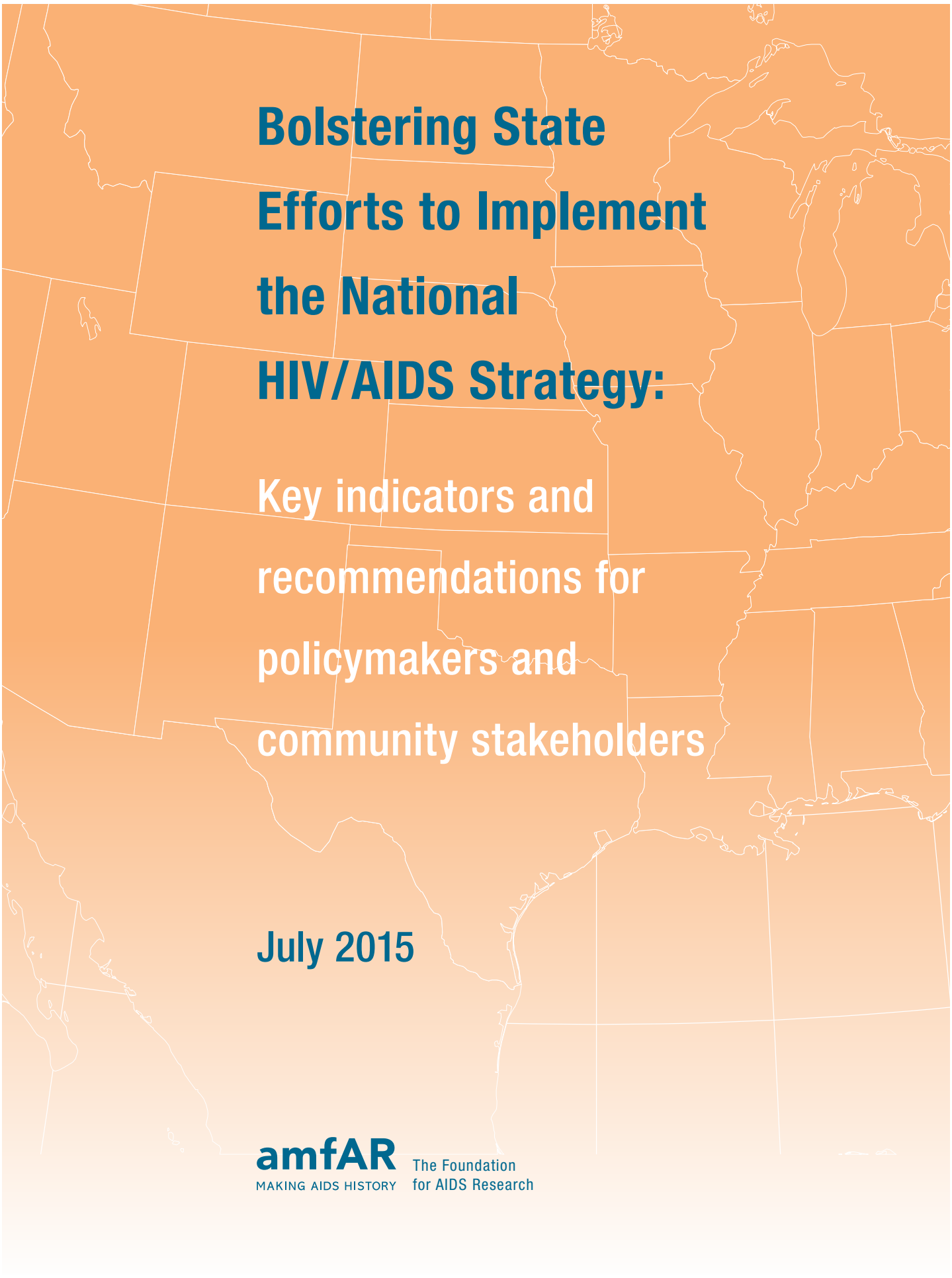

Bolstering State Efforts to Implement the National HIV/AIDS Strategy:

Key indicators and recommendations for policymakers and community stakeholders

July 2015

amfAR
MAKING AIDS HISTORY
The Foundation for AIDS Research

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EXECUTIVE SUMMARY

Four years since the release of the *National HIV/AIDS Strategy for the United States,* significant activities have taken place in states and communities throughout the country to strengthen the response to the domestic HIV epidemic. While federal leadership and action remain vital, successful implementation of the Strategy increasingly demands an emphasis on state-level leadership to target resources, decrease disparities, and improve outcomes. To that end, amfAR, The Foundation for AIDS Research, working in collaboration with the National HIV/AIDS Initiative at the O'Neill Institute for National and Global Health Law at Georgetown Law, has reviewed state progress in nurturing a policy environment for operating effective HIV programs.[1]

This project seeks to build upon the *State HIV Prevention Progress Report,* issued in 2014 by the Centers for Disease Control and Prevention (CDC).[2] We acknowledge the very significant policy and programmatic changes that states have put in place in recent years, ranging from implementing the CDC's High Impact Prevention (HIP) initiative to implementing the Affordable Care Act (ACA).[3] Yet and still, there are concrete actions that all states can take today to seize the opportunity to increase their impact. Importantly, while many of these actions can be taken by health department staff, some require leadership from governors, legislatures, other state actors, and/or public-private partnerships.

States are starting in different places…

There is a great deal of variability across states in levels of resources available, priorities of elected officials, and the epidemiology of HIV.

States have just been through the most severe economic downturn in more than a generation and this often has led to reduced state funding for a number of public health programs. Consistent with the National HIV/AIDS Strategy, the CDC also has implemented a new HIV prevention funding formula for funding health departments to better match the burden of the epidemic nationwide. Implementing the CDC's new HIV prevention framework, High Impact Prevention (HIP), has shifted federal resources among state and local health departments based on the number of persons living with HIV. This means that some states that had been underfunded are operating in an environment of significantly increased federal resources for HIV prevention, while other states are dealing with significant cuts.

Implementing the ACA's Medicaid expansion to low-income Americans is perhaps the single most important action that states can take to strengthen their HIV response, both to better support people with HIV in care and reduce HIV transmission. The split between states that have and have not expanded Medicaid, especially Southern states with high rates of HIV diagnoses, may serve to increase variability in HIV outcomes and health disparities in the future.

Priority actions for states are:

Achieving a More Coordinated National Response to the HIV Epidemic

- Develop integrated HIV prevention and care plans for each state that are consistent with the National HIV/AIDS Strategy
- Foster collaboration between state and local health departments and other human services agencies
- Strengthen public engagement in HIV policy by producing annual consumer-friendly reports on state progress in achieving critical HIV prevention