peer-led discussion focused on strengthening stakeholder engagement by employing specific models and structures.

Implications: Meaningful key stakeholder engagement in the HIV planning process must remain a priority for jurisdictions in the current changing environment. Utilizing the peer-to-peer learning model, sharing experiences around successful and transferable activities will continue to strengthen HPGs and ensure their function serves to strengthen the local HIV prevention response. Roundtable participants will have an opportunity to engage with health department and community HIV planning leadership from urban jurisdictions that have seen declines in new HIV infections among key populations and learn about key activities around stakeholder engagement that have lead to progress in decreasing new HIV infections.

Track E

Session ER05 - Access to Sterile Syringes – Challenges and Solutions

Room: Fairlie (Hyatt Regency Atlanta)

Abstract 2378 - Access to Sterile Syringes – Challenges and Solutions

Author(s): *Alessandra Ross, William McColl, Robert Childs, Beth Meyerson, Dan Bigg*

Issue: Injection drug use appears to be on the rise in many U.S. states. Increases in hepatitis C among young injectors have been documented in several states and a cluster of new injection-related HIV infections in Southern Indiana has drawn national attention. The ongoing ban on the use of federal funds for syringe exchange, coupled with poor local availability of medication-assisted therapy and other evidence-based substance use disorder treatment, present enormous challenges for people who inject opiates and other people at risk for HIV through shared injection equipment. At the same time that these longstanding challenges remain, options for expanding syringe access do exist, including collaboration with partners such as pharmacies and law enforcement to influence the risk environment in which people live, work and use drugs.

Key Points: Cross-sector collaborations can help improve access to sterile syringes in states and counties that have not authorized syringe exchange and are unlikely to do so. Nonprescription sale of syringes in pharmacies has been documented to reduce risk of sharing injection equipment among people who use injection drugs (PWID), and is legal in almost every state. Alliances between public health agencies and pharmacies can significantly improve syringe access, and pharmacist education about the role pharmacies can play in HIV prevention may be conducted with federal funds. Similarly, cross-sector work on opiate overdose can bring harm reduction and HIV prevention organizations to the table with law enforcement and change the relationship between law enforcement and drug users with whom they may have contact. The roundtable will also review the potential contribution of syringe prescription by medical personnel to lessen disease spread. This roundtable will present examples of reforming current law enforcement practice through training and working with law enforcement leaders, as well as a discussion of partial syringe decriminalization laws, 911 Good Samaritan and naloxone laws that have opened legislators' minds on syringe access and harm reduction along with legal developments in the South and Midwest. Group discussion will center on what HIV prevention providers may do to protect and improve the health of PWID in states where legal and cultural barriers to such an approach remain high.

Implications: In many counties and states, syringe exchange seems unlikely to be established even if funding were to become available. However, syringe exchange is just one way of improving the health of PWID. Continuing to focus on only one avenue – syringe exchange – may lead to inaction, or to activities that have little evidence of effectiveness in improving and protecting the health of PWID. The ban on the use of federal funds for syringe exchange often causes local and state officials to also maintain a ban on state and local funding and to deemphasize syringe access services for prevention. This roundtable will present examples of structural interventions that improve drug user health that can be scaled up and implemented with a relatively small financial investment.

Track A

Session A05 - Youth + Intimate Partner Violence + Sexual Risk Behaviors = Need for Strengthened HIV Prevention Efforts

Room: Baker (Hyatt Regency Atlanta)

Abstract 1367 - Influence of Race and Gender on Sexual Initiation in High School Students in the Southern States of the United States

Author(s): *Malendie Gaines, Megan Quinn, Liang Wang, Charlotte Powers*

Background: Human Immunodeficiency Virus (HIV) incidence rates are highest in the southern states of the United States (US) with adolescents residing in the southern states as one of the most highly affected groups in the country. Shown to increase risk of HIV infection, the prevalence of early sexual initiation is especially high in minority adolescents potentially contributing to racial disparities in HIV infection in the US. In addition, white and minority males are at an increased risk for early sexual initiation compared to their female counterparts, illustrating gender differences in this behavior. The objective of this study was to evaluate self-reported data from US high school students in the southern states on gender and racial disparities in sexual initiation.

Methods: Weighted data were obtained from the 2011 and 2013 National Youth Risk Behavior Survey (N=93,544). Early sexual initiation was defined as an individual engaging in sexual intercourse for the first time before the age of 13. Multiple logistic regression was used to examine the influence of race and gender on early sexual initiation among southern high school students after controlling for the age of the students, body weight perception, dating violence, depression, HIV education, contraception, forced sex, and substance use before sex.

Results: The sample included the following proportions: male (47.48%), female (52.52%), minority (38.06%), and white (61.94%). Early sexual initiation was reported by 6.7% of the sample. Early sexual initiation for the sample was distributed as follows: respondents aged 16 (26.14%), minority male (45.49%), body weight perception of “about the right weight” (41.70%), no dating violence (76.26%), no depression (63%), HIV education (76.19%), non-effective contraceptive use (53.25%), no forced sex (73.52%), and no substance use before sex (57.88). Minority males were over 10 times more likely to engage in early sexual initiation compared to white females (OR-10.40; CI-9.03-11.98). Minority females and white males were also more likely to engage in early sexual initiation compared to white females (OR-2.11; CI-1.81-2.46, OR-3.73; CI-3.23-4.30, respectively). In addition, age group <15 (OR-2.60; CI-2.19-3.09), body weight perception of “underweight” (OR-1.36; CI-1.20-1.54), experiencing dating violence (OR-1.48; CI-1.31-1.67), depression (OR-1.13; CI-1.02-1.25), no HIV education (OR-1.42; CI-1.26-1.59), non-effective methods for contraception (OR-1.56; CI-1.42-1.72), experiencing forced sex (OR-

2.63; CI-2.32-2.97), and using substances before sex (OR-2.24; CI-2.03-2.47) all increased the odds of early sexual initiation.

Conclusions/Implications: Gender and race were associated with early sexual initiation in high school students in the southern states. Psychosocial factors, such as forced sex and using substances before sex, were also recognized as predictors for this population. These results can be utilized to target HIV/AIDS awareness and prevention activities to key affected populations.

Abstract 1799 - Associations of Teen Dating Violence and Forced Sexual Intercourse with Sexual Risk Behaviors in the United States

Author(s): *Zewditu Demissie, Heather Clayton*

Background: Dating violence and other forms of intimate partner violence are associated with adverse physical, psychosocial, and economic outcomes. In studies of young adult populations, dating violence and forced sexual intercourse (FSI) show associations with a variety of health outcomes, including behaviors that may increase the risk for sexually transmitted infections (STIs) and HIV infection. This study examined associations of teen dating violence (TDV) and FSI with sexual risk behaviors among U.S. high school students.

Methods: Data were obtained from the 2013 National Youth Risk Behavior Survey, a cross-sectional survey conducted among a nationally representative sample of 13,633 students in grades 9–12. Three separate questions assessed lifetime FSI, physical TDV during the past 12 months, and sexual TDV during the past 12 months. These questions were combined to create a 4-level variable: no TDV or FSI, TDV but no FSI, FSI but no TDV, and both TDV and FSI. Logistic regression models were used to estimate adjusted prevalence ratios (PRs) and 95% confidence intervals (CIs) for sex-stratified associations between the combined TDV/FSI variable and sexual risk behaviors, including current sexual activity (past 3 months), age at first sexual intercourse, lifetime number of partners, alcohol or drug use before last sexual intercourse, condom use during last sexual intercourse, no method of birth control during last sexual intercourse, and HIV testing. The analysis was restricted to students who had dated or gone out with anyone during the past 12 months and who had ever had sexual intercourse (5,777 students).

Results: Approximately one-quarter (24.5%) of students — 32.9% of female students and 15.7% of male students — experienced either form of TDV or FSI. Among both male and female students, those who experienced both TDV and FSI were more likely than those who did not experience either to have had sexual intercourse before age 13 (PR and 95% CI for females: 4.01, 2.68–5.99; for males: 3.30, 2.60–4.20), have 4+ lifetime partners (females: 2.12, 1.76–2.56; males: 1.91, 1.60–2.27), be currently sexually active (females: 1.08; 1.02–1.15; males: 1.23, 1.11–1.36), use alcohol or drugs before last sexual intercourse (females: 2.41, 1.92–3.04; males: 2.62, 2.07–3.31), use no method of birth control during last sexual intercourse (females: 1.86, 1.36–2.55; males: 3.30, 2.10–5.18) and to have been tested for HIV (females: 1.50, 1.18–1.92; males: 1.68, 1.09–2.61) Students who experienced both TDV and FSI were also less likely to use a condom during last sexual intercourse (females: 0.79, 0.64–0.97; males: 0.58, 0.43–0.78).

Conclusions/Implications: TDV and FSI are significantly associated with sexual risk behaviors among female and male students. Therefore, it is appropriate and valuable for mental health and social services addressing these types of violence to target both female and male students. Additionally, HIV/STI and pregnancy prevention efforts may consider incorporating messages and tools to address violence prevention and skills for developing healthy relationships.

Abstract 2026 - HIV-Related Risk Behaviors among Male High School Students Who Have Had Sexual Contact with Males, by Race/Ethnicity, Selected US Cities, 2009-2013

Author(s): *Laura Kann, Richard Wolitski, Emily O'Malley Olsen, Elana Morris, Steve Kinchen*

Background: Young people aged 13 to 24 accounted for an estimated 26% of all new HIV infections in the US in 2010. Most new HIV infections among youth occur among males who have sex with males. From 2008 to 2010, estimated new infections increased 22% in this group. Among all males who have sex with males, young black males accounted for the largest number of new HIV infections in 2010. The purpose of this analysis was to determine if the prevalence of HIV-related risk behaviors among black male high school students compared to the prevalence among white and Hispanic male students who had had sexual contact with males contributed to the racial/ethnic disparities in new HIV infections. Although other studies have examined HIV-related risk behaviors among young black males who have sex with males, little is known about those under the age of 18.

Methods: Data from 32 YRBSs conducted by 17 large urban school districts during 2009-2013 were combined into a single data set. In each survey, a 2-stage cluster sample design was used to produce representative samples of public school students in grades 9–12. Data were weighted to provide large urban school district-level estimates. For this analysis, MSM were defined only as male students in grades 9-12 who indicated they only had sexual contact with males or with both females and males. The final combined data set contained 1681 records from MSM.

Results: Black MSM compared to white MSM had a lower prevalence of drinking five or more drinks of alcohol in a row (22.9% vs 38.0%); ever using inhalants (21.5% vs. 35.0%), heroin (16.5% vs. 29.1%), ecstasy (19.6% vs. 40.0%), and prescription drugs without a doctor's prescription (31.4% vs. 47.8%); and drinking alcohol or using drugs before last sexual intercourse (32.6% vs. 72.6%). Black MSM also had a lower prevalence than Hispanic MSM of drinking five or more drinks of alcohol in a row (22.9% vs. 34.5%) and ever using cocaine (17.9% vs. 29.3%), inhalants (21.5% vs. 35.0%), methamphetamines (18.1% vs. 28.7%), ecstasy (19.6% vs. 32.1%), and steroids without a doctor's prescription (14.9% vs. 25.6%). However, black MSM had a higher prevalence than white MSM of ever having sexual intercourse (89.1% vs. 67.4%) and using a condom during last sexual intercourse (among sexually active students) (47.4% vs. 25.2%) and black MSM had a higher prevalence than Hispanic MSM of ever having sexual intercourse (89.1% vs. 79.2%).

Conclusions/Implications: Although risk behaviors are necessary for HIV transmission, these findings do not provide evidence that HIV-related risk behaviors drive the higher numbers of HIV infections among young black males who have sex with males compared to young Hispanic and white males who have sex with males. Indeed, though too many MSM report HIV-related risk behaviors, black MSM often had a lower prevalence of these behaviors. While these results do not explain the disparities in HIV incidence

by race/ethnicity, they do highlight the need to develop HIV prevention strategies that specifically address males who have sex with males regardless of their race/ethnicity.

Session A12 - The Nuances of HIV Transmission among Men Who Have Sex with Men (MSM): Time to Infection, Exchange Sex and Geographic Differences

Room: Courtland (Hyatt Regency Atlanta)

Abstract 1315 - HIV Prevalence Among Men who Have Sex with Men and Exchange Sex for Money or Drugs

Author(s): *Lina Nerlander, Kristen Hess, Charles Rose, Anna Thorson, Catlainn Sionean, Dita Broz, Gabriela Paz-Bailey*

Background: More than half of all new HIV-infections in the United States (US) occur among men who have sex with men (MSM). Little is known about the prevalence of sex in exchange for money or drugs, among MSM in the US and the prevalence of HIV among this group. We used 2011 data from the National HIV Behavioral Surveillance System (NHBS) to estimate the percentage of MSM who received money or drugs in exchange for sex in the past 12 months, hereafter referred to as 'exchange sex', to compare HIV testing and HIV risk behaviors among MSM who exchanged sex and those who did not, and to investigate factors associated with being HIV-positive but unaware of one's infection.

Methods: We analyzed data from sexually active MSM, aged ≥ 18 years, recruited using venue-based sampling in 20 US cities, interviewed and tested for HIV. MSM testing positive who did not report a prior positive HIV test were considered to be unaware of their infection. Using chi-square tests, we assessed differences in HIV risk behaviors, HIV testing, HIV prevalence and the percentage HIV-positive but unaware of their infection among MSM who did and did not exchange sex in the past 12 months. To evaluate the association between exchange sex and being HIV-positive but unaware, we used generalized estimating equations with robust standard errors, clustered on recruitment event.

Results: Among 8,411 MSM, 585 (7%) reported exchange sex in the past 12 months. MSM who exchanged sex, compared to those who did not, were more likely to have ever injected drugs (23% versus 5%, $p < 0.001$), report higher number of condomless anal sex partners in the past 12 months (mean 4.3 vs. 1.8, $p < 0.001$), test positive for HIV (29% vs. 18%, $p < 0.001$) and be HIV-positive but unaware (13% vs. 6%, $p < 0.001$). There was no difference in HIV testing in the past 12 months between MSM who exchanged sex and those who did not (66% vs. 67%, $p = 0.54$). In multivariable analysis, after adjusting for age, race/ethnicity, education, poverty and injection drug use, exchange sex was associated with being HIV-positive but unaware (adjusted prevalence ratio 1.34, 95% confidence interval 1.05-1.69).

Conclusions/Implications: MSM who exchanged sex were more likely to report HIV risk behaviors and to be HIV-positive but unaware of their infection. HIV prevention efforts may benefit from strengthening risk-reduction interventions such as pre-exposure prophylaxis among HIV-negative MSM who exchange sex, and increased HIV testing and linkage to care and treatment for those testing positive.

Abstract 1598 - Incidence of HIV diagnosis among Men Who Have Sex with Men Attending STD clinics, STD Surveillance Network (SSuN)—January 2009 to June 2013

Author(s): *Eloisa Llata, Christina Schumacher, Ryan Murphy, Preeti Pathela, Lenore Asbel, River Pugsley, Roxanne Kerani, Hillard Weinstock*

Background: Men who have sex with men (MSM) are disproportionately affected by HIV in the United States. STD clinics serve a high risk MSM population and information on new HIV diagnoses is important to plan future HIV prevention strategies. We estimate the time to new HIV diagnoses in MSM attending STD clinics and identify demographic and clinical factors that impact the probability of a HIV diagnosis.

Methods: The STD Surveillance Network (SSuN) is a sentinel surveillance system comprising state and local health departments that collect demographic and clinical data on all patients attending participating STD clinics. We analyzed data from all MSM attending one of the 31 STD clinics across 8 jurisdictions (Baltimore, Denver, Los Angeles, New York City, Philadelphia, Richmond, San Francisco, and Seattle) during 2009-2013. MSM had to have at least 2 HIV tests, with an initial negative HIV test required for staggered cohort entry. Follow up time was accrued from the date of the first recorded negative HIV test to the most recent negative HIV test or the first positive test result for HIV. Sexually transmitted infections (STI) during the follow up time, but prior to the HIV diagnosis were reviewed. Annual incidence was estimated as the number of HIV diagnoses over the total number of person years at risk.

Results: There were 889 HIV diagnoses that occurred among 16,569 individuals contributing 28,604 person-years (PY) of observation, for an overall incidence of HIV diagnosis of 3.1 per 100 PY (95% confidence interval (CI) 2.9, 3.3). Median time to HIV diagnosis was 1.4 years. Cumulative incidence was 19.7%. HIV diagnosis incidence rates (IR) decreased as age increased with the highest rate in the 19 years age group (5.9 per 100 PY; 95% CI 4.9, 7.1) and was highest among Non-Hispanic (NH) blacks (5.2 per 100 PY; 95% CI 4.7, 5.8) with a gradient of risk NH black >Hispanic (3.0 per 100 PY; 95% CI 2.6, 3.4) >NH white (2.2 per 100 PY; 95% CI 1.9, 2.5) >other (2.0 per 100 PY; 95% CI 1.6, 2.6). The incidence of HIV diagnosis among MSM diagnosed with primary & secondary syphilis was 5.9 per 100 PY (95% CI 4.8, 7.2), with rectal gonorrhea was 5.0 per 100 PY (95% CI 4.2, 5.9), with rectal chlamydia was 4.4 per 100 PY (95% CI 3.8, 5.1), and 3.1 per 100 PY (95% CI 2.5, 3.7) for those with pharyngeal gonorrhea. The incidence of HIV diagnosis among MSM who were not diagnosed with any STI during the follow up time was 2.6 per 100 PY (95% CI 2.3, 2.8).

Conclusions/Implications: These findings reveal a high rate of HIV diagnosis among MSM attending STD clinics and suggest that young, minority and those having a history of a STI have the highest rates. While prevention efforts are often targeted at these subpopulations at highest risk, our observed 3.1% annual incidence of HIV diagnosis speaks to the burden of HIV acquisition among MSM attending STD clinics. HIV prevention strategies, including pre-exposure prophylaxis, should be considered for all HIV-negative MSM attending STD clinics.

Abstract 1862 - Correlates of HIV Risk among Men who have Sex with Men in Los Angeles County (2014)

Author(s): *Ekow Sey, Yingbo Ma*

Background: The HIV/AIDS epidemic in Los Angeles County (LAC) is largely driven by HIV transmission among men who have sex with men (MSM). In order to inform prevention interventions, the association between demographic and behavioral factors and newly- diagnosed HIV infection (≤ 12 month prior to interview) was examined.

Methods: From July through November 2014, venue- based sampling was used to successfully recruit 525 MSM from public venues in LAC to complete an anonymous interviewer- administered behavioral survey and HIV, HBV and HCV screening. To restrict this investigation to newly- diagnosed cases, MSM who had received an HIV diagnosis > 12 months prior to the interview were excluded from the analysis. Descriptive statistics and logistic regression were conducted using SAS.

Results: The majority of participants were recruited from bars (55%) and dance clubs (22%). Among the 523 consenting MSM, 52 had received an HIV diagnosis more than 12 months prior to study enrollment and were excluded from the analysis. Of the remaining 471 MSM, 49% were less than 30 years old, 41% were Latino, 29% were White and 17% were Black; 83% identified as homosexual and 16% as bisexual; 82% had completed some college education and 75% had health insurance. In addition, 7%(n=34) tested positive for HIV and 79%(n=27) of positives were unaware of their infection.

The proportion of new HIV diagnoses among Blacks (16%) was significantly higher than for Whites (3%) and Latinos (8%) ($p < 0.01$). However, Blacks, compared with Whites and Latinos respectively, reported similar or lower levels of unprotected anal sex (63% vs. 69% and 69%; $p = 0.54$), sexual partners (7 vs. 12 and 8; $p = 0.06$), non-injection drug use (61% vs. 70% and 66%, $p = 0.46$), monthly binge drinking (49% vs. 62% and 63%, $p = 0.07$) and HIV testing within the past 12 months (80% vs. 81% and 74%; $p = 0.27$). After controlling for age, access to health care, number of sex partners, age of sex partners, non-injection drug use and reporting a Black partner at last sex, race was no longer associated with HIV infection (AOR.: 1.2, 95% C.I.:0.5, 2.8). However, respondents who reported a black partner at last sex were more likely to be newly diagnosed with HIV (AOR.: 6.8, 95% C.I.:2.9, 16.0).

Conclusions/Implications: Our findings support the hypothesis that despite reporting similar or lower risk behavior, the elevated prevalence of HIV within the sexual networks of Black MSM places them at higher risk for HIV as compared with non-black MSM.

Abstract 2534 - Characteristics of African-American Men who have Sex with Men in Baltimore, Philadelphia, and Washington, DC

Author(s): *Danielle German, Kathleen Brady, Irene Kuo, Jenevieve Opoku, Colin Flynn, Joella Adams, Rudy Patrick, Ju Nyeung Park, Wendy Davis,*

Background: Baltimore, Philadelphia, and Washington, DC are geographically proximate cities with high HIV prevalence. Using data collected among men who have sex with men (MSM) as part of CDC's National HIV Behavioral Surveillance project in the three cities, we compared socio-demographic characteristics, HIV risk behaviors, and HIV service utilization among African-American MSM to explore similarities and differences that could inform local and regional HIV intervention approaches.

Methods: African-American MSM were recruited through venue-based time location sampling in Baltimore (n=344), Philadelphia (n=340), and Washington, DC (n=169) between June and December, 2011. Participants completed identical socio-behavioral surveys and voluntary HIV testing. Analyses were conducted among the full sample and limited to those aged 18-24 (B: n=114; P: n=61; W: n=36) using Pearson's chi-square test to compare proportions across cities where cell sizes allowed.

Results: Participants across the three cities differed by age (18-24 years old in Baltimore: 33%; Philadelphia: 19%; Washington, DC: 22%, $p < 0.0001$) and sexual orientation (Baltimore: 59% identified as gay/homosexual, 36% bisexual, 5% heterosexual; Philadelphia: 81% gay/homosexual, 17% bisexual, and 2% heterosexual; Washington DC: 77% gay/homosexual, 23% bisexual, and 4% heterosexual, $p < 0.0001$). Findings across cities show a median of 3 past year partners and similar condom use behaviors, but notable differences in HIV prevalence, socio-demographic characteristics, and social determinants. HIV prevalence was 46.8% in Baltimore, 22.3% in Washington DC, and 14.7% in Philadelphia ($p < 0.0001$; 38.6%, 11.1%, and 9.1% respectively among 18-24 year olds, $p < 0.0001$). Compared to Philadelphia and Washington, DC, Baltimore participants had the highest proportion with less than high school education (B: 16%, P: 8%; W: 0.6%, $p < 0.0001$), unemployment (B: 36%, P: 21%, W: 14%), incarceration (B: 54%, P: 24%, W: 18%, $p < 0.0001$), and past year homelessness (B: 19%, P: 13%, W: 9%, $p < 0.0005$). Baltimore participants less commonly met partners online (B: 8%, P: 28%, W: 26%) and more commonly reported a history of injection drug use (B: 9%, P: 3%, W: 2%, $p < 0.0001$). Marijuana was the most common non-injection drug in all cities, but other drug use among non-injection drug users varied: most common in Baltimore was crack cocaine (32%), powder cocaine (24%), and ecstasy (24%); in Philadelphia was powder cocaine (33%), painkillers (16%), and ecstasy (14%); and in DC was powder cocaine (30%), poppers (31%), and ecstasy (18%). Most of the self-reported HIV positive participants in each city had seen an HIV provider at least once (B: 96%, P: 97%, W: 89%), and the majority was currently on ARVs (B: 74%, P: 79%, W: 76%).

Conclusions/Implications: These results prompt a variety of hypotheses about the continued HIV epidemic among African-American MSM within and across these geographically proximate cities. Ecologically, it appears that social determinants such as rates of unemployment, incarceration, and homelessness explain differences in HIV prevalence across the three cities more than sexual behaviors. When targeting services for MSM, social determinants of disease and population heterogeneity in addition to race/ethnicity must be considered.

Track B

Session B09 - Not Yet Grown: Understanding the Unique Sexual Health and HIV/STD Risks Among Adolescents and Young Adults

Room: Embassy D (Hyatt Regency Atlanta)

Abstract 1205 - HIV Prevention Education and Services in a Nationally Representative Sample of U.S. Schools, 2014

Author(s): Nancy Brener, Laura Kann

Background: Because schools have direct contact with more than 95% of the nation's children and adolescents for about six hours a day for up to 13 years of their development, schools play a critical role in preventing HIV infection among young people. This study describes the extent to which schools in the United States offer HIV prevention education and services to students, and also examines the professional development teachers and school staff receive on HIV prevention.

Methods: This study uses data from the School Health Policies and Practices Study (SHPPS) conducted by the Centers for Disease Control and Prevention in 2014. SHPPS collected data from a nationally representative sample of public and private elementary, middle, and high schools (n=631). SHPPS also collected data from a nationally representative sample of required health education classes and courses (n=495). Data were obtained through face-to-face computer-assisted personal interviews conducted in schools with administrators, teachers, school nurses, school counselors, and other school staff.

Results: In 2014, 16.0% of elementary schools, 57.9% of middle schools, and 81.7% of high schools required students to receive instruction on HIV prevention. Middle schools spent a median of 1.1 hours of instructional time on HIV prevention and high schools spent a median of 2.1 hours. In the area of health services, 18.0% of middle schools and 40.2% of high schools offered HIV counseling, testing, and referral to students; 17.7% of middle schools and 47.2% of high schools offered HIV prevention in one-on-one or small-group settings. During the two years before the study, 32.0% of school health services coordinators and 22.2% of school mental health and social services coordinators received professional development on HIV prevention, and 18.2% of health education classes and courses had a teacher who received professional development on HIV prevention during this same time period.

Conclusions/Implications: While the majority of middle schools and high schools in the United States require HIV prevention education for students, fewer schools are providing HIV-related services. This is a missed opportunity given the amount of time young people spend in school. Room for improvement also exists in the extent to which teachers, school health services staff, and school mental health and social services staff are receiving up-to-date professional development on HIV prevention.

Abstract 1664 - An Exploration of Barriers and Facilitators of HIV Testing in Adolescents in an Urban Setting in New York City

Author(s): *Cynthia C Lee*

Background: HIV Testing behavior is important in understanding the high rates of undiagnosed infections among youth and adolescents between 13-24 years old. This study examined relationship between HIV testing status and HIV perceptions, risk profile, knowledge, and access/barriers to health care using the constructs of the Extended Parallel Process Model (EPPM).

Methods: The cross-sectional data collection method was utilized through the use of purposive sampling, with remuneration for survey completion. The validated 68-item HIV knowledge survey was administered using computer assisted self-interviewing (CASI) structured face-to-face survey data collection in which respondents used an iPad to complete the survey questionnaire. (n = 100) participants between the ages of 18 – 24 completed the survey. The analysis focused on respondents' history of HIV testing and an individual's decision to test for HIV using the constructs of the EPPM.

Associations between HIV testing were measured by socio-demographic factors, perceived susceptibility, severity, response-efficacy and self-efficacy. Descriptive statistics and logistic regression were conducted in SPSS.

Results: Among the participants surveyed, 43% reported having an HIV test, 57% had never tested. Among the tested 39% had tested in the last 2 years, 44.19% tested in the last 6 months and 63% had tested more than once, 53% of the non-testers felt that they were not at risk for HIV infection, 77% of non-testers stated that they see the same doctor, 86% see the same doctor at least once a year, 82.5% stated that they were unlikely susceptible to HIV infection, 67% of non-testers felt that HIV was no big deal (severity), 84% had low response-efficacy, and 58% non-testers had low self-efficacy. More than half (54%) had low HIV knowledge, 76% had at least one access to healthcare barrier, and 86% were low risk, 59% had low self-efficacy and at least 1 negative HIV belief, and 79.6% stated that they had no fear of contracting HIV. Age, religion and being a parent was significantly associated with having an HIV test.

Conclusions/Implications: HIV testing is now offered as part of routine care for persons 13-64, yet 1 in 4 new HIV infections is among youth ages 13-24, most are unaware of their status and can unknowingly pass the virus on to others. The study reveals that, there is low perception of risk, low HIV knowledge, fear and stigma regarding HIV testing uptake and HIV infection, and the ability to access to healthcare services.

Abstract 1751 - Individual-Level Protective Factors for Sexual Health Outcomes among Sexual Minority Adolescents and Young Adults: A Systematic Mapping of the Literature

Author(s): *Riley Steiner, Paula Jayne, Heather Armstrong, Oscar Beltran*

Background: Sexual minority youth (SMY) are at disproportionate risk for adverse sexual health outcomes, including HIV and other sexually transmitted infections (STIs). Although factors associated with increased sexual risk behavior and negative health outcomes have been well-documented, protective factors that can reduce risk, improve outcomes, and inform public health interventions have been less studied among this population. We sought to summarize the current state of science on individual-level protective factors for SMY and identify gaps to inform future research in this area.

Methods: A list of individual-level factors conceptualized as protective factors in the adolescent health literature was developed from a scan of peer-reviewed and grey literature. We then conducted a systematic search of nonintervention empirical research published in peer-reviewed journals in the past fifteen years. Nineteen academic databases were searched using keywords from four categories—adolescence, sexual orientation, sexual health outcomes, and protective factors—and identified abstracts were screened. Articles were eligible for inclusion if they examined an association between an a priori identified individual-level protective factor and at least one sexual health outcome using significance testing and reported findings from a sample or subsample of SMY aged 10-24 years in Western, industrialized countries.

Results: Authors screened 3401 abstracts and 101 articles were identified for full text review. A total of 22 articles were included that reported data from 15 unique studies. Although the scope of the literature search included gay, bisexual, lesbian, and other SMY, only two studies described findings for

young sexual minority women. With the exception of one article that presented findings from the Netherlands, all articles were based on U.S. data. The majority of articles (78.1%) reported only cross-sectional findings. Across the articles reporting findings for young men who have sex with men, a total of 12 individual-level protective factors were examined in 65 associations. Subjective peer norms about condom use, attitudes related to sex, self-efficacy, and clear and positive identity were the individual-level protective factors most studied. The majority of the associations (n=37, 57%) examined unprotected anal intercourse as the primary outcome. Subjective peer norms and attitudes related to sex were repeatedly protective in cross-sectional analyses. Findings related to self-efficacy, self-esteem, and clear and positive identity were more mixed.

Conclusions/Implications: The findings of this review suggest that attitudes, intentions, and subjective peer norms related to condom use are promising intervention targets for YMSM. There is a need, however, for longitudinal research to confirm these protective effects and consider them among other SMY. Moreover, protective factors related to skills and competencies, including problem solving, social competence, and self-regulation, have not yet been studied among SMY. By systematically describing these promising findings and important gaps, we hope this review will guide the development of a robust body of evidence that can be meaningfully synthesized to inform programmatic efforts for SMY. More broadly, this approach can serve as a model for mapping an emerging literature that should be informed by prior theoretical and empirical work, as is the case with protective factors for adolescent HIV prevention.

Abstract 1836 - Individual and School-related Characteristics that Predict STD and HIV Testing among Sexually Active Adolescents

Author(s): *Catherine Lesesne, Andrew Hebert, Elizabeth Kroupa, Catherine Rasberry, Elana Morris*

Background: Background: STD and HIV infection rates among young people in the United States are unacceptably high; almost half of new STD infections each year occur among persons aged 15–24 (Satterwhite et al., 2013), and approximately 25.7% of estimated new HIV infections in 2010 occurred among persons aged 13–24 (Centers for Disease Control and Prevention, 2012). School-centered HIV/STD prevention programs have promise for decreasing infection rates among youth. However, census survey data on high school students' behavior and receipt of school-based and school-linked sexual health services are rarely available. Data from the evaluation of a program funded by the Centers for Disease Control and Prevention's Division of Adolescent and School Health aimed at reducing HIV and STDs among adolescents at disproportionate risk provide insight into risk behavior patterns among all sexually active high-school students in 7 schools in Broward County, Florida.

Methods: Methods: A 46-item paper-and-pencil questionnaire assessing sexual risk and protective behaviors, school connectedness, school environment, and bullying experiences was administered to 11,681 students in 7 high schools. Data on the sexually active subset of students (n=4563) were analyzed; 83.7% (n=3817) of participants were racial/ethnic minorities; 57.7% (n=2631) were male; and 16.7% (n=763) were sexual minorities. Principal component analysis was performed for item reduction and development of scales to measure bullying experience and homophobic school environment. A standardized 4-item scale was used to measure school connectedness. A logistic regression model to

determine potential predictors of sexually active youth reporting having ever received an HIV or STD test (n=1321) was tested.

Results: Results: Potential predictors of having ever been tested for HIV or STDs were identified using bivariate correlation, with significant correlates entered into regression models. Significant correlates in the initial regression model were male sex, age, ethnic/racial minority status, sexual minority status, knowing LGBT teachers, seeing safe spaces posters/stickers, bullying experience, school connectedness, and receiving a referral for HIV testing, STD testing, or sexual health services. Predictors with p-values $>.1$ (bullying experience and school connectedness) were removed stepwise to determine the final regression model. The final model included the following predictors of self-reported STD/HIV testing in sexually active youth: male sex ($p<.01$, $OR=.705$), age ($p<.01$, $OR=1.14$) minority race/ethnicity ($p<.01$, $OR=1.27$), knowing LGBT teachers ($p<.01$, $OR=1.12$), seeing a safe-spaces poster/sticker ($p=.01$, $OR=1.31$), receiving a testing or services referral ($p<.01$, $OR=2.49$), and sexual minority status ($p=.06$, $OR=1.23$).

Conclusions/Implications: Conclusions/Implications: Results of regression analyses demonstrate that teacher referrals played a primary role in determining whether or not youth received HIV or STD testing. Programs could focus on teacher referrals to encourage youth, especially males, to get tested. Knowing an LGBT teacher was associated with an increased likelihood of having been tested. Interventions empowering LGBT staff to make referrals for testing services may encourage these youth to get tested. Additionally, since seeing a safe spaces poster/sticker was also associated with testing, providing safe spaces for staff to talk with youth may facilitate discussion and referral making. Further research is needed on how teacher referrals to testing sources can be enhanced, for example, through professional development.

Session B22 - EBIs and HIP: Identifying and Disseminating Evidence-Based Interventions in the Era of High-Impact Prevention

Room: Embassy A/B (Hyatt Regency Atlanta)

Abstract 1536 - Evidence-Based, Behavioral Risk-Reduction Interventions and High-Impact Prevention: The Role and Direction of the CDC's Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention

Author(s): *Brittney Baack, Julia DeLuca, Darrel Higa*

Issue: The CDC's Division of HIV/AIDS Prevention (DHAP) identifies and disseminates evidence-based interventions (EBIs) that reduce risky sexual behaviors and injection drug use for primary HIV prevention. As a result of recent advances in the field, DHAP has pivoted toward a high-impact HIV prevention (HIP) approach, which seeks to integrate behavioral, biomedical and HIV care continuum activities to achieve maximum reductions in new HIV infections through consideration of efficacy, cost and impact. In this context, we discuss the role of the CDC's Prevention Research Synthesis (PRS) project's systematic review to identify efficacious risk-reduction (RR) interventions in the era of HIP.

Setting: The PRS RR efficacy review, initiated in 1996, identifies EBIs, which are added to the CDC's Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention (aka the

Compendium). The EBIs highlighted in the CDC Compendium can be used by HIV prevention planners and providers and may be considered for DHAP research translation and dissemination activities.

Project: The PRS RR-efficacy review is an ongoing systematic review that identifies interventions scientifically proven to reduce risky sexual behaviors, injection drug use, or HIV/STI incidence. PRS conducts annual searches using a comprehensive strategy. All US-based HIV/STI intervention studies evaluated with a comparison arm, published in a peer-reviewed journal, and reporting ≥ 1 relevant RR outcome are evaluated against criteria related to study design, analysis, and strength of findings. HIV/STI intervention studies that meet these criteria are published in the Compendium. The April 2015 update includes studies published between 1988 and 2014.

Results: As of 2015, 93 RR EBIs have been included in the Compendium. The majority of included EBIs have targeted populations at lower risk of HIV, including heterosexual adults and adolescents (63%). Of these, only 15% are brief interventions (2 sessions and total duration 120 minutes), suggesting that most would require a substantial dedication of resources to achieve an appreciable reduction in HIV acquisition. Fewer RR EBIs have targeted high-priority populations, including PLWH (16%) and MSM (15%), and very few have targeted MSM of color (8%) or young MSM (2%). However, attention to these populations appears to be increasing over time, with 0% and 20% of identified EBIs published between 1991-1999, 19% and 8% of EBIs published between 2000-2009, and 30% and 25% of EBIs published between 2010-2014 targeted to PLWH and MSM, respectively.

Lessons Learned: The PRS RR Compendium increasingly includes EBIs targeted to high-priority populations. Nonetheless, to remain relevant in the era of HIP, identifying those EBIs that have the greatest impact on reducing HIV disease burden should be a high priority. As such, moving forward PRS will primarily focus its review of RR interventions to those targeting PLWH, MSM, transgender people and other DHAP-identified high-priority populations. Identifying high-quality behavioral interventions for PLWH and MSM, especially for MSM of color and YMSM, will be critical to future HIV prevention efforts.

Abstract 1553 - Scientifically proven Interventions for Linkage to, Retention and Re-engagement in HIV Medical Care and HIV Medication Adherence

Author(s): *Darrel Higa, Brittney Baack, Julia DeLuca*

Background: High-impact prevention (HIP) entails using combinations of scientifically proven, cost effective, and scalable interventions that focus on priority populations such as persons living with HIV (PLWH). Improving outcomes for PLWH along the HIV care continuum to help PLWH achieve viral suppression (VS) is a national public health priority. Linkage to, retention and re-engagement in HIV medical care (LRC) and HIV medication adherence (MA) are crucial for achieving VS, but recent national surveillance data from 2011 indicate of persons diagnosed with HIV, only 30% were virally suppressed. Identifying scientifically proven interventions for LRC and MA may help to increase the percentage of PLWH who are virally suppressed. This presentation describes scientifically proven interventions for LRC and MA identified from on-going systematic reviews conducted by CDC's Prevention Research Synthesis (PRS) project.

Methods: PRS staff developed LRC and MA evaluation criteria based in part on previously established risk-reduction efficacy criteria and also on consultations with CDC researchers, external subject matter experts, and federal partners. LRC and MA intervention studies with a comparison group are evaluated against evidence-based (EB) criteria that assess the risk of bias and strength of findings. LRC and MA interventions meeting EB criteria are known as evidence-based interventions (EBIs). The lack of controlled trials for LRC required the development of evaluation criteria for LRC interventions tested with one-group study designs. LRC interventions meeting this set of criteria are considered evidence-informed (EIs). We systematically searched the PRS cumulative database that is updated annually with automated and manual searches to identify relevant intervention studies published between 1996 and 2014. After multiple levels of screening, we identified and evaluated 21 eligible LRC and 88 MA intervention studies.

Results: Twenty-three interventions (5 LRC EBIs, 6 LRC EIs, 12 MA EBIs) have met PRS evaluation criteria. Most LRC EBIs focused on retention. LRC EBIs used various strategies such as strengths-based case management, service co-location, patient tracking systems for providers, and supportive personal contacts. LRC EIs also used diverse strategies such as displaying printed material in clinics, adding staff with expertise in subpopulations (e.g., youth, Hispanic clients), and care coordination services. Re-engagement interventions were not identified. Most MA EBIs were intensive, multi-session interventions or included ongoing adherence support through home visits, telephone calls, or messaging. Other strategies employed by MA EBIs included directly administered ART (DAART), peer/partner support, and computer-based counseling.

Conclusions/Implications: It is encouraging that we identified several scientifically proven interventions for LRC and MA, key contributors to VS. Depending on resources and capacity, providers and prevention planners may want to consider implementing these interventions that are appropriate for their clinics, agencies, or communities. Besides the urgent need for re-engagement interventions for PLWH who have fallen out of care and MA interventions that are brief and more integrated with clinical services, data on cost-effectiveness and scalability for LRC and MA interventions are needed to better address high-impact prevention.

Abstract 1830 - Prioritization, Policy, and Reinvention – The Recent Course of Dissemination of Evidence-based HIV Behavioral Interventions in the United States

Author(s): *Charles Collins*

Issue: High-impact HIV prevention seeks to maximize reductions in new HIV infections through the prioritization of interventions that are efficacious, cost-effective, scalable and impactful. Since 2011, the CDC's Division of HIV/AIDS Prevention (DHAP) has supported this strategy in order to allocate resources efficiently. This presentation describes a selection criterion developed by DHAP to identify and prioritize evidence-based behavioral HIV prevention interventions (EBIs) that are not only efficacious, but are also targeted to priority populations, high impact, and cost saving, as well as a subsequent process to reinvent the supported EBIs by integrating HIV testing and continuum-of-care activities.

Setting: The DHAP prioritization and resulting funding policy shifts have national significance on EBIs implemented by community-based organizations and health departments.

Project: A prevention benefit index (PBI) was developed to estimate the cost of achieving a prevention benefit with one would-be incident individual for each EBI. Intervention costs per client, intervention effects, and HIV incidence in various target populations were considered. The results of that prioritization resulted in a Dear Colleague Letter instructing DHAP-funded health departments and community-based organizations of those EBIs that will and will not be supported by DHAP funds in the future. The remaining supported EBIs began an extensive process of reinvention so that sexual risk reduction, HIV testing, linkage to care, PrEP and ART adherence could be integrated into the same EBI format and delivery protocol.

Results: We examined the prevention benefit of a total of 48 intervention and target population combinations and communicated the results to DHAP grantees. The remaining EBIs underwent a process of reinvention to maximize intervention outcomes across the HIV Continuum of Care. Twelve months of EBI training data reveal a dramatic decrease in demand as compared to DHAP-supported EBIs and DHAP strategies that focus on HIV testing and linkage to medical care.

Lessons Learned: Prioritization, policy changes and communication of those policy shifts to grantees, and a process of expanding EBI activities to include HIV Continuum of Care outcomes, has resulted in new EBI implementation directions that will improve the cost-saving aspects of current HIV prevention efforts.

Session B23 - Criminal Justice Populations and the HIV Care Continuum

Room: Embassy C (Hyatt Regency Atlanta)

Abstract 2252 - Gender Differences Among HIV-Positive Individuals Involved in the Criminal Justice System: The CARE+ Corrections Study in Washington, DC

Author(s): *Irene Kuo, Ann Kurth, Tao Liu, Claudia Trezza, Rudy Patrick, Lauri Bazerman, Breana Castonguay, Halli Olsen, Stephen Abbott, Curt Beckwith*

Background: Previously incarcerated individuals, particularly those recently released, have suboptimal linkage and engagement in community HIV care. Gender disparities exist among HIV-positive incarcerated individuals, with women and transgender persons (TG) experiencing worse outcomes particularly with accessing care in the community. We are conducting a randomized trial of an mHealth intervention (CARE+ Corrections) to increase linkage to community care among HIV-positive persons involved in the criminal justice (CJ) system. We explored gender differences by examining pre-incarceration baseline HIV risk behaviors and HIV care characteristics in our study sample.

Methods: We recruited HIV-positive incarcerated individuals in the District of Columbia jail (7/2014-present) and HIV-positive individuals recently released from a correctional facility (within 6 months) through community and street outreach (8/2013-present). Enrollment and follow-up are ongoing. Participants completed a baseline interview regarding substance use (TCU drug dependence scale and WHO AUDIT), sexual risk behaviors, and HIV care and medication adherence prior to their most recent incarceration. CD4 and HIV plasma viral load (PVL) testing were performed or obtained through medical records at study enrollment. Preliminary summary statistics of baseline characteristics were compared

across genders (male, female, male-to-female transgender) using Fisher's exact and rank-sum tests with a significance level of $p < 0.05$.

Results: Among 102 individuals, 69% were enrolled in the community; 59% were men, 23% women, and 18% TG. Median age was 42 (IQR:30-50), and 85% were Black. Participants had a median of 7 (IQR:4-15) previous incarcerations, for a cumulative median length of 7 years (IQR:2-15). Women reported the highest proportion of drug dependence (70.8% women, 53.3% men, 55.6% TG), while a higher proportion of men reported high-risk hazardous alcohol use (33.3% men, 25.0% women, 27.8% TG) and past injection drug use (21.7% men, 8.3% women, 0% TG); there were no statistically significant differences across groups. Overall, 56.0% of those who had sex reported any condomless sex in the 3 months prior to incarceration, which did not differ across groups. Exchange sex was significantly higher among TG and women (66.7% TG, 54.2% women, 11.7% men, $p < 0.001$). Among men and TG, 28% and 72% reported ever having sex with a man, respectively. Prior to the most recent incarceration, 81% reported having a regular HIV provider, and more than half were taking HIV medications (55% men, 50% women, 72% TG) and TG reported the highest proportion of $\geq 90\%$ adherence (66.7% vs. 53.3% women and 44.74% men), although neither was statistically significant. Preliminary analyses at study enrollment showed women had the lowest proportion of viral suppression (PVL ≥ 200 copies/mL) (35% women, 71% men, 81% TG, $p = 0.01$). Mean CD4 count at enrollment was 507 cells/ μ L (range 17-1186) and did not differ across genders.

Conclusions/Implications: Overall, participants in the CARE+ Corrections trial represent a vulnerable population highly involved in the CJ system with significant substance abuse co-morbidities. There were gender differences across substance use, sexual risk behaviors and some measures of HIV care and adherence. While most have previously been in care, HIV medication adherence and viral suppression remain inadequate. Innovative interventions to address gender differences in this population are needed.

Abstract 2288 - Factors Associated with Undergoing Rapid HIV Testing among Individuals on Probation or Parole

Author(s): *Michael Gordon, Timothy Kinlock, Josiah Rich, Michelle McKenzie*

Background: Despite the strong risk of HIV among corrections populations, testing and prevention efforts have largely been ignored among individuals on parole or probation. This study is a secondary analysis that compared baseline characteristics of individuals under community correction supervision who completed rapid HIV testing with those who refused such testing.

Methods: This study involved a two-group randomized controlled trial in which 2382 male and female individuals on probation or parole in Baltimore City, Maryland ($n = 1182$) and Providence and Pawtucket, Rhode Island ($n = 1200$) were recruited to complete an assessment, then were randomly assigned to one of two treatment conditions: 1) On-site rapid HIV testing conducted by research staff co-located for the purposes of this study at the probation/parole office; or 2) Off-site referral for rapid HIV testing at a community health center or HIV testing clinic. We examined the relationships between the willingness to receive rapid HIV testing among several domains: demographic; criminal justice; substance abuse; and risky behaviors. First, the relationship between the predictor variables (see domains above) and the

criterion variable, underwent rapid HIV testing, was determined at a bivariate level. Second, logistic regression was used to determine which predictors were related to undergoing HIV testing.

Results: Results indicate that the following variables were significantly associated with undergoing rapid HIV testing: black race ($X^2 = 5.27, p=.02$), homelessness ($X^2 = 7.57, p=.01$), early age of crime onset ($X^2 = 12.63, p=.000$), higher rate of drug use during the past 90 days ($X^2 = 4.87, p=.03$), and greater likelihood of heroin use (ever) ($X^2 = 4.36, p=.03$). Specifically, being black, homeless, reporting earlier onset of criminal activity, self-reporting more drug use days during the past 90 days, and reporting ever used heroin were more likely to undergo rapid HIV testing.

Conclusions/Implications: This secondary analysis indicates that those who complete testing are at high risk of HIV transmission, and are more likely to be of black race, homeless, drug and heroin users, and have a younger crime of onset age. Such findings make it especially important that individuals under community supervision be linked with services in the community to ensure that HIV testing and healthcare planning occur simultaneously. Because HIV is a prevalent health problem in the correctional system, it makes for ample opportunity to both test inmates for HIV status and potentially treat them as well. Finally, given the increased risk of HIV among probationers/parolees, the opportunity should not be missed to test and treat such individuals while they are under community supervision

Abstract 2328 - Adherence and Retention in Care Among Recently Released Prisoners, Following a Period of Virologic Suppression in an HIV Telemedicine Program

Author(s): *Jeremy Young, Mary Mackesy-Amiti, Karen Zynda, Pyrai Vaughn, Lawrence Ouellet*

Background: BACKGROUND: A large proportion of HIV-infected offenders housed in the Illinois Department of Corrections (IDOC) have excellent adherence to antiretroviral therapy (ART) and virologic suppression during incarceration, while being managed in a subspecialty telemedicine clinic. However, studies of the correctional population show that adherence often decreases significantly post-release. This study examined post-release ART adherence, virologic suppression, and retention in care among former offenders, nearly all of whom were adherent to ART while incarcerated.

Methods: METHODS: This was a study of former offenders living with HIV and recently released from IDOC. All subjects were managed in a subspecialty telemedicine clinic while incarcerated, and were told about the study just prior to release. We assessed the proportion of subjects who were virologically suppressed while in-care during incarceration, subjects who presented in-person for study enrollment after release, those who presented for a follow up visit, self-reported ART adherence, and the viral load of each subject at follow up. The primary outcome of interest was proportional virologic suppression while in-care in the telemedicine clinic as compared to virologic suppression – as a measure of ART adherence – upon follow up. Virologic suppression was defined as an HIV viral load <200 copies/mL. Complete virologic suppression was defined as an HIV viral load reported as non-detectable, <20 copies/mL or <48 copies/mL.

Results: RESULTS: Of 151 offenders informed of the study during incarceration, 52% ($n=78$) presented for enrollment post-release. Most (87%) of the 78 who enrolled were virologically suppressed while managed in the telemedicine clinic, just prior to release. At the time of this abstract, 51 of the 78

subjects were eligible for 6-month follow-up, of whom 27 had been assessed. Of those assessed, 81% (n=22) were virologically suppressed and 74% (n=20) were completely suppressed. However, under a worst-case assumption that those not found for follow-up were also unlikely to be adherent to HIV medical care, the proportion of virologically suppressed subjects may be as low as 43%.

Conclusions/Implications: CONCLUSIONS: While most subjects had excellent virologic suppression during incarceration, a large proportion of released offenders did not present for enrollment in the study. Among those who engaged in the 6-month follow-up assessment, virologic suppression was high. However, if those who did not enroll in the study, or enrolled but were unable to be found for follow-up, are also likely not to be engaged in or adherent to ART, then HIV virologic suppression among released ex-offenders appears to be low, a finding consistent with other studies. This study provides further support for focusing public health interventions on connecting, and retaining, the incarcerated population with care upon release in order to reduce HIV-related morbidity, mortality and transmission in the communities to which offenders return.

Abstract 2337 - The HIV Care Cascade Among Persons Under Community Supervision in Baltimore, MD
Author(s): *Nickolas Zaller, Mike Gordon, Monique Wilson, Irene Kuo, Lauri Bazerman, Curt Beckwith*

Background: Interventions to improve HIV outcomes among persons involved with the criminal justice (CJ) system are urgently needed. CJ-involved persons have high rates of substance use disorders; are prone to social and structural barriers to HIV care including poverty and unstable housing; and have high rates of medical co-morbidities including mental health disorders and hepatitis C infection. The community supervision (probation or parole) segment of the CJ system is the least studied in terms of HIV infection and other health outcomes. In this study, we sought to examine the HIV “cascade of care” among a community supervision population in order to identify priority areas for intervention.

Methods: This is an observational pilot study of a convenience sample of HIV-positive community supervised participants in Baltimore, MD. Potential participants were screened and provided informed consent upon determination of eligibility at the Community Supervision Central Intake Unit. Participants were administered an on-site rapid HIV test (OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test) to confirm HIV-positive status. Participants completed a one-time computer administered survey of biopsychosocial assessments, engagement in HIV care, and provided a blood specimen for HIV plasma viral load (PVL) testing.

Results: Of enrolled participants (N=92), 64 (70%) were male and 85 (92%) identified as Black/African American. Fifty-seven (62%) reported being diagnosed with hepatitis C virus. Participants reported a mean of 17.5 (SD=29.4) days of substance use within the past 90 days, with 44 (48%) reporting lifetime intravenous drug use. Seventy-six (83%) reported receiving HIV care in the last 12 months; 68 (74%) reported receiving care in the last 90 days; 74 (80%) reported being prescribed any HIV medications in the last 90 days. Among those who reported receiving medical care in the last 12 months, 55 (72%) were classified as achieving viral suppression (PVL<200 copies/ml). Among the 92 participants, 37 (40%) were classified as not successfully engaged in HIV care; including those who had not received HIV care in the

past 12 months (N=16), and those who had received HIV care yet did not achieve viral suppression on antiretroviral treatment (ART) (N=21).

Conclusions/Implications: Close to one-half of community-supervised individuals sampled were not optimally managing their HIV disease or were not successfully engaged in HIV care. Interventions are needed to improve retention in community HIV care, as well as access to and maintenance on ART in order to achieve viral suppression among HIV-positive persons under community supervision.

Session B24 - Online Approaches to Identify and Engage at-risk MSM in HIV Prevention and Testing
Room: Embassy E/F (Hyatt Regency Atlanta)

Abstract 2079 - Will MSM Use At-Home HIV Test Specimen Collection Kits Distributed Through the Internet?

Author(s): *Patrick Sullivan, Alexandra Ricca, Christine Khosropour*

Background: Men who have sex with men (MSM) are disproportionately affected by the HIV epidemic in the US. To increase HIV testing frequency among MSM and to reach MSM in rural areas, offering HIV test specimen collection kits ordered through the internet and delivered to men's homes holds promise. However, it is unclear whether men will return specimen for testing, and whether men with positive results will link to care in a timely way. We describe willingness of US MSM to collect and return dried blood spot specimens for HIV testing and associated factors.

Methods: Between August and December 2010, we recruited internet-using self-reported HIV-negative or -unknown MSM to participate in a 12-month study of behavioral risks. Consenting men provided a mailing address to receive a commercially available at-home HIV test kit. Eligible participants were >18 years of age; were white non-Hispanic, black non-Hispanic or Hispanic; had at least one male sex partner in the past 12 months; and were willing to take an at-home HIV test. Men with positive test results were offered support for referral, and offered the opportunity to be re-contacted every two months to report information on linkage to care.

Results: Eight hundred ninety-six kits were distributed, 735 (82%) men returned their kit to the study laboratory and 25 (3.4%) received a positive HIV result. HIV test kit return by race differed significantly between white non-Hispanic (85% returned) and black non-Hispanic (73%) participants ($p=0.0004$) but not between white non-Hispanic and Hispanic (79%) participants ($p=0.06$). Of these 25 men with HIV-positive results, 11 were white non-Hispanic (2% seropositivity), 9 were black non-Hispanic (8% seropositivity) and 5 were Hispanic (4% seropositivity). Seven lived in rural areas (3.0% seropositivity) and 18 lived in urban areas (3.9% seropositivity). Of the 25 HIV-positive men, 15 elected to respond to followup data collections. Of these, 12/15 (80%) reported having had a first visit with a medical provider by the end of the 12-month followup.

Conclusions/Implications: We demonstrated willingness of MSM to return biological specimens from at-home specimen collection kits, although return rates were likely artificially high in the research context because of a modest incentive provided to participants. Seropositivity overall and racial patterns of seropositivity were similar to those observed in CDC-supported HIV testing and counseling programs.

There was substantial HIV seropositivity in rural MSM who returned specimens. Linkage to care among men who agreed to provide follow-up information was similar to that observed in CDC-supported HIV testing and counseling programs. Providing the opportunity for MSM to collect specimens at home for HIV testing holds promise to increase HIV testing options for this most impacted populations in the US, especially for rural MSM.

Abstract 2268 - Challenges and Emerging Evidence in Online Recruitment and Retention of MSM in HIV Trials

Author(s): *B. R. Simon Rosser*

Background: New technology holds unprecedented potential to recruit MSM in HIV prevention trials.

Methods: Between 2002 and 2015, we recruited over 17,000 MSM into online HIV prevention studies.

Results: Without block stratification by race/ethnicity, about 85% of participants in a typical MSM study will be white. Fraudulent participation is problematic: across several studies we found multiple participation by an individual(s) and/or participation by ineligible persons. Sub-studies reveal challenges at study entry and consent with 20-30% drop out of high risk MSM, and high drop out of lower SES and African American MSM. Four of the first five RCTs on HIV prevention for MSM failed because of inadequate retention protocols.

Conclusions/Implications: Our experience identifies seven key lessons:

Lesson 1: Participant verification is critical in online trials. Tailored de-duplication and cross-validation protocols are an essential minimum standard for all online MSM trials.

Lesson 2: It's not enough to recruit: retention is a parallel challenge. It's a mistake to think about recruitment in isolation from retention. Thinking about recruitment-retention dynamically may help address trade-offs. Longitudinal online studies face additional retention challenges. Technology-tailored protocols to address compensation/bonuses, timing and formats of automated and human reminders, are essential for success.

Lesson 3: Study entry methods need to evolve in the era of smart technology. While smart technology emphasizes direct, efficient engagement using technology, most studies retain verbally dense, non-visual methods developed for the type-writer. Study entry is a particular challenge. With 20-30% of high risk MSM dropping out during consent, new approaches are needed. Research on drop outs suggest that we prioritize the needs of researchers and IRBs above what participants want and need to know.

Lesson 4: Tailoring to specific demographics can be helpful. Rates of technology adoption show that mobile/online methods, with few exceptions (e.g. senior MSM), reach the majority in all demographics of MSM. In a study of gay and bisexual men aged 60+, we provided both online and phone options. Almost all chose to be screened and consented online but interviewed by phone. Tailoring and mixing methods to specific demographics may increase access to difficult-to-reach segments of MSM.

Lesson 5: Engaging MSM of Color is particularly challenging. Minority drop-out continues to be conceptualized as a minority "person" problem, but a technology-person-interface likely contributes to this disparity. More research is needed to identify technology-specific recruitment and retention challenges.

Lesson 6: When recruiting from high risk environments, we need to recognize MSM are primed for sex not research. Approximately, a quarter of the Internet is devoted to sex, and MSM are often recruited from highly sexually explicit sites. To pretend these sexual environments are non-sexually charged, neutral environments is a critical error. We need to study the Internet as sexual environment and how to transition high risk MSM into studies.

Lesson 7: Because online studies are more public, a protocol to address public relations aspects are prudent. Online HIV trials are typically more publicly accessible, including by those opposed to it. A written protocol that addresses sensitivities proactively can be essential.

Abstract 2292 - Online Screening to Identify MSM Who Are Considering PrEP and Those Who Have Taken PrEP: Implications for HIV Prevention Researchers and Providers

Author(s): *Christian Grov, Ruben H, Jeffrey T*

Background: At present, pre-exposure prophylaxis (PrEP) is one of the most promising biomedical interventions to prevent onward HIV transmission. Both the CDC and the WHO have recommended men who have sex with men (MSM) consider PrEP as part of their strategies to prevent HIV transmission. It is becoming increasingly essential to identify MSM who are considering starting PrEP (and linking them to care) as well as identifying those who have taken PrEP (such to monitor adherence and sexual behavior).

Methods: Data were gathered between August 2014 and April 2015 by the research team at the Center for HIV/AIDS Educational Studies and Training (CHEST) which conducts formative behavioral research as well as develops/tests interventions to improve health outcomes among MSM. Given that CHEST conducts several studies at any given time—each with unique eligibility criteria—we developed a single screening tool that can quickly determine potential participants' eligibility across multiple research studies. This screening tool was used in multiple environments (e.g., Facebook ads, Adam4Adam.com, on two geo-social-sexual networking (GSN) apps, and list-serves for sex parties and night clubs). For the present analysis, we report data on MSM who would consider starting PrEP as well as those who have taken PrEP based on which avenue they were surveyed/screened. Data were restricted to MSM from New York City.

Results: In total, 1,972 MSM completed the screening tool (Facebook=468, Adam4Adam=144, GSN app 1 =673, GSN app 2 =333, sex party list-serves=122, and night club list-serves=231). HIV seropositivity was as follows: Facebook=19.4%, Adam4Adam=33.3%, GSN app 1 =15.0%, GSN app 2 =20.4%, sex party list-serves=13.9%, and night club list-serves=14.3%, ChiSquare(5)=32.25, $p < .001$. Among HIV-negative MSM, mean number of male partners (< 3 months) were as follows: Facebook, $M=5.74$, $SD=8.08$; Adam4Adam, $M=23.09$, $SD=87.37$; GSN app 1, $M=9.03$, $SD=10.51$; GSN app 2, $M=15.89$, $SD=17.79$; sex party list-serves, $M=13.02$, $SD=12.87$; and night club list-serves $M=7.62$, $SD=11.43$; $F=13.76$, $p < .001$. Among HIV-negative MSM, those saying they would "probably" or "definitely" take PrEP if it were 90% effective were as

follows: Facebook=71.0%, Adam4Adam=65.6%, GSN app1 =69.9%, GSN app2 =70.8%, sex party list-serves=67.0%, and night club list-serves=51.1%, ChiSquare(5)=26.37, $p<.001$. Finally, among HIV-negative MSM, those reporting to have taken PrEP at some point was as follows Facebook=9.9% Adam4Adam=3.1%, GSN app 1 =11.7, GSN app 2=13.7%, sex party list-serves=16.2%, and night club list-serves=8.6%, ChiSquare(5)=12.85, $p=.025$.

Conclusions/Implications: We screened nearly two thousand MSM, of which 72% were HIV-negative and thus potential candidates for PrEP. PrEP acceptability was high—nearly two-thirds of these men indicating they "probably" or "definitely" would take it—highest among MSM surveyed via Facebook and GSN apps. This suggests social networking platforms may be a useful tool to identify MSM interested in starting PrEP. And although in the minority, between 3 and 16% of HIV-negative MSM had prior experience taking PrEP—highest among men surveyed via sex parties. In total, our findings indicate that PrEP acceptability as well as prior experience using PrEP differs based on where participants are initially identified. Our findings inform researchers and providers with regard to the effective targeting of enrollment and services.

Abstract 2346 - A Social Network-Based Intervention on Facebook to Increase Home-Based HIV Testing among Black and Latino MSM

Author(s): *Sean Young*

Background: Use of social media has grown exponentially, especially among communities of African Americans, Latinos, and MSM. These networks are thus potentially useful platforms for delivering HIV prevention interventions. We developed the HOPE (Harnessing Online Peer Education) intervention, a 12-week, Facebook-based intervention in which participants receive information on HIV prevention from trained peers. We conducted a randomized, controlled trial to assess the feasibility, acceptability, and preliminary effectiveness of the HOPE intervention to increase HIV testing among African-American and Latino MSM in Los Angeles.

Methods: We recruited and randomly assigned 112 men who have sex with men (MSM), more than 85% of whom were African-American or Latino, to either a "control" Facebook group where general health topics were discussed (e.g. exercise and healthy eating) or an "intervention" Facebook group where HIV prevention was discussed. Sixteen trained peer leaders (also MSM and African-American or Latino) were instructed to initiate private and group conversations throughout the 12-week study duration. After participants accepted a request to join the group, participation was voluntary. Participants could request a free, home-based HIV testing kit and completed questionnaires at baseline and at 12-week follow-up. We measured participant acceptance of and engagement in the intervention, social network participation, and rates of home-based HIV testing. Participant public group conversations were qualitatively and thematically analyzed.

Results: Almost 95% of intervention participants and 73% of control participants voluntarily communicated using the social platform. Twenty-five of 57 intervention participants (44%) requested home-based HIV testing kits compared with 11 of 55 control participants (20%) (difference, 24 percentage points [95% CI, 8 to 41 percentage points]). Nine of the 25 intervention participants (36%) who requested the test took it and mailed it back compared with 2 of the 11 control participants (18%)

who requested the test. Retention at study follow-up was more than 93%. Within the intervention groups, those who posted about prevention and testing were over 11 times more likely to request an HIV testing kit than participants who did not discuss those topics.

Conclusions/Implications: Peer-led, social media-based interventions such as HOPE are feasible, acceptable, and potentially effective for increasing HIV testing among African-American and Latino MSM.

Track C

Session C06 - Health Department Data Use to Implement High Impact Prevention

Room: A704 (Atlanta Marriott Marquis)

Abstract 1844 - Health Department Data to Implement High Impact Prevention

Author(s): *Todd Harvey*

Issue: The potential of client-level health data to catalyze action to improve lives, as well as to identify opportunities and obstacles to optimal HIV-related health outcomes has never been greater. Data use supports access to a continuum of HIV prevention and care services. State and local health departments are uniquely situated to lead local, data-driven responses through use of health department datasets. To address persistent health inequities in HIV health outcomes, health departments must strive to make client-level data use acceptable to communities relying on data-driven services.

Setting: This state health department program has been implemented in a low-incidence Midwestern jurisdiction.

Project: In 2011, the CDC re-distributed HIV Prevention funding in the United States based on HIV incidence. Low-incidence states experienced gradual funding decreases amounting to as much as half of their budgets. During this same time, the HIV prevention and care landscape underwent significant changes. Low incidence states, after losing so much Prevention funding, were not in a position to implement new prevention strategies utilizing CDC funding. However, data indicate that there vulnerable populations who are at high-risk for HIV, and health departments desire to reduce transmission within their state using adaptations of high impact prevention strategies. This has led to an increase in collaboration and integration of funding with other programs. In Iowa, a mathematical modeling exercise indicated that prevention with positives programming (PwP) may be an effective way to reduce new infections. This resulted in collaboration with the Ryan White Part B program to implement PwP programming through Part B case management agencies. Additionally, after data indicated that Iowa ranked 47th in the number of residents ever tested for HIV, a partnership was established with the Primary Care Association to implement routine, opt-out HIV testing at several federally qualified health centers in Iowa. Both of these strategies address HIV prevention, but neither is funded by CDC. The monitoring and evaluation of these activities is a challenge since they are funded by other sources. These challenges include the collection and storage of data, as well as the measurement and reporting of outcomes. It remains a priority of the HIV prevention program to determine how to

monitor and evaluate these data for making programmatic decisions to ensure that prevention services are targeting those most at risk for HIV.

Results: This portion of the panel presentation will provide an overview of how state health departments in low incidence states have adapted to reductions in HIV prevention funding. Although the collaboration and integration of funding with other programs is a strategy to implement prevention programming, there are monitoring and evaluation challenges that this presents.

Abstract 2191 - Health Department Data to Implement HIP – Iowa

Author(s): *Nicole Kolm Valdivia*

Issue: The potential of client-level health data to catalyze action to improve lives, as well as to identify opportunities and obstacles to optimal HIV-related health outcomes has never been greater. Data use supports access to a continuum of HIV prevention and care services. State and local health departments are uniquely situated to lead local, data-driven responses through use of health department datasets. To address persistent health inequities in HIV health outcomes, health departments must strive to make client-level data use acceptable to communities relying on data-driven services.

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Project: In 2011, the CDC re-distributed HIV Prevention funding in the United States based on HIV incidence. Low-incidence states experienced gradual funding decreases amounting to as much as half of their budgets. During this same time, the HIV prevention and care landscape underwent significant changes. Low incidence states, after losing so much Prevention funding, were not in a position to implement new prevention strategies utilizing CDC funding. However, data indicate that there vulnerable populations who are at high-risk for HIV, and health departments desire to reduce transmission within their state using adaptations of high impact prevention strategies. This has led to an increase in collaboration and integration of funding with other programs. In Iowa, a mathematical modeling exercise indicated that prevention with positives programming (PwP) may be an effective way to reduce new infections. This resulted in collaboration with the Ryan White Part B program to implement PwP programming through Part B case management agencies. Additionally, after data indicated that Iowa ranked 47th in the number of residents ever tested for HIV, a partnership was established with the Primary Care Association to implement routine, opt-out HIV testing at several federally qualified health centers in Iowa. Both of these strategies address HIV prevention, but neither is funded by CDC. The monitoring and evaluation of these activities is a challenge since they are funded by other sources. These challenges include the collection and storage of data, as well as the measurement and reporting of outcomes. It remains a priority of the HIV prevention program to determine how to monitor and evaluate these data for making programmatic decisions to ensure that prevention services are targeting those most at risk for HIV.

Results: This portion of the panel presentation will provide an overview of how state health departments in low incidence states have adapted to reductions in HIV prevention funding. Although

the collaboration and integration of funding with other programs is a strategy to implement prevention programming, there are monitoring and evaluation challenges that this presents.

Lessons Learned: Low-incidence states have a unique set of challenges in implementing HIV prevention programs under High-Impact Prevention. Collaboration and integration can leverage separate HIV funding streams to most adequately address jurisdictional needs. Health department data is essential to define what these needs are in low-incidence jurisdictions.

Abstract 2219 - Health Department Data to Implement HIP – Pennsylvania

Author(s): *Benjamin Takai*

Issue: The potential of client-level health data to catalyze action to improve lives, as well as to identify opportunities and obstacles to optimal HIV-related health outcomes has never been greater. Data use supports access to a continuum of HIV prevention and care services. State and local health departments are uniquely situated to lead local, data-driven responses through use of health department datasets. To address persistent health inequities in HIV health outcomes, health departments must strive to make client-level data use acceptable to communities relying on data-driven services.

Setting: This local health department program has been implemented in a high-incidence Northeastern jurisdiction.

Project: Washington DC has been at the forefront of HIV prevention for many years, more recently switching the focus of HIV prevention to target treatment as prevention, targeting PrEP programs and linkage to care for new HIV positive individuals as prevention. In 2014, the District announced that two PrEP programs would receive public funding, signaling a concentration on innovative methods of prevention. This funding was designed to support education and recruitment to existing PrEP programs as the entryway into exploring how PrEP could be an effective component in HIV prevention in Washington DC. DC has also instituted Red Carpet Entry programs which provides framework for expedited access to care for newly infected HIV individuals. One of the program goals is to identify HIV positive patients during their acute infection stage, when they are most infectious, and link them to care which will significantly decrease further HIV transmission.

Results: DC is changing the discussion of how we measure successes in terms of monitoring and evaluation as it must change in the light of incorporating new and innovative programs into HIV prevention. The number of new infections identified and the number of condoms distributed will no longer be sufficient to describe the effectiveness of such programs in a changing prevention landscape. New indicator variables must now be used in conjunction with ones currently being used to measure any gaps in program implementation and to identify chemoprophylaxis programs that are successful. This may include reporting on prescription filling, regular doctor's visits, and biomedical markers when and if available from lab testing performed on these individuals.

Lessons Learned: Monitoring and evaluation of HIV prevention continues to add new indicators for program success. In the context of PrEP health departments will have to build monitoring and evaluation

systems that can be merged with other datasets to generate a more complete understanding of the state of HIV prevention in the jurisdiction.

Abstract 2320 - Health Department Data to Implement HIP – Washington, DC

Author(s): *Nicole Graci*

Issue: The potential of client-level health data to catalyze action to improve lives, as well as to identify opportunities and obstacles to optimal HIV-related health outcomes has never been greater. Data use supports access to a continuum of HIV prevention and care services. State and local health departments are uniquely situated to lead local, data-driven responses through use of health department datasets. To address persistent health inequities in HIV health outcomes, health departments must strive to make client-level data use acceptable to communities relying on data-driven services.

Setting: This state health department program has been implemented in a high-incidence Northeastern jurisdiction.

Project: In addition to state funds, the Pennsylvania Department of Health receives funding from the Centers for Disease Control and Prevention (CDC) to implement comprehensive HIV prevention programs to reduce morbidity, mortality, and related health disparities; in accordance with the National HIV/AIDS Strategy (NHAS). In 2013, two key performance measures were unable to be met; linkage to care of at least 80% of newly identified HIV positive persons and Partner services interviews with at least 75% of newly identified HIV positive persons. As a result, Pennsylvania decided to take a unique approach to High Impact Prevention (HIP) by implementing case specific monitoring of all new Partner Services (PS) investigations. In addition to further aligning Pennsylvania with the NHAS by increasing the effort of HIV prevention efforts and providing a more targeted approach, case specific monitoring of all new HIV positives allowed Pennsylvania the opportunity to monitor individual outcomes versus population outcomes, to effectively use HIV surveillance data for HIV Prevention activities, and to begin laying the foundation for future consideration of the development of other HIP programs, such as PrEP.

Results: Case-specific monitoring helped Pennsylvania meet performance standards set by the CDC on linkage of HIV-positive individuals and partner services interviews. The process improved relationships between health department staff, field staff and clients while identifying gaps in state data systems.

Lessons Learned: While case specific monitoring provides an effective way to not only monitor and evaluate the HIV prevention program, it is not done without many challenges and much collaboration. Not only is it essential to have competent central office and health department staff, collaboration must occur within the field for case specific monitoring to be effective. The data received from case specific monitoring should not only be used to monitor and evaluate partner services cases, it should be used to provide feedback and to develop a more targeted approach on specific geographical locations that may need more assistance in meeting performance measures of linkage to care and partner services. Health departments have to find a way to use their data to drive HIV prevention, specifically an approach to HIP.

Session C17 - The Effective Patient-Centered Medical Home

Abstract 1810 - Use and Impact of a Patient Portal in HIV Safety-Net Clinics: A Qualitative Study in California

Author(s): Shannon Fuller, Kimberly Koester, Wayne Steward

Background: The Patient-Centered Medical Home (PCMH) model may increase retention in care and viral suppression for people living with HIV. In 2011 the California HIV/AIDS Research Program funded an initiative to support the implementation and evaluation of five PCMH demonstration projects in HIV safety-net care settings. Electronic health records (EHR) systems are a key component of the PCMH model. Advanced EHR systems offer a portal by which patients may access health information, communicate with clinic staff and schedule appointments online. In this analysis, we examined how such patient portal use might contribute to improved engagement in care.

Methods: We conducted in-depth post-implementation interviews with 53 patients across all five sites, 53 pre-implementation interviews with providers/staff in all sites, and 11 post-implementation interviews with providers/staff in one site with a well-developed patient portal. These interviews were part of our overall assessment of PCMH interventions. Here we draw from themes that emerged in response to questions about the patient portal. In sites that did not implement a portal, we asked about feasibility and acceptability. In sites with a portal, we asked about acceptability and impact. Interviews were transcribed verbatim and we conducted a thematic analysis.

Results: Providers and staff believed that the portal had helped or could help patients manage and take greater interest in their health care. In the site with a well-developed portal, we found that patients liked the portal and used it frequently via smart phone, although many needed training and assistance to initially create an account. Patients utilized the portal in ways that facilitated active engagement with their care and improved monitoring of disease, such as scheduling appointments, communicating with providers (e.g., to obtain medication refills), checking labs, and monitoring trends in lab values. One challenge arising from this increased engagement was additional work for providers who had to respond to more frequent patient inquiries.

Patients in clinics that did not have a portal exhibited interest in using the technology. In particular, they hoped it would overcome challenges they experienced when trying to contact their clinics, although many had already identified informal workarounds (e.g., calling or emailing providers directly). Importantly, only one patient in these clinics described systematic efforts to save and organize paper copies of lab results, suggesting that a portal could offer tools to foster a greater role for patients in the management of HIV.

Conclusions/Implications: The EHR portal is a promising mechanism for enhancing engagement with care and patient self-management of disease in a safety-net setting. It had high levels of acceptability and uptake among our informants. To facilitate uptake elsewhere, clinics need to train patients on use of the portal and provide tools within it that are likely to engage the interests of patients, such as capacities to track lab values and reach out to clinic providers and staff for information. Further research can be done to determine if portal-facilitated engagement with care leads to meaningful changes on key

HIV care continuum indicators, such as longer-term retention in primary HIV care, adherence to ARVs, and viral suppression.

Abstract 2096 - The Impact of Patient-Centered Medical Homes on ART Prescription, Retention in Care, and Viral Suppression Among HIV Patients in Publicly Funded Clinics

Author(s): *Wayne Steward, Aaron Cook, Mary Guzé, Shannon Fuller, Kimberly Koester, Starley Shade*

Background: The patient-centered medical home (PCMH) involves practice transformations intended to facilitate access to services, better coordinate care, enhance patient engagement with services, and improve overall quality of care. PCMH-related changes typically include a transition from clinician-centered care to clinician-directed, team-based care; expanded hours and/or more flexible appointment scheduling; tools, such as a patient portal in an electronic health record, that encourage communication between patients and providers; and implementation of quality improvement practices. Beginning in 2011, the California HIV/AIDS Research Program supported an initiative to implement and evaluate PCMH components in publicly funded HIV clinics. We examined whether PCMH implementation was associated with changes in outcomes related to the HIV care continuum.

Methods: Five demonstration projects, encompassing publicly funded HIV care sites in diverse parts of California, took part in the initiative. A cross-site evaluation center was funded separately. Demonstration sites submitted copies of de-identified data from their annual Ryan White Services Report (RSR). The RSR tracks services delivered to, and HIV-related outcomes observed among, patients whose care is supported at least in part by the Ryan White HIV/AIDS Program. The data for these analyses included unique patient records from the year immediately prior to PCMH implementation ($n = 5929$) and the year immediately after PCMH implementation ($n = 6385$). We specifically examined changes in the proportion of patients who were fully engaged in care over the course of each year (minimum of two primary care visits spaced at least three months apart), had been prescribed antiretroviral therapy (ART) at some point during the year, and were virally suppressed as of their most recent viral load test.

Results: After PCMH implementation, there was an increase in the proportion of patients retained in care (61.7% vs. 64.3%, $p < .05$) and a smaller but still significant increase in the proportion of patients who were prescribed ART (82.2% vs. 83.9%, $p < .05$). Overall, the proportion of patients with viral suppression did not change during PCMH implementation (60.4% vs. 60.0%, ns). There were also important differences by site. The most substantial increase in retention (from 64% to 71%, $p < .05$) was observed at a clinic that focused its PCMH implementation on expanding use of a patient portal and implementing intensive efforts to monitor and improve care patterns and provide feedback to providers. This site was the only one that also reported a small increase in viral suppression (72% vs. 74%, $p < .05$). Other sites had smaller or non-existent improvements in retention, and no changes in viral suppression.

Conclusions/Implications: The PCMH is a potentially useful model for improving retention in care, as well as other HIV care continuum outcomes that are predicated on good retention (e.g., viral suppression). Its success at improving these outcomes appears to be dependent on where practice transformation efforts are focused. A greater impact on retention is more likely when efforts are

focused on facilitating patient-provider communication and closely monitoring outcomes as part of an intensive quality improvement process.

Abstract 2405 - A Patient-Centered CareTeam Approach at a State Health Department: Facing the New Realities of Government HIV/AIDS Primary Care and Treatment

Author(s): *Dr Teniade Fann, Dr Ewa Szczypinska, Dr Lynn Hopkins*

Issue: The primary care medical home and its patient-centered approach is revolutionizing America's primary care system. This transformational concept increases access to care, improves clinical efficiency, improves patient outcome and overall satisfaction, and helps to maximize on revenue.

People living with HIV/AIDS have complex health needs and often are uninsured. Government healthcare providers of HIV/AIDS treatment and care are typically the safety-net for this population by default, not by choice.

Setting: The Florida Department of Health in Orange County (FDOH-Orange) is an urban state-ran county health department in Orlando, FL. With over 2400 HIV+ patients attending it's HIV clinic called "The Sunshine Care Center (SCC)", it is one of the oldest and largest government providers of HIV primary and specialty care, as well as prenatal care to HIV+ women.

Facing the realities of the "Affordable Care Act" and the new medical economy (like the rest of America's healthcare industry), FDOH-Orange had to look for an innovative strategy to improve the provision of high-quality care in a government setting. The key goals were to:

- 1) Increase productivity and revenue
- 2) Improve patient health outcomes (decrease HIV prevalence in community)
- 3) Improve clinic/program efficiency
- 4) Increase patient customer satisfaction and community-responsiveness
- 5) Maintain and uphold the organization's public health mission, vision and goals

Project: After much consideration and research on the PCMH, the SCC decided to conduct a 2-month pilot project of a PCMH-like hybrid called "The Patient Centered Care Team (PCCT)". The fundamental concept of this integrated approach included a team driven by a physician, an ARNP, a RN, medical case managers, a medical assistant, and an HIV+ peer focused on patient adherence and compliance.

Continuous monitoring and evaluation of the model would be ongoing after months 1 and 2.

If the preliminary results were favorable, an attempt to expand the project into a larger demonstration project of 4 physician-driven teams total would be made over the course of 6 months.

Results: During the 1st week of implementing the first team, the patient no-show rate decreased to 20%. The SCC's no-show rate ranges between 40 - 60% on average.

Patients were educated by their nurses and case managers about the PCCT and reportedly were excited about this new way to engage them in their HIV care and treatment.

Key staff "buy-in" was strong and overall staff morale improved during the 1st month.

Given the early successes, a decision was made to roll out the remaining 3 teams.

Lessons Learned: The most important early lessons learned within the first month of implementation:

1) Attaining an optimal functioning patient centered team model that is self-sustaining requires a thorough evaluation beforehand of positions that are essential to supporting the model vs. those that will be rendered obsolete

2) Clinical support must be increased to support an increase in provider productivity

3) A patient-centered primary care medical home approach requires a financial paradigm shift (need to change the billing and supportive financial infrastructure) to optimize of generation of revenue; this can create challenges for traditional government agencies

4) Change is hard

Session C23 - HIV Testing: Data Analysis and Utilization

Room: A706 (Atlanta Marriott Marquis)

Abstract 1165 - The MSM Testing Initiative (MTI): Innovative approaches for HIV testing and linkage to medical care

Author(s): *Elizabeth DiNenno, Luke Shouse, Tricia Martin, Muazzam Nasrullah, Chanza Baytop, Alex Orr, Liza Solomon*

Issue: CDC estimates that in 2011 more than half of the number of diagnosed HIV infections in the United States were attributed to male-to-male sexual contact, indicating that gay, bisexual and other men who have sex with men (MSM) continue to be most impacted by HIV. The high prevalence of unrecognized HIV infection among MSM highlights an urgent need to expand HIV testing efforts and identify best practices for identifying the previously undiagnosed.

Setting: In 2011, CDC funded the MSM Testing Initiative (MTI). The purpose of this testing program was to identify HIV diagnoses among MSM who are unaware of their infection status, with particular focus on African American and Hispanic/Latino MSM, ensure that they are linked to HIV medical care, and document best practices in a report.

Project: MTI was a contract awarded to Abt Associates, Inc. Activities began in May 2012 and continued through May 2015. Goals of the project were to test approximately 60,000 men who reported sex with one or more men ever in their lifetime, identify 3,000 MSM with undiagnosed infection, and link at least 2550 (85%) to medical care within 90 days of their diagnosis. Five HIV testing strategies were implemented: venue-based testing, couples-based voluntary counseling and testing, large-scale episodic

events, social network strategy, and home-based testing. Over the course of the project, 37 partners from across the U.S. were subcontracted to perform these strategies.

Results: As of February 2015, 64,912 eligible men were tested for HIV, 1,954 (3%) previously undiagnosed men received an HIV diagnosis, and 1,328 (68%) men were linked to care within 90 days. A vast majority of the HIV tests (94%) and new diagnoses (94%) were obtained in a venue-based setting. Age and race/ethnicity characteristics were available on a subset of 1,127 MSM who were tested and identified as newly HIV-positive prior to June 2014. Of these, 33% were Hispanic/Latino, 46% black, and 21% were some other race. Most newly diagnosed HIV-positive men were aged 13-29 years old (60%). Social network strategies had a high yield of identifying new HIV diagnoses (12 new HIV-diagnosed MSM for 174 tests, or 6.9%), but was a resource-heavy strategy for partners to implement.

Lessons Learned: The MTI project demonstrated that a large-scale HIV testing contract can be used to engage multiple partners across the country and successfully test large numbers of MSM – in particular, black and Hispanic MSM – and link those who are diagnosed with HIV infection to medical care. Venue-based HIV testing can yield a high proportion of newly diagnosed HIV cases but challenges remain, such as identifying suitable and productive venues. In addition, linking MSM to HIV medical care immediately following diagnosis, particularly in non-clinical settings, is challenging and requires additional staff and support. Finally, in cities where both MTI and other CDC-funded testing programs were operating, local organizations experienced considerable overlap. A more coordinated effort should be implemented for the success of future HIV testing campaigns.

Abstract 1203 - Factors Associated with HIV Testing History among Persons at High Risk for HIV Infection, 2006-2010

Author(s): *Michelle Van Handel, Bridget Lyons, Emeka Oraka, Muazzam Nasrullah, Elizabeth DiNenno, Patricia Dietz*

Background: The Centers for Disease Control and Prevention and the United States Preventive Services Task Force recommend at least annual HIV screening for persons at high risk for HIV infection. This testing strategy is important for achieving one of the goals of the National HIV/AIDS Strategy (NHAS): to increase the percentage of persons living with HIV who know their serostatus to 90% by 2015. We estimated the percentage of US persons who report a behavior that increases their risk for HIV infection (i.e., high-risk persons) and assessed their testing history and factors associated with testing.

Methods: The analysis included 10,403 men and 12,279 women aged 15-44 from the 2006-2010 National Survey of Family Growth. Respondents who reported at least 1 sexual or drug-use risk behavior in the past year, such as male-to-male sex, injection drug use, or multiple sex partners, were classified as 'high-risk.' Respondents were characterized as 'recently tested' (i.e., tested in the last 12 months), 'tested more than 12 months ago,' or 'never tested.' Separate logistic regression models estimated adjusted prevalence ratios (APR) and 95% confidence intervals (CI) assessing the association between demographic and health-related factors and having recently tested or tested more than 12 months ago compared with never been tested.

Results: Overall, 12.6% of respondents (an estimated 15.6 million US persons) were classified as high-risk for HIV; 14.7% of men and 10.5% of women. Among high-risk men, 29.3% had recently tested for HIV, 30.7% tested more than 12 months ago, and 40.0% had never been tested. Among high-risk women, 38.0% had recently tested, 36.9% tested more than 12 months ago, and 26.1% had never been tested. High-risk men who were aged 40-44 (APR=1.54; 95% CI=1.04-2.27) , black/African American (APR=1.43; 95% CI=1.19-1.73), homosexual/gay (APR=1.94; 95% CI=1.59-2.36) or bisexual (APR=1.70; 95% CI=1.37-2.10), and had visited a doctor in the past year (APR=2.83; 95% CI=2.22-3.61) were more likely to have recently tested than those who were aged 15-19, white, heterosexual, and had not recently visited a doctor. High-risk women who were black/African American (APR=1.39; 95% CI=1.22-1.59), had visited a doctor in the past year (APR=1.82; 95% CI=1.36-2.43), and were currently (APR=2.06; 95% CI=1.65-2.56) or previously (APR=1.83; 95% CI=1.52-2.20) pregnant were more likely to have recently tested than those who were white, had not recently visited a doctor, and had never been pregnant. Factors associated with recent testing and testing more than 12 months ago were similar.

Conclusions/Implications: An estimated 15.6 million US persons aged 15-44 are at increased risk for HIV infection, yet only approximately one-third of them had been tested for HIV in the last 12 months as recommended and an additional one-third had never been tested. These results highlight the high-risk subgroups most likely to be screened for HIV annually, and suggest potential gaps in testing. All opportunities to screen persons at high risk of HIV infection need to be optimized to achieve the NHAS goal of diagnosing 90% of persons living with HIV infection by 2015.

Abstract 1505 - Analyzing Risk Disclosures & HIV Seroconversion in HIV Testing Data to improve HIV Testing Outcomes

Author(s): *Curt Hicks, Fangchao Ma*

Issue: Effectively targeting HIV prevention services to identify and link to services undiagnosed HIV-infected persons is critically important to High Impact Prevention, particularly in jurisdictions with diminishing federal and state resources. In 2013, Illinois PS12-1201 funded risk-targeted testing statewide barely exceeded the CDC performance standard of 1% HIV seropositivity, in part because Illinois risk definitions for Injection Drug Users and High Risk Heterosexuals recommended by the HIV Planning Group were prioritizing for sets of persons who tested positive at substantially below 1% HIV seropositivity statewide. Furthermore, complex 2013 risk definitions resulted in a lengthy risk assessment problematic for providers and clients. A means of raising overall HIV testing seropositivity using simpler risk assessments was needed.

Setting: The Illinois Regional HIV Prevention Grant funds comprehensive HIV prevention services for prioritized high risk clients in every region within IL DPH's PS12-1201 jurisdiction (the State of Illinois excluding the City of Chicago). The PS12-1201 supported Regional grant funds over 50 providers serving 8 regions statewide to conduct HIV and integrated STI testing, prevention for positives identified both through surveillance and through outreach, and prevention for high risk negatives. Regional grantees provide risk-targeted HIV testing to roughly 7000 Illinois residents each year in both Healthcare and NonHealthcare settings.

Project: The Illinois Department of Public Health HIV Prevention Unit in consultation with the IL HPG used HIV testing data to revise the risk group definitions for its 2014 priority populations. The new risk group definitions were based on an analysis of over 9,400 Illinois HIV counseling and testing sessions identifying the risk disclosures most strongly associated with new HIV diagnoses. The goals of the analysis were to craft risk group definitions that (1) prioritized at pre-test more of new testing-identified positives, (2) increased the seropositivities found for prioritized populations overall, but particularly for High Risk Heterosexuals and Injection Drug Users, and (3) require fewer questions to categorize a client as prioritized than were required by the 2012 and 2013 risk definitions.

Results: Comparing results of Illinois Regional HIV Prevention Grantee testing for CY2013 to CY2014, testing guided by the data-based risk definitions improved in overall HIV seropositivity from 1.08% to 1.33%, a 23% increase with fewer risk assessment questions needed to establish a client as meeting the new risk definitions. High Risk Heterosexual serositivity increased from 0.54% to 0.75%, a 39% improvement. IDU serositivity remained essentially unchanged from 0.88% to 0.87%. MSM serositivity increased from 1.5% to 1.8%, a 20% improvement. MSM/IDU serositivity increased from 1.1% to 1.6%, a 45% improvement. The percentage of newly identified positives classified by risk assessment prior to testing as non-prioritized remained essentially stable from 6.7% to 6.8% categorized as non-prioritized risk prior to the test result. Several critical improvements and no decreases in diagnostic efficiency were achieved with greatly simplified risk assessments. Data-based risk question improvements will be discussed.

Lessons Learned: Analysis of HIV testing records to identify specific risk disclosures which best predict new HIV diagnoses can strengthen prioritized risk definitions resulting in substantially improved statewide HIV seropositivity rates for risk-targeted HIV testing programs.

Abstract 5005 - Characteristics of MSM Who Complete Home HIV Testing Versus Those Who Do Not: eSTAMP Online MSM HIV Home Testing Study, United States, 2014

Author(s): *Robin MacGowan, Pollyanna Chavez, Craig Borkowf, AD McNaghten, Sabina Hirshfield, Arin Freeman, Laura Gravens, Mary Ann Chiasson, Akshay Sharma, Patrick Sullivan*

Background: Research studies designed to gain a better understanding of home HIV testing among at-risk men who have sex with men (MSM) are critical to reducing incidence in this population. Recruiting MSM online for HIV research studies may help improve access to research and services for hard-to-reach MSM. To determine characteristics associated with completing home HIV testing as part of an online research study, we assessed demographic and behavioral differences between MSM who did and did not complete home HIV testing.

Methods: MSM who reported unknown or negative HIV status were recruited using internet banner ads from May – October 2014. After completing an online baseline survey, participants received a package with 1 OraQuick® In-Home HIV Test (OQ), 1 SURE CHECK® HIV 1/2 Rapid HIV Test (SC), and a dried blood spot (DBS) specimen collection kit. Participants were provided with written instructions and videos on how to conduct each testing activity. Participants were instructed to report the results of their rapid tests online (positive, negative or invalid/not working) and mail the DBS card for lab testing. Stepwise

logistic regression analysis was conducted to compare participants who completed all three HIV testing activities to those who did not; $p < 0.05$.

Results: Of 838 MSM who received the HIV testing study package, 64% were 18-34 years old, 59% white, 22% Hispanic, 10% black, 51% college graduates, 85% homosexual/gay, 19% had never tested for HIV, and 36% reported more than 1 male partner with whom they had anal sex without a condom in the past 12 months. Many (519, 62%) reported both home HIV test results and returned the DBS card, 16% completed 1 or 2 testing activities, and 22% did not complete any activities. Black and Hispanic men, men who did not identify themselves as homosexual or gay, men who had never tested for HIV, and men who had 2 or more male partners with whom they had anal sex without condoms in the past 12 months were less likely to complete all study activities. Education and age were not significant in the model.

Characteristic, Odds Ratio, 95% Confidence Interval: Other vs White (OR 0.750) (95% CI 0.448 - 1.254); Black vs White (OR 0.558) (95% CI 0.346 - 0.901); Hispanic vs White (OR 0.562) (95% CI 0.394 - 0.800); Homosexual/Gay vs Other (OR 1.958) (95% CI 1.324 - 2.896); Never HIV tested vs Prev tested (OR 0.654) (95% CI 0.451 - 0.947); < 2 MASPWOC* vs ≥ 2 MASPWOC* (12 months) (OR 1.617) (95% CI 1.198 - 2.181); *(MASPWOC=Male anal sex partners without condoms)

Conclusions/Implications: Many participants reported their HIV home test results online and mailed in their DBS cards for lab testing. Additional efforts may be needed in future web-based HIV testing studies to improve completion of study activities among black and Hispanic MSM, and other MSM who may benefit from HIV testing.

Session C25 - New Media Technology Use for Engagement and Health Outcome Improvements

Room: A707 (Atlanta Marriott Marquis)

Abstract 1350 - Using Text and Email Messages to Improve the HIV Care Continuum

Author(s): *Dano Beck, Bhupendra Sheoran, Ruth Helsley*

Issue: Health routines play a significant role in improving the HIV care continuum. For people with ongoing risk behaviors, regular HIV testing allows those who acquire HIV to benefit from early diagnosis and treatment and to take steps to protect their partners. For people living with HIV (PLWH), daily medication adherence is key to optimizing health outcomes and reducing the risk of transmission.

Setting: To support regular HIV testing and medication adherence, the Oregon Health Authority and YTH (youth+tech+health) launched a mobile health service called Oregon Reminders in 2013. Anyone can enroll in the service by visiting <http://www.OregonReminders.org>. Oregon Reminders is promoted through one-on-one conversations with clients, as well as an online social marketing campaign targeted to men who have sex with men (MSM) and PLWH in Oregon.

Project: Oregon Reminders offers text, email, and voice reminders to take medications daily, to refill prescriptions monthly, and to get tested for HIV and other sexually transmitted infections (STIs) every 3 to 6 months. Users also can sign up for weekly health tips. The service and its marketing campaign were

developed with input from the target populations and other key stakeholders. Ongoing input and process evaluation have led to a number of improvements and new features designed to reduce barriers to enrollment and to testing and medication adherence. To assess changes in HIV testing behaviors and medication adherence, Oregon Reminders users were grouped by the month they enrolled and invited to complete an online survey at 6, 12 and 18 months following their month of enrollment. At each interval, the survey questionnaire remained identical. For this analysis, responses to the 6-, 12-, and 18-month surveys were aggregated. This presentation will highlight surveys findings, as well as process evaluation findings.

Results: Two years after its launch, Oregon Reminders had 1,384 active users. HIV/STI test reminders were the most popular service selected (1,086 users), followed by medication reminders (292 users), health tips (181 users), and prescription refill reminders (121 users). Through February 2, 2015, 110 surveys were completed by Oregon Reminders users. Of the respondents receiving HIV/STI test reminders, the majority (57%) indicated that Oregon Reminders helps them remember to test for HIV/STDs, and more than a quarter (29%) reported testing for HIV more frequently since signing up for Oregon Reminders. Of the respondents receiving HIV medication or prescription refill reminders, nearly three-fourths reported that Oregon Reminders helps them remember to take their medication (74%) and that they have missed a dose of their medication less frequently since signing up (72%).

Lessons Learned: Survey findings suggest text and email reminders can help users maintain or improve HIV testing behaviors and medication adherence. While health promotion efforts have historically focused on providing education to encourage behavior change, this project adds to the evidence that there is a need and interest in tools that help people actually implement those behaviors. Our process evaluation findings emphasize the importance of obtaining and responding to community input to ease client concerns and better meet their needs.

Abstract 1879 - Taking Social Network Strategy off the shelf: Testing Young, Black, MSM with SNS in the Era of Social Media

Author(s): *Melissa Morrison, Shanell McGoy, Darion Banister, Brandon Williams, Carolyn Wester*

Issue: Young Black MSM are the fastest rising cohort of new HIV infections in Tennessee, and in the US. In 2013, Tennessee data show Black/African American men 13-34 years of age comprised nearly half (48%) of new HIV cases acquired by male-to-male sexual contact in Tennessee (228/473).

Setting: This project takes place in two urban cities in Tennessee, Memphis and Nashville. Tennessee Department of Health (TDH) has contracted with three community based organizations in these two cities to conduct Social Network Strategy targeting young black MSM in both cities.

Project: TDH received CDC funding as part of the CAPUS demonstration project to implement Social Network Strategy among young Black MSM. TDH contracted with three CBOs who were experienced doing rapid HIV testing in the black gay community. The first 18 months of implementation were between June 2013 and November 2014 at three agencies. The SNS Personnel consisted of a Program Coordinator, and three SNS Specialists. Recruiters were identified by SNS specialists using social media (facebook, grindr, jack'd), bars and night clubs, underground greek life, and gay family networks. Each

recruiter received a \$20 gift card incentive for each network associate they identified who eventually came in and was tested for HIV. Each Network Associate also received a \$20 incentive if they agreed to participate in the program.

Results: In the first 18 months of the project, 1199 tests were conducted across all three agencies with a total positivity rate of 6.5% (37 new/41 prior). In total, Social Network Specialists identified 460 Recruiters and 1199 Network Associates to participate in the program. Linkage to care for newly diagnosed individuals found through the program was 91% (29/32). Only 32 of the 37 new cases were outside the 90 day linkage window at the time initial data was compiled. Use of social media was key to reaching out to new recruiters and to communicate with network associates, with greater than 50% of contacts using social media to communicate with the SNS coordinator.

Lessons Learned: Social Network Strategy, while not a new intervention, can be highly effective in reaching young black MSM for HIV testing interventions, especially when social media is incorporated as a communication tool and a way to locate potential recruiters. When using this culturally targeted strategy, TN has achieved positivity rates 6 times higher than with traditional outreach testing programs previously implemented.

Abstract 1931 - The DIFFA Project: Linking MSM to HIV/STD Prevention Messages and Services through Dating Sites

Author(s): *James Berglund*

Issue: Due to the evolving social media landscape, matchmaking online is a popular way for men who have sex with men (MSM) to seek companionship, often times for short-term sexual encounters. Many MSM in this community are at highest risk for HIV acquisition or transmission and are unlikely to access a clinical setting for prevention services. Furthermore, recent studies show that a high percentage of individuals report a negative status on their profiles, when in fact they have never been tested or have not tested since their last possible exposure.

Setting: The DIFFA project is a novel approach to HIV prevention being utilized by AIDS Arms, Inc. in Dallas, TX. The main objective of the DIFFA project is to utilize dating/hookup applications and websites to provide opportunities for candid discussion about HIV, testing, and lowering risk for HIV/STD acquisition. In addition, creating a forum for individuals to ask questions about sex and HIV without being stigmatized will allow for successful linkage to prevention and treatment services.

Project: With the support of a grant from the Design Industry Foundation Fighting AIDS (DIFFA), AIDS Arms, Inc. conducts outreach utilizing dating/hookup websites and applications that are used by MSM. Staff has established profiles through these networks, allowing for users to engage with a risk reduction specialist and ask questions about HIV/STD's, testing, PrEP, serodiscordance, condom use, etc. Once engaged with a user, staff is able to provide additional referrals for services such as further STD testing, accessing medications, and linkage to care for individuals who are HIV+. AIDS Arms has also created a specialized web page link that is sent to users. This provides testing hours and locations, additional HIV information, prevention videos created by AIDS Arms, and information on receiving an incentive for testing.

Results: From February 2014 through March 2015, the DIFFA project generated a total of 2,560 messages from users and 1,058 interactions – a response rate of 41%. The demographics of the men responding have been 18% African-American, 47% Caucasian, 22% Latino, 5% other, and 6% not reported. Nearly 60% of respondents were between the ages of 18 and 34.

The majority of conversations, 55%, have been men saying thank you for being visible online. Other conversations have covered a range of topics including, but not limited to, testing availability, PrEP, sero-discordant couples, strategic positioning and accessing services for PLWHA. 39 high-risk individuals have come to AIDS Arms for HIV testing as a direct result of interacting with a risk reduction specialist via the outreach profiles. Of those, one previously undiagnosed individual was successfully linked to care. A number of other individuals have also been referred to other STD testing and treatment, as well as linkage to HIV medical care and support services.

Lessons Learned: Utilizing these platforms has allowed for prevention messages to be disseminated immediately to a segment of MSM that are engaging in sex “right now” and may not receive needed information elsewhere. This innovative approach to outreach has increased testing of a high-risk population, along with linkage to other necessary services.

Abstract 2526 - Tech to Teach: Mobile Health Technologies as a Platform for HIV Health Education
Author(s): *John Guigayoma, Erika Dugay*

Issue: HIV continues to have a growing impact on younger generations, with the highest rates of infections among young men who have sex with men ages 13 to 24, but traditional health education interventions require platforms of communication such as in-person multi-session workshops and face-to-face discussion that might not fit into the lives of these populations. mHealth strategies such as mobile apps and single-message-system platforms can provide new opportunities to engage with these populations through the technologies in which they socialize.

Setting: Asian & Pacific Islander Wellness Center is a community-based organization that provides family planning and STD testing services in the Tenderloin neighborhood of San Francisco, one of the densest, poorest urban neighborhoods in the country where youth experience some of the highest rates of teen pregnancy and STD infections in the city. This program targets Tenderloin area youth ages 13 to 18.

Project: Teen Mobile: Stress Less About Sex is a program at A&PI Wellness Center that provides sexual health education and family planning referrals to Tenderloin area high school aged youth through a customized cell phone message platform. The distribution and content of these text messages is through an adaptation of Popular Opinion Leader, a CDC Diffusion of Effective Behavioral Interventions program for HIV. As programs struggle to engage hard-to-reach populations through HIV prevention interventions and HIV and STD screenings, Teen Mobile was able to reach nearly 150 youth across San Francisco in one year to participate in an eight-week sexual health education program, all through the mobility, immediacy and community-building power of mobile health technology. Teen Mobile was funded by a Google Impact Challenge award.

Results: From November 2014 to February 2015 a group of 64 Tenderloin area youth participated in the first round of text messages through Teen Mobile: Stress less About Sex. Baseline surveys asked questions around “knowledge of sex and sexual health,” “knowledge of birth control methods,” and “knowledge of STDs” across three categories: “a lot of questions,” “pretty good” and “share info with friends.” Exit surveys implemented at the end of the intervention revealed marked increases in knowledge, including a 19 percent increase in knowledge of birth control methods from “pretty good” to “share info with friends” and a 10 percent increase in knowledge of sex and sexual health in the same markers.

Lessons Learned: The primary lesson we learned from program implementation is the use of mHealth technology not as a replacement for human interaction, but rather as a conduit for face-to-face interaction as an opportunity for community building. Popular Opinion Leader meetings were originally to monitor user engagement and troubleshoot platform issues but quickly became opportunities for engaged youth to work on longer-term projects and further disseminate sexual health messaging through new media formats. An organizational learning was around coordination of services from prevention to medical services, both in patient privacy and in patient referral. In order to best funnel clients from mobile health technologies to medical services, all services must be in alignment and have adequate infrastructure to take on these referrals.

Session C28 - PrEP: Capacity-building with Youth and Latino MSM

Room: A601 (Atlanta Marriott Marquis)

Abstract 1140 - ¡Listo!/Ready!: A Culturally Tailored Pre-exposure Prophylaxis Campaign for Latino MSM
Author(s): *Natalie Sanchez, Ramon Garcia, Thomas Siegmeth*

Issue: In 2012, the FDA approved the use of Truvada as a form of Pre-Exposure Prophylaxis(PrEP) for the prevention of HIV. Despite its approval there has been minimal awareness and even less uptake from populations at greatest risk of HIV including Latino MSM. In LA County, Latino men comprised 36% of the AIDS epidemic (46% among HIV-positive men), making them the most impacted population. Of those Latinos recently diagnosed with HIV infection, 61% were born outside of the U.S. (i.e. Mexico and Central America). This large percentage of immigrants highlights the importance of considering cultural attributes and language when developing health education materials and creating public health awareness campaigns. AltaMed has been the first organization in Southern California to develop a bilingual, English and Spanish, PrEP awareness campaign targeting Latino Men who Have Sex with Men.

Setting: Community Health Centers and LGBT Venues throughout Los Angeles, CA

Project: In response to the tremendous need for community awareness around PrEP, AltaMed embarked on developing a bilingual culturally tailored PrEP Awareness Campaign targeting Latino MSM in Los Angeles and Orange Counties. The goal of the “¡Listo!/Ready!: PrEP Campaign” was to increase PrEP knowledge and encourage PrEP use among Latino MSM. In tandem with the campaign PrEP Screening and Patient Navigation were incorporated into the program. The campaign and outreach materials were culturally‐tailored to the different populations of Latino Men who have sex with Men including English and Spanish speaking populations as well as gay and non-gay identified MSM. The

campaign included an online presence via websites, social networking sites such as Grindr targeting gay and bisexual men. The PrEP campaign is a community-level approach that utilized professionally produced videos that played at targeted venues. AltaMed will share information on the development of the campaign, show the PrEP Campaign videos and promotional materials, and discuss outcomes of the campaign

Results: AltaMed has been successful with its PrEP awareness campaign that de‐stigmatized PrEP in Latino MSM communities and fostered conversations around PrEP as a credible prevention method. AltaMed's PrEP campaign found that utilizing alternative outreach strategies were more effective with Latino populations not typically reached through conventional forms of outreach such as the distribution of printed health education materials.

Lessons Learned: The use of social media, Grindr advertising and displaying PrEP videos at club venues were most impactful in disseminating PrEP information to this MSM community. As the largest Latino HIV Provider in Southern California, AltaMed continues to develop innovative approaches for High Impact Prevention and incorporates videos to engage the community in conversations about sexuality and safer sex options.

Abstract 1227 - PrEP arandonos: Mobilizing communities to reach Latino gay and bisexual men and transgender individuals.

Author(s): *Luis Scaccabarozzi, Bolivar Nieto*

Issue: While the CDC made recommendations and provided guidelines in 2014 on PrEP, there is a pressing need of translating the intricate science of PrEP into cultural competent information towards application/implementation for service providers who are serving communities at risk; especially gay, bisexual, MSM, and transgender individuals within communities of color. There is a continued need for dialogue, targeted education, and resources building to address the increasing stigma around PrEP, its misconceptions, acceptability, and accessibility barriers.

Setting: PrEPárate is a national community mobilization/social messaging campaign led by Latino Commission on AIDS that combines traditional community mobilization and current mobilization trends via social media and messaging. It is perhaps the first national bilingual (English and Spanish) PrEP effort developed and implemented by a community based organization targeting healthcare and service providers, as well as potential consumers who could benefit from using PrEP throughout the U.S., Puerto Rico and U.S. Virgin Islands.

Project: PrEPárate's goal is to increase awareness and education; decrease stigma, and address the structural barriers surrounding PrEP through the provision of culturally competent and linguistically appropriate information via the development and implementation of a toolkit and web portal mainly designed for services providers working with those at high risk. Services include: updates on PrEP guidelines, trainer-of-trainers manual, participant manual; information dissemination through social marketing efforts delivered via traditional outlets and social media; and capacity building/technical assistance services (trainings on "how to"). This presentation highlights concept development, implementation, and preliminary evaluation results.

Results: From January 2014 through December 2014, a total 120,000 people were reached via social media (analytics: likes, re-tweets, comments, sharing) and over 2 million exposures to the campaign. A toolkit was disseminated to over 120,000 people, with over 1000 downloads. In addition, five (5) national training-of-trainers and five (5) trainings (New York City, Miami/Fort Lauderdale, Chicago, Los Angeles and San Juan, Puerto Rico) were implemented with a cumulative total of 300 people in attendance.

Lessons Learned:

- Better understanding of services providers needs in addressing and communicating information on PrEP,
- Better understanding of community acceptability measured through knowledge, attitudes, beliefs, and behavior towards PrEP,
- The impact of acceptability and stigma (people inquiring about it and accessing PrEP may indicate a decrease in stigma),
- Understanding that acceptability needs to be supported by availability and accessibility (resources, referrals, and linkages)

Abstract 2002 - PrEP Works, but Only When You [Have Access to] Take It: Improving PrEP Access for Young People in Chicago and Philadelphia

Author(s): *Caitlin Conyngham, Cassie Warren, Caroline Sloan, Catherine Dezynski, Giffin Daughtridge, Liz Franco, Helen Koenig*

Issue: While HIV traditional prevention methods have proven successful in some settings, the sustained incidence of HIV among people <30 years, both nationally and in large urban areas (notably Chicago and Philadelphia), suggests a need to scale up effective biomedical/ behavioral prevention interventions. In May 2014, the CDC recommended offering Pre-exposure Prophylaxis (PrEP) to people at high-risk of HIV. As the cultural acceptance and uptake of PrEP increases, there is a need for programs that effectively and sustainably increase barrier-free access to PrEP within communities at greatest risk of acquiring HIV by situating these programs in well-established youth-centered programs that offer healthcare, comprehensive social services in a supportive environment.

Setting: Y-HEP Health Center (YHC) in Philadelphia and Broadway Youth Center (BYC) in Chicago are community centers that take a trauma-informed and transformative justice approach to providing youth with low-threshold accessible on-site healthcare and support as they work toward their goals. Our programs and services address psychosocial and emotional issues, history of trauma, social skills, knowledge and training, development of community support, youth activism, and overall health. YHEP works to support young folks ages 13-24 years old and BYC is a space for Lesbian, Gay, Bisexual, Transgender, Queer and Gender Non-conforming (LGBTQNC) young people between the ages of 12-24.

Project: Our clinics have implemented early adoption of PrEP access, and approached young people's access to PrEP in a holistic, youth-centered space. Both programs have focused medication assistance, benefits enrollment, local and national advocacy, and have been attentive to identifying and reducing barriers to PrEP access for young people. Although the two clinics arose separately, this project: 1)

identifies qualities, common to both settings, that promote PrEP access and 2) provides descriptive data on clients and program utilization.

Results: We identified three common areas of our programs that have made us successful in promoting PrEP uptake: 1) the tools used to retain and create measured outcomes and frameworks through which we operate our services, 2) the support and protocol for medication assistance, and 3) our clinic flow and timeline for starting young people on PrEP. Since December 2012 YHC and BYC have initiated 96 and 118 people <30 years on PrEP. YHC's PrEP program has seen 1 seroconversions and BYC's PrEP program has seen 0 seroconversions. The programs identified and linked to care a total of 12 (8 at YHEP and 4 at BYC) new HIV diagnosis through baseline screening.

Lessons Learned: The PrEP programs at BYC and YHC have demonstrated the need for and success of offering PrEP for young folks at the margins in two different urban settings. Despite high rates of bacterial STIs the PrEP programs had few seroconversions among participants who are at the highest risk for HIV acquisition. Creating systems within the practice to decrease barriers to PrEP initiation, increase adherence, and provide holistic support to young folks has been at the center of building programs that are both successful and that meet the needs of a patient population with specific needs.

Abstract 5010 - Early Lessons Learned in Recruitment and Outreach Strategies in Promoting Access to PrEP for Young MSM of Color: The CRUSH Project

Author(s): *Ifeoma Udoh, Mi-Suk Kang DaFour, Mazdak Mazarei, Dena Quinones, Remi Frazier, Kristin Kennedy, Jeffrey Burack*

Issue: While the FDA approved the use of Truvada™ as PrEP for men and women in 2012, many communities vulnerable to HIV still have little or no knowledge about this highly effective strategy for preventing HIV transmission. Local health jurisdictions such as Alameda County are struggling to integrate and implement recommendations for PrEP access into HIV programs. Community based outreach organizations have limited resources to train staff in culturally appropriate language to in order promote PrEP as a prevention tool . The CRUSH Project (Connecting Resources for Urban Sexual Health), launched in 2013, is one of three demonstrations studies in California, to examine the implementation of PrEP as part of a package of sexual health services for young MSM, transgendered persons, and partners of HIV positive individuals

Setting: The main project site for CRUSH is located at the East Bay AIDS Center (EBAC) in Oakland, California. CRUSH partners with three community based organizations to support outreach and education in the East Bay- Asian Health Services, HIV Prevention and Education Project of Alameda County (HEPPAC), and RYSE Youth Center.

Project: The goal of the CRUSH Project is to evaluate the effectiveness of a tailored package of HIV care, treatment and prevention interventions to address the sexual health care needs of young people aged 18-29 years old. One of the aims of the project is to test and link 400 + young MSM and transgendered persons into sexual health services, including PrEP. In order to support this aim, outreach activities to identify potential participants and provide information about CRUSH were conducted by community partners. One specific activity used an adaption of Social Network Testing (SNT) for recruitment.

Through the CDC's Capacity Building Assistance (CBA) Program, CRUSH staff and outreach partners were trained in the adapted SNT protocol by the Primary Care Development Corporation. They also supported the development of monitoring tools for partners to document progress.

Results: CRUSH began enrollment in February 2014. Since March 2014, a total of 208 persons have enrolled. In October of 2014, our CBA provider implemented recruitment outreach training for all partners, which was then immediately rolled out into the field. From November 2014-March 2015, partners implemented a total of 282 community events. Thirteen percent of participants enrolled in CRUSH self-report having learned about CRUSH from another participant of the study. Eighty-five percent of those initiating self-referrals are using PrEP and 77% of participants enrolling in CRUSH because of their counterparts' word-of-mouth referrals have accessed PrEP, compared to 54% of participants not referred by word-of-mouth or the structured social network referral strategy.

Lessons Learned: Social network strategies need to be thoughtfully adapted for community organizations to use as an outreach tool for PrEP and sexual health service programs. Working with CBA providers can support PrEP programs in adapting and tailoring outreach approaches to support uptake. A robust "word of mouth" strategy has proven to be the most effective component of the CRUSH recruitment strategy. PrEP users may become important "opinion leaders" who then refer or enable more individuals to access PrEP.

**Session C32 - Identifying HIV Prevention Success Stories as a Component in the Evaluation Process:
Expected and Unexpected Results**

Room: A708 (Atlanta Marriott Marquis)

**Abstract 1246 - Identifying HIV Prevention Success Stories as a Component in the Evaluation Process:
Expected and Unexpected Results**

Author(s): *Janet Heitgerd, Tamika Hoyte*

Issue: CDC is held accountable for the impact of its HIV prevention funding toward meeting the goals of the National HIV/AIDS Strategy (NHAS). Making connections between CDC-funded health department and community-based organizations prevention program activities and their impact on the epidemic is complicated by factors such as delay in availability of surveillance data and the difficulty in establishing attribution over contribution. Success stories can be a useful evaluation tool to illustrate progress in the complex process of achieving NHAS goals.

Setting: A systematic process was piloted to collect, analyze, and report success stories from CDC-funded health departments and community-based organizations (CBOs). These success stories were identified through activities reported by grantees for different funding announcements (e.g., health department flagship prevention program, demonstration projects, and CBO programs targeting highest-risk groups). Success stories have the potential to communicate local successes to a variety of audiences and can highlight specific NHAS-related outcomes for decision makers, such as Congressional staffers.

Project: In 2014, CDC collected success stories from the following projects: Enhanced Comprehensive HIV Prevention Program (ECHPP), Care and Prevention in the United States (CAPUS), Comprehensive HIV

Prevention Program for Health Departments (PS12-1201), and Human Immunodeficiency Virus (HIV) Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color (PS11-1113). Potential success stories were identified through document review using quantitative and qualitative criteria. Follow-up confirmatory information was obtained during site visits, by email, and by phone call.

Results: Using an inductive process that allowed grantees to promote their own stories of success, the largest number of stories and most detailed information was identified from ECHPP. These success stories have been shared with the Division of HIV/AIDS Prevention (DHAP) leadership and are being disseminated to grantees through the DHAP Update. In contrast, selecting grantees based on quantitative indicator data resulted in the fewest success stories; however, unexpectedly, these stories also provided important information on the various ways grantees are interpreting and reporting on key HIV testing and Partner Services indicators. This information is being used by DHAP leadership to improve its ongoing monitoring and evaluation efforts.

Lessons Learned: Success stories are an important evaluation tool for filling information gaps but they may be difficult to construct and the activity resource intensive. For example, the identification of ECHPP success stories was aided by dedicating staff time and contractual support to the activity. Key considerations for story development include the target audience (e.g., public, Congress, peers), available and appropriate interpretation of evidence (e.g., quantitative, qualitative), project phase (i.e., beginning, mid-project, end), and intent (e.g., best practices, accountability). In response to a need for an active, systematic, and standardized process to develop success stories, DHAP's Office of Policy and Communication is developing a standardized template to streamline the collection of success stories.

Abstract 1355 - Success Stories: Examples from Two CDC-Supported HIV Prevention Demonstration Projects

Author(s): *Tamika Hoyte, Holly Fisher, Amanda Jones, Janet Heitgerd, Barbara Maciak, Mesfin Mulatu, Kim Williams, Stephen Flores*

Issue: Demonstration projects typically involve a new or innovative approach to implementing HIV prevention programs, which can require forming new relationships, building capacity, conducting pilot programs, developing standard operating procedures, and establishing new data systems and policies. These activities can be resource intensive, making it difficult to identify programmatic successes early on. Success is usually defined by project outcomes. However, CDC leadership may request examples of success before a project ends, long before outcome data are available.

Setting: The Enhanced Comprehensive HIV Prevention Planning Project (ECHPP), 2010-2013, supported health departments in 12 metropolitan areas with the highest AIDS burden, to enhance planning and implementation of a variety of interventions to improve local impact (Chicago, Miami, New York City, Los Angeles, San Francisco, San Juan, Baltimore, Atlanta, Houston, Dallas, District of Columbia, and Philadelphia). The Care and Prevention in the United States Project (CAPUS), 2012-2015, supports eight state health departments to expand HIV testing and optimize linkage and retention in care, among racial and ethnic minorities (Georgia, Louisiana, Tennessee, North Carolina, Virginia, Illinois, Missouri, and Mississippi).

Project: We adopted a systematic approach to identify and develop success stories for ECHPP. The approach specified selection criteria, potential data sources, and data collection tools. CDC project officers, evaluators, policy office representatives, and health department grantees were all engaged in the process. The approach used in CAPUS was primarily driven by very specific requests from CDC leadership and involved a review of the progress reports, as well as grantee engagement.

Results: The success stories selected for ECHPP and CAPUS highlight key efforts that show promising progress towards the National HIV/AIDS Strategy (NHAS) goals. Two examples will be provided demonstrating success in ECHPP: one addresses the NHAS goal of preventing new HIV infections through HIV testing activities targeting men who have sex with men (MSM), and the other addresses the NHAS goal of achieving a more coordinated response to the HIV epidemic through the integration of Ryan White Part A and HIV Prevention Planning Councils. For CAPUS successes, two additional examples will be presented, each addressing the NHAS goal of improving health outcomes for people living with HIV. The first example is the implementation of a new policy that enables the transfer of clinical information between the health department and medical providers and the second is the innovative use of data. These CAPUS activities will allow the health departments to identify people living with HIV who are out of medical care and provide linkage, retention, and re-engagement services as needed.

Lessons Learned: Success stories are useful for highlighting programmatic efforts during project implementation, before longer term project outcomes are available. Ideally, story development requires clear selection criteria, stakeholder engagement, and standardized data collection. These stories can serve as part of an overall evaluation and communications strategy for assessing the performance of CDC-supported HIV prevention programs.

Abstract 1453 - Approaches to Identifying Success Stories among CDC-funded Health Departments

Author(s): *Kristina Cesa, Aba Essuon, Jarvis Carter, Nadia Duffy*

Issue: Health departments (HDs) are using innovative strategies to deliver services to populations most affected by the HIV epidemic. The Centers for Disease Control and Prevention (CDC) seeks to highlight these strategies in success stories to facilitate peer-to-peer capacity building and inform stakeholders. HD program data can be used as a source of information for these success stories; however, the submitted data have several shortcomings (e.g., limited detail, lack of standardization) that present challenges for fully developing these stories.

Setting: CDC's Division of HIV/AIDS Prevention (DHAP) funds 61 health departments (HDs) to implement HIV prevention programs through funding announcement PS12-1201. HDs describe programmatic successes and challenges through required interim and annual progress reports (APR) for four core program components of PS12-1201: 1. HIV testing; 2. comprehensive prevention with positives (CPP); 3. condom distribution; and 4. policy initiatives. In addition, HDs are required to submit biannually National HIV Prevention Programs Monitoring and Evaluation (NHM&E) data for HIV testing, Partner Services (PS), and Risk-Reduction Activities (RRA).

Project: We used qualitative and quantitative approaches to identify potential success stories for PS12-1201. In the qualitative approach, we systematically reviewed the PS12-1201 Year 2 APRs for common successes experienced by HDs while implementing CPP activities. For this approach we performed a complete document review and did not have pre-set criteria of success. In the quantitative approach, data outcomes were used as a criteria for success, and sites with less than 5% missing PS data and greater than 50% of HIV-positive partners linked to HIV medical care were eligible to be included as a potential success story. Of the eligible sites, three HDs were selected for in-person site visits to discuss success stories and highlight innovative strategies used in their PS programs.

Results: We were able to describe commonly reported successes for CPP program activities by performing a qualitative review of APRs. For example, HDs described adopting high-impact prevention program models to integrate HIV testing programs with PS, linkage to HIV medical care, and STD testing as a successful strategy to integrate service delivery. The description and detail of the described successes were limited by the amount of information provided in the APRs. We were only able to identify one success story for PS programs by reviewing quantitative data. Of the three HDs originally selected for in-person meetings, one was found to have issues with local interpretations of variable definitions and one had data system issues. For this reason, it was determined that only one HD could be considered for a success story.

Lessons Learned: Document review and quantitative selection criteria are important approaches to consider when developing success stories. However, in order to develop success stories stemming from these approaches further exploration with HDs is needed in order to gather more detailed information and fully describe the innovative strategies used by the program. Analyzing quantitative data as the sole source of information for the development of success stories may be misleading due to variations in program implementation and interpretation of success.

Abstract 1818 - Identifying Success Stories among CDC-funded Community-Based Organizations: Examples from four PS11-1113 Grantees

Author(s): *Carolyn Wright, Shaliondel Benton, Adanze Eke, Jane Mezzoff, Andrea Moore, Taran Jefferies Pierce, Renee Stein, Gary Uhl, M. Angie Allen, Renata Ellington, Roderick Joiner, Kevin Ramos*

Issue: Because of their credibility with and access to populations at greatest risk for HIV infection, the Centers for Disease Control and Prevention (CDC) funds CBOs to provide HIV prevention services to groups that may not be reached by other programs.

Setting: Through funding opportunity announcement (FOA) PS11-1113, CDC funded 34 community-based organizations (CBOs) in the United States and Puerto Rico to provide HIV prevention services targeting groups at greatest risk for HIV infection: Young Men of Color Who Have Sex with Men and their partners (Category A) and Young Transgender Persons of Color and their partners (Category B).

Project: In 2014, CDC conducted site visits with 24 of the 34 CBOs and conducted phone interviews with three CBOs. As part of the site visit protocol, CDC selected four CBOs who achieved their FOA objectives during the first two years of program implementation to share their experiences. We developed a standardized set of questions to capture facilitators and barriers to their success, implications of

success, and program impact since implementation. Criteria for determining which CBOs would participate were based on data reported in their Annual Progress Reports (APRs) for year 1 (September 30, 2011 – September 29, 2012) and year 2 (September 30, 2012 - September 29, 2013) of the project period. We synthesized the data from the APRs and disseminated to CBOs through Rapid Feedback Reports (RFRs). The RFRs present data in the focus areas of HIV testing, HIV positivity, and linkage to HIV medical care.

Based on program achievements in year 1 and year 2, four of 34 CBOs, (two from Category A and two from Category B) were chosen to participate in the success story discussion. These CBOs met or exceeded at least two of the FOA requirements in 1) testing at least 600 (Category A) or 75 (Category B) clients; 2) HIV positivity of at least 4%, and 3) linking at least 70% of HIV-positive clients to HIV medical care.

Results: All four CBOs attribute the success of their programs to the dedication and hard work of their staff, and the overall support of the organization. However, when we asked the CBOs to describe their programs, we determined that the data reported in their APRs are interpreted differently across the four agencies. For example, one agency defined “linkage” as scheduling the appointment; whereas another agency defined linkage as providing a referral.

Lessons Learned: Success stories can be a valuable tool for highlighting program achievements. By using data presented in the RFRs, we were able to identify four CBOs to showcase their success in HIV testing, HIV positivity, and linking HIV-positive clients to HIV medical care. However, it is important to understand factors such as varying data collection and reporting methods, and data interpretation when making comparisons across agencies to evaluate success.

Track D

Session D04 - Getting to Zero: Important Considerations to HIV Planning

Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1712 - San Francisco's Getting to Zero Initiative

Author(s): *Shannon Weber, Dana Van Gorder, Jeff Sheehy, Neil Guiliano, Hyman Scott, Diane Havlir, Susan Buchbinder*

Issue: Issue: Given advances in biomedical prevention and treatment strategies, we now have the scientific means to end sexual HIV transmission. With advances in HIV treatment, those living with HIV who initiate and sustain treatment can expect a normal life expectancy. Since the beginning of the HIV epidemic, San Francisco's public health response and community-based efforts have pioneered prevention and treatment approaches: widespread HIV testing, early antiretroviral (ARV) treatment, syringe exchange programs, a decade of all San Franciscan babies born HIV-free, community led disclosure and seroadaptive practices, and early implementation of pre-exposure prophylaxis (PrEP). As such, currently 94% of HIV infected San Franciscans are aware of their status, 89% of those living with HIV are linked to medical care within 90 days of their diagnosis, approximately 85% of all San

Franciscans living with HIV are receiving ARV treatment, and new HIV diagnoses have fallen to 359 in 2013.

Setting: Setting: San Francisco is on the path to one of the first municipal jurisdiction in the United States to achieve the UNAIDS vision of “Getting to Zero”: Zero new HIV infections, Zero HIV deaths and Zero HIV stigma. In 2014, the San Francisco Getting to Zero initiative formed a multi-sector independent consortium operating under the principles of collective impact.

Project: Project: San Francisco’s Getting to Zero consortium’s short term goals are to reduce both HIV infections and HIV deaths by 90% from their current levels by 2020. To reach these ambitious goals all San Franciscans, including youth, need be knowledgeable about expanded HIV prevention methods with those living with HIV having support for health and wellness. It will take a broad coalition of community members, schools, businesses, government agencies, and HIV providers working together to achieve this vision. With increased knowledge and access to prevention strategies, increased services for HIV-infected people not in care, and providing services for substance use, housing instability, and mental health promotion, can we reach the Getting to Zero goals.

Results: Results: San Francisco’s Getting to Zero strategic plan calls for 3 signature initiatives – PrEP expansion, immediate ARV therapy initiation for new HIV diagnosis (the RAPID approach) and retention and re-engagement in care. All initiatives support expanded options to eliminate new HIV infections, prevent HIV-related disease complications and reduce health disparities for HIV infected and affected populations in San Francisco. The Getting to Zero strategy relies on measurable objectives with business plans to support metrics. As such, public and private entities are being engaged to fund the consortium’s first initiatives. Requesting support across sectors is recognizes of the need for broad cross-sector engagement to achieve these goals. Getting to Zero has leveraged the multi-sector consortium to gain political endorsement with specific funding allocated in the Mayor’s 2015-16 budget.

Lessons Learned: Lessons Learned: Developing a community-based framework is possible and provides opportunities for broad-support and engagement including both in-kind and novel funding strategies. Leveraging existing successes, identifying and prioritizing local gaps in prevention and care continuums are key to scaling up the Getting to Zero efforts in San Francisco’s already highly successful model.

Abstract 1713 - Building a Movement: Getting to the End of AIDS in Washington State

Author(s): *Maria Courogen*

Issue: Since the 1980s, Washington has taken bold action on the AIDS epidemic. Resources have been focused on areas of the state with most disease and interventions most likely to interrupt disease transmission. As a result, nearly 90% of people living with HIV (PLWH) know their status. More than 70% of PLWH were in care in the last 12 months, and nearly 60% of PLWH are virally suppressed. There have been decreases in new HIV infections, new AIDS cases and deaths in PLWH. Due to a confluence of current factors, Washington is poised to accelerate progress. With flexible resources, we can give people access to new prevention tools like pre-exposure prophylaxis (PrEP). Through the Affordable Care Act, more people than ever have access to health care. People least likely to get diagnosed and maintained in care over time are those who struggle with issues such as mental illness, chemical dependency, and

unstable housing. A priority of the transformation of Washington's health system is to integrate physical and behavioral health care and social supports for high-need individuals. This system-wide transformation will contribute to our efforts to End AIDS.

Setting: In 2014, Governor Jay Inslee proclaimed December 1st as the beginning of our work to End AIDS in Washington. This statewide call-to-action asks that public health experts, health care providers and systems, community advocates, businesses, state agencies, customers, and others work together to End AIDS.

Project: End AIDS Washington involves building on existing frameworks and structures. The development of the Washington State Strategic HIV Prevention Framework created a foundation. The framework focuses on six geographically and population focused outcomes that directly influence HIV transmission. The End AIDS campaign was proposed to the Governor by Washington's newly-integrated (2014) prevention/care planning group, the HIV Planning Steering Group (HPSG), and the Governor empowered the HPSG to lead a process of generating recommendations to achieve the goals of End AIDS Washington, including reducing the rate of new HIV diagnoses by 50% by 2020 and reducing disparities in health outcomes.

Results: In early 2015, the HPSG launched a workgroup to develop an action plan to End AIDS to present to the Governor by December 1, 2015. Through mid-2015, there will be a robust effort to collect recommendations using a combination of survey, social media, town hall meetings, and other methods. Recommendations will be sorted and prioritized using a "strategic filter" composed of a key set of questions. Acceleration of efforts will be realized as we engage a broad scope of partners, align our interventions with health systems that are evolving across the state, and engage the Governor in using his legislative and executive authorities to break down silos and barriers.

Lessons Learned: As we have embarked on this work, we have seen the importance of defining what "End AIDS" means, seeking not to alienate those who are important to the efforts, specifically PLWH. We are also learning that building a movement to end a disease does not look like building a system to manage a disease.

Abstract 1990 - Frameworks for Getting to Zero: The New York State Plan to End AIDS by 2020

Author(s): *Johanne Morne, Demetre Daskalakis, Mark Harrington, Charles King, Virginia Shubert, Kimberleigh Smith, Daniel Tietz*

Issue: In June 2014, Governor Andrew Cuomo made history by committing New York State (NYS) to end AIDS as an epidemic by 2020. This ambitious goal is grounded in reality. NYS is a center of innovation in the fight against AIDS, and has in the last decade reduced the number of annual new HIV infections by 40% while no decline in infections was seen nationally. With the expansion of healthcare, successful Medicaid redesign, and dissemination of antiretroviral medications as treatment and prevention, NYS has the tools to stop new HIV infections and eliminate AIDS deaths.

Setting: NYS bears the highest burden of HIV in the United States. The NYS AIDS Institute estimates that 154,000 New Yorkers are living with HIV, about 130,000 are aware. While 80% of cases are in New York

City (NYC), NYS has urban and rural epidemics with all 62 counties reporting HIV cases. Although HIV has touched every population in NYS, 79% of persons with HIV are people of color and 56% of new HIV diagnoses in 2013 were among men who have sex with men (MSM).

Project: Governor Cuomo's "Bending the Curve" plan to end the AIDS epidemic includes: 1. Identifying persons with HIV who remain undiagnosed and linking them to health care; 2. Linking and retaining persons diagnosed with HIV to health care and getting them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission; and 3. Providing access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

Results: In October 2014 Governor Cuomo appointed an Ending the Epidemic (ETE) Task Force of HIV/AIDS experts from public and private industry and health and community organizations. Task Force workgroups developed recommendations for prevention, care, housing/supportive services, and data. In early 2015 the Task Force completed a Blueprint to not only meet the Governor's mandate to "bend the curve" but to exceed that mission with proposals to "get to zero" new infections and HIV-related deaths. NYS recently allocated \$10million in funding for ETE implementation and made changes to NYS laws that had previously undermined the effectiveness of condom and clean syringe distribution. NYS has also:

- Updated HIV testing and surveillance laws to lower the administrative threshold for testing and facilitate the use of surveillance data to facilitate care.
- Negotiated HIV drug discounts to expand treatment access
- Put in place an affordable housing protection for disabled persons with HIV in NYC
- Moved towards transgender equality

Lessons Learned: The NYS ETE plan is the product of ongoing collaboration of community, government, researchers and healthcare providers. Community members work together through a broad End AIDS NY 2020 coalition. NYS and NYC strategize to leverage rather than duplicate efforts. To date, the NY experience provides a template for action with a new approach to controlling the HIV epidemic. Key participants in the NY process propose to share the components of their strategy as well as methods for assessing efficacy of their action to end AIDS.

Session D11 - TRANSforming Testing to Care: Transgender Prevention Initiatives

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1193 - HIV Prevalence among Transgender Women and Men: Results from the STD Surveillance Network, 2010-2013

Author(s): Marc Pitasi, Eloisa Llata, Mark Stenger, Roxanne Kerani, Robert Kohn, Ryan Murphy, Preeti Pathela, Laura Ruise, Christina Schumacher, Irina Tabidze

Background: Prior research suggests that male-to-female transgender persons (i.e., transgender women) are at high risk of HIV infection. However, less is known about the burden of HIV infection among transgender men, and few studies have directly compared HIV risk in these groups with other high-risk groups such as men who have sex with men (MSM). We estimated the prevalence of HIV infection among transgender women and transgender men attending sexually transmitted disease (STD) clinics across geographically diverse sites in the United States and compared HIV prevalence and

demographic characteristics among various subgroups defined by gender, sex, and sexual identity and behavior.

Methods: We analyzed data abstracted from the medical charts of self-identified transgender women (n=443) and transgender men (n=106), MSM (n=44,002), cisgender (i.e., non-transgender) men who have sex with women only (MSW; n=113,241), and cisgender women (n=125,255) who had one or more visits to a selected STD clinic participating in the STD Surveillance Network (SSuN), a sentinel surveillance system of collaborating STD clinics that follow common protocols for data collection and management. This analysis included visits to participating clinics in Los Angeles, San Francisco, New York City, and Seattle from January 1, 2010 through December 31, 2013. Cisgender men who reported sex with a man during the three months prior to any visit or who self-identified as gay or bisexual were classified as MSM. Positive HIV status was ascertained through a combination of self-report, clinician diagnosis, and/or laboratory test result across all recorded clinic visits. Unadjusted prevalence and corresponding 95% confidence intervals (CI) were estimated as the proportion of all clinic attendees over the study period that had evidence of HIV infection at any clinic visit. Pearson's chi-squared tests were used to compare prevalence estimates between subgroups.

Results: MSM had the highest overall HIV prevalence (18.3%; 95% CI: 18.0%, 18.7%), followed by transgender women (15.4%; 95% CI: 12.1%, 19.1%), transgender men (1.9%; 95% CI: 0.2%, 6.7%), MSW (0.6%; 95% CI: 0.6%, 0.7%), and cisgender women (0.5%; 95% CI: 0.5%, 0.5%) ($p < 0.01$). HIV prevalence was higher among black transgender women (34.7%; 95% CI: 25.4%, 45.0%) compared with their white (9.1%; 95% CI: 3.0%, 20.0%) or Hispanic (11.5%; 95% CI: 7.7%, 16.4%) counterparts ($p < 0.01$).

Conclusions/Implications: Transgender women attending STD clinics have a high prevalence of HIV infection that is comparable to the prevalence among MSM attending STD clinics. HIV prevalence was lower among transgender men compared with MSM and transgender women but over 3 times as high as the prevalence among MSW and cisgender women; however, this finding was limited by the small number of transgender men in our sample. Transgender women and men are populations with HIV burdens that warrant further study and increased prevention efforts. Further research is needed to better understand factors that may be important to HIV prevention efforts in these populations.

Abstract 1284 - HIV Risk Behaviors and Prevention Experiences of Black and Latina Transwomen in Three U.S. Cities: Results from the Transgender HIV Behavioral Survey Pilot

Author(s): *Damian Denson, Paige Padgett, Nicole Pitts, Jeffrey Herbst, Trista Bingham, Juli-Ann Carlos, Pamela McCann, Nikhil Prachand, Jan Risser, Teresa Finlayson*

Background: In the US, prevalence estimates for HIV infection among transwomen are high, particularly among racial/ethnic minorities. Despite increased risk for acquisition and transmission of HIV and evidence of racial disparities, few data are available to inform HIV prevention efforts. This study will describe the 1) sociodemographic characteristics, 2) reported HIV/STD-related risk behaviors, and 3) HIV testing and prevention activities as reported by black and Latina transwomen in three U.S. metropolitan regions: Chicago, Houston, and Los Angeles County.

Methods: The Transgender HIV Behavioral Survey Pilot conducted in 2009 in three US metropolitan regions (Chicago, Houston, Los Angeles) used respondent-driven sampling to recruit 227 black (n = 139) and Latina (n = 88) transwomen. We estimated sociodemographic characteristics (e.g., health insurance, employment, homelessness, and incarceration), HIV/STD-related risk behaviors (e.g., substance and injection drug use, exchange sex) and HIV/STD testing of the sample. Descriptive statistics were further stratified by race/ethnicity. Chi-square analyses were used to test for racial/ethnic differences in risk and preventive behaviors that may be associated with HIV infection.

Results: Of the 227 black and Latina transwomen in the survey, many reported annual incomes less than \$15,000 (73%), lack of health insurance (60%), being unemployed (61%), or being homeless in the past 12 months (46%). A quarter (24%) reported being incarcerated in the past 12 months. Hormone use was common (83%), with half of transwomen reporting injection of hormones within the past 12 months. Fewer transwomen reported injection of silicone or other substances (27%). Many transwomen had exchanged sex for money or drugs in the past 12 months (40%). Transwomen reported high prevalence of anal sex without condoms (63%), but lower prevalence of illicit non-injection drug use (37%) and illicit injection drug use (4%) in the past 12 months. Visiting a healthcare provider (80%) or participation in HIV behavioral interventions (64%) in the past 12 months was common, but hepatitis C and syphilis testing rates were not optimal (40% and 46%, respectively). Of the 156 (69%) transwomen tested for HIV in the past 2 years, 28% self-reported being HIV-positive. Differences by race/ethnicity were observed in use of crystal methamphetamine (black 15% vs Latina 48%, $p=0.002$) and ecstasy (black 39% vs Latina 18%, $p=0.035$) by transwomen who reported drug use in the past 12 months. Black transwomen were also more likely than Latina transwomen to have health insurance (black 29% vs Latina 11%, $p=0.006$) and to inject hormones (black 59% vs Latina 39%, $p=0.005$) in the past 12 months.

Conclusions/Implications: These data reveal the socioeconomic disadvantages faced by black and Latina transwomen that may heighten their risk for HIV transmission and infection. While these findings suggest that many transwomen access healthcare and HIV prevention efforts, there is a need for economic programs to increase opportunities for employment training, housing, and other basic needs. These pilot data can also be used to strengthen culturally competent HIV prevention programs that may reduce sexual and injection risk behaviors among racial/ethnic minority transwomen at high risk for HIV transmission or acquisition.

Abstract 2334 - TRANSforming Dade: Utilizing a Work Group to Address the Needs of the Trans-Identified Community in Miami-Dade County

Author(s): *Geralbert "Alex" Barros, Sarah Kenneally, Francesco Duberli*

Issue: There is an estimated trans-identified population of 5,020-20,080 individuals living in Miami-Dade County (MDC), Florida. Although there are no national prevalence estimates of HIV amongst the transgender community, local efforts have recognized that trans-identified is at high risk for HIV infection. Sex work related activities, poverty, and violence have become the perfect combination to place this community, especially those working in the sex industry, at high risk for engaging in sexual behaviors leading to an increase of acquiring HIV. Florida Department of Health – MDC utilized a workgroup to address Transgender and HIV.

Setting: Miami-Dade's unique geographic location and cultural diversity have made it a gateway for Latino Transgender and gender non-conforming immigrants from the Caribbean, Mexico, and Central and South America. The strong Latino culture, that has influenced Miami social and economic development, makes the language and acculturation processes less of a barrier for Latino transgender immigrants. In particular, transgender communities have found Miami a more accessible environment, where gathering and social nets are easier to develop. These social nets are fundamental in promoting, teaching and developing new survival skills and work related activities in an environment influenced by poverty, violence, discrimination, and trans phobia.

Project: Transgender workgroup (TGW), a think tank of community experts, was created to provide strategies that address the growing HIV rates and health disparities amongst trans-identified. This workgroup gathered data, built a coalition, and identified an organization, Survivor's Pathway, to work with transgender. Survivor's Pathway created the Trans-Latina project, focusing on the Latino transgender needs and gender non-conforming communities of Miami. This organization provides a safe and affirming environment, offering culturally and gender oriented mental health, HIV testing, legal advocacy and emigration services. Currently 200 Latino transgender women (MTF) and gender non-conforming individuals are registered in this program.

Results: Sharing findings, data, and monthly reports to the local planning prevention group have prioritized transgender issues. Since 2012, the first transgender drop in resource center opened doors with two more organizations creating resource centers. Survivor's Pathway, in the first two funding quarters, has achieved a 9.2% positivity rate with a 65% linkage to care rate. Overall the number of tests and positives identified has increased to a 2.82% positivity rate since focusing community and organization efforts on the trans-identified.

Lessons Learned: Despite efforts to curb HIV and bring social services to this community, homelessness, poverty, mental health, substance abuse, and lack of gender specific and competent services are negatively influencing HIV positive individuals. As a result, there has been an increasing difficulty accessing medical services and adhering to medication for this group. The level of violence experienced by the Latino trans-gender women has exacerbated the isolation, invisibility, and lack of employment opportunities. Sex work related activities, poverty, and violence have become the perfect combination to drive rates; leading to an increase of HIV infection rates.

Track E

Session E06 - Trauma and Co-Morbidities that Create Risks for HIV Transmission

Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1856 - Corrections Community Reentry Project: Bridging Gaps and Restoring Lives

Author(s): *Karen Reitan, Fikirte Wagaw*

Issue: Nearly 40,000 individuals exit the Illinois state prison system annually, and the majority return to Chicago's low-income and predominantly African-American communities. One in seven people living with HIV (PLWH) interact with the correctional system in the U.S.

The Community Reentry Project (CRP) was created to address the complex needs of incarcerated individuals living with and at highest risk for HIV as they reintegrate in their communities.

Setting: CRP is a partnership of the Illinois Department of Public Health (IDPH), five direct service providers, an HIV training center and a coordinating agency. The group meets monthly to plan and coordinate direct services to ensure continuity of care for individuals leaving correctional facilities and to identify and address policy and system level issues that benefit from broad-based coordinated efforts. In addition, CRP hosts quarterly statewide video conference meetings which are focused on understanding and addressing system-level policy and administrative issues that affect the target population and providers.

Project: CRP has always focused on multi-faceted, culturally competent HIV services for reentry populations. More recently, CRP's work began to include policy and system-level administrative issues as a way to improve services and program participant's health and social outcomes.

In 2011, as part of this system-level work, CRP lead the creation of the first ever Corrections, Reentry and HIV Section of the "Illinois HIV Strategy". This Section was created with the input of many stakeholders, and served to identify and prioritize myriad HIV and related issues that affect reentry adults.

Results: CRP is successful in improving client outcomes. Thousands of incarcerated, detained and reentry individuals receive HIV/STI education and are tested for HIV; nearly 80% of HIV-positive clients are meaningfully engaged in medical care, and the recidivism rate among clients is 28% compared to the statewide rate of 51%.

Since the creation of the Strategic Plan, CRP and partners have used the plan to focus meetings, discussions and strategies. Policy and system-level changes that CRP has lead or supported include: implementation of opt-out HIV testing in the Illinois Department of Corrections (IDOC) system and Cook County Jail, ensuring that reentry adults living with HIV are released from state prison with 30 days of HIV medication, allowing pre-enrollment for Medicaid reinstatement to begin prior to release, understanding and monitoring Medicaid expansion and Accountable Care Act enrollment for PLWH and reentry populations, work with IDPH to identify the need for and ensure access to select Ryan White services when inmates are in work release programs, and work with IDPH to create a reentry section on the statewide HIV Care Connect website.

Lessons Learned: It is essential to consistently hear from clients and direct service providers in order to fully understand and document the intended and unintended consequences of laws, policies and administrative decisions.

Similarly, it is important to create opportunities for legislators, policy makers, leaders of large systems to come together with community-based direct service providers in order to hear about the impact of policies and decisions; and collectively work towards solutions.

Abstract 2075 - Introducing a Single Session Intervention Program (SIP) for Binge Drinking Gay and Bisexual Men of Color in San Francisco

Author(s): *Gavin Morrow-Hall, Hanna Hjord, Tim Matheson, Seth Pardo, Dara Geckeler, Monica Rose, Tracey Packer*

Issue: Heavy alcohol consumption among gay and bisexual men of color (GBMOC) is an identified HIV-transmission driver in San Francisco. Many engage in binge drinking behavior but may not identify it as a “problem” and are therefore unlikely to access counseling. Factors further contributing to binge drinking among GBMOC include feelings of isolation, a pervasive culture promoting alcohol consumption, and a dearth of alcohol harm reduction messaging and interventions.

Setting: SAMHSA’s Minority AIDS Initiative-Targeted Capacity Expansion (MAI-TCE) is part of National HIV/AIDS Strategy, expanding San Francisco Department of Public Health’s (SFDPH) capacity to address behavioral health needs of people living with or at risk for HIV. In response to the need for innovative services to reach GBMOC who binge drink, the Single-Session Intervention Project (SIP) was implemented by the SFDPH Center for Public Health Research (CPHR) Branch Substance Use Research Unit. CPHR is a well-known and respected hub for HIV studies and interventions nationwide.

Project: SIP is a single-session intervention designed to reduce the associated with binge drinking. Using motivational interviewing and Personal Cognitive Counseling, SIP is non-shaming, sex positive and client centered. Counselors meet the client where he/she is in terms of readiness to change, explores the pros and cons of one’s alcohol consumption, examines in detail an alcohol drinking experience with unwanted consequences and supports the development of a harm reduction plan. Clients are primarily recruited through active street outreach at locations where GBMOC congregate. A multi-step screening process, designed to reach binge drinkers, includes questions about alcohol and other substance use, sex, and HIV status and testing. Supplementing recruitment is an ad campaign designed for GBMOC. Data is collected using a SAMHSA-mandated interview pre/post intervention and three months after participating. Enrolled clients received a \$40 gift card and an optional check-in call three weeks later. Clients are reassessed after three months and receive one \$20 gift card.

Results: Between October 2014 and March 2015, 554 people were recruited. 53% participated in a phone screen. 27% were ineligible due to their level of alcohol or meth use. Of the 86 people enrolled, 55% were GBMOC, 80% were HIV negative, 98% identified as male. The majority completed the intervention with intentions of changing drinking patterns. 25% stated they would be more mindful; 46% indicated the intervention resulted in reinforcing plans to reduce alcohol. 16% of clients said it made them more comfortable discussing their alcohol consumption with friends. 16% of clients were unsure why they asked to participate and felt the intervention was better suited for “problem” drinkers. Motivation for participation fell into three primary areas: altruism, compensation and concern about personal health.

Lessons Learned: Many people who do not identify as having a drinking problem can be encouraged to reduce harm. Altruism is a powerful motivator in recruitment GBMOC and can lead to increased knowledge and perceptions of risk. Consistent recruitment and culturally appropriate media can lead to successful participation in a community intervention resulting in increased intention to reduce alcohol

consumption. Additionally, development of rigorous screening tools increases efficiency of recruitment efforts.

Abstract 2250 - The Winding and Bumpy Road: Successes, Challenges, and Lessons Learned to Integrating Behavioral Health Services into HIV Primary Care

Author(s): *Uyen Kao, Pamela Ogata, Juhua Wu, Elena Fernandez, Keith Heinzerling, Steve Shoptaw*

Issue: Racial/ethnic minority populations are disproportionately impacted by HIV and are at increased risk for substance use and mental health (MH) disorders. When behavioral health (BH) problems are untreated, they are associated with increased HIV morbidity and mortality, poor quality of life, and medical and behavioral challenges, including inconsistent medical care and adherence.

Setting: The 3-year project was conducted at two community health clinic sites in Los Angeles, serving predominately low-income African Americans and Latinos who are at high risk for or have a mental and/or substance use disorder and who are at risk for or are living with HIV/AIDS.

Project: The project aimed to ensure that patients received access to appropriate BH services, HIV care and medical treatment in an integrated behavioral health and primary care setting. Service integration was enhanced by incorporating onsite HIV testing, evidence-based BH screening, psychiatric services, MH treatment, and substance abuse prevention and treatment. The project provided infrastructural support, care coordination, capacity building assistance, and staff training. To evaluate the program, a 21-item survey was administered to primary care providers to obtain their feedback on the integrated program. Semi-structured, in-person interviews were also conducted with key BH staff (n=6) to assess their experience with specific program elements, including screening and referral process, service delivery, monitoring patient progress, documentation, staff communication, and training needs.

Results: All providers (n=21) rated routine MH screening as being very important and a high priority (8.4 on a 10 point scale) among their other clinic duties, whereas only 76% reported routine alcohol and drug screening as being very important and a moderate priority (6.2 out of 10). About half (48%) reported an increase in comfort level in talking to clients about substance use and (52%) in delivering a brief intervention as a result of the program. Having access to an on-site psychiatrist, substance abuse counselor, and BH clinicians were reported as key elements to integration and improved patient care because they allowed for successful 'warm-hand offs', same-day appointments, and in-person staff consultation. Incorporating a 2-item alcohol and drug abuse screener into an electronic health record (EHR) system was also reported as a core element of the integrated program. The most frequently reported challenges were not having enough behavioral health staff or access to the on-site psychiatrist to meet the high demands of the client population as well as high staff turnover.

Lessons Learned: (1) Integration of behavioral health into primary care is a complex process that requires continuous reassessment and refinement to address the constant changes and demands of a busy community clinic. (2) Integration involves investment in training of staff to improve screening, diagnosis, treatment, and referrals of behavioral health conditions. (3) Adequate supervision, monitoring, and support of staff are critical for delivering effective integrated care. (4) EHR systems that facilitate screening, allow for data sharing, monitoring patient progress, communicating message alerts,

and evaluation for quality improvement are vital. (5) Providing comprehensive BH and primary care services that are co-located improves linkage, re-engagement, and retention in care.

Abstract 2291 - “Everybody in There Knows”: A Qualitative Study of Disclosing HIV-Positive Status in California Prisons and Jails

Author(s): *Megan Comfort, Lynn Wenger, Andrea Lopez, Alex Kral*

Background: The National AIDS Strategy calls for improving access to care for people living with HIV and reducing health disparities. Incarceration has been identified as a “public health opportunity” to provide HIV treatment to impoverished populations. To receive HIV treatment in correctional settings, individuals who know they are HIV-positive must disclose their status. This study explored people’s experiences disclosing their HIV-positive status and accessing HIV treatment in prisons and jails in California.

Methods: Participants were recruited through referrals from community-based service providers working with HIV-positive people and formerly incarcerated people in Oakland and San Francisco, CA. All eligible participants were aware of their HIV status while recently incarcerated in a California state prison or a local county jail. Cross-sectional semi-structured qualitative interviews were conducted with 57 participants from November 2013 through April 2015. Interviews were recorded and transcribed verbatim, and transcripts were coded using Atlas.ti. Weekly analysis meetings occurred throughout the data collection period to review coding output, discuss emerging themes, and develop lines of analytic inquiry.

Results: Among participants, 71% identified as male, 20% as female, and 9% as transgender (male-to-female). The majority (70%) identified as African American, and 44% of participants had received an HIV diagnosis while incarcerated at some point in the past. Nearly all participants had disclosed their HIV-positive status to medical personnel during their most recent incarceration. The primary motivation for disclosure was to access HIV treatment, although participants also expressed fear of reprisals from correctional staff if they did not disclose and were later found to be HIV-positive. Participants articulated a wide variety of beliefs around whether or not correctional medical records reporting HIV status were transferred from one facility to another. Confusion regarding these policies led some people to assume their status had been disclosed to correctional staff without their consent. Participants also described a host of institutional policies that revealed their HIV-positive status to other people in the correctional facility, including being placed in segregated housing for people with medical needs, receiving extra meals or bedding due to their medical condition, and being called for appointments with an HIV-specialist physician. Many participants described high levels of stigma and direct experiences of discrimination in correctional settings as a result of being known to be HIV-positive.

Conclusions/Implications: HIV-positive people want to receive treatment while incarcerated and are highly motivated to disclose their status to medical personnel in order to do so. This disclosure comes with a cost of loss of confidentiality that is particular to correctional settings. There is a critical need to develop policies to protect medical confidentiality in jails and prisons so that the privacy rights of HIV-positive people are respected and so that they can receive HIV treatment according to the Health Information Portability and Accountability Act (HIPAA) protections afforded to the general population.

There is a continuing need to provide HIV education to correctional staff and incarcerated people, particularly around transmission risks and treatment advances, in an effort to reduce HIV stigma and improve quality of life for HIV-positive people in jails and prisons.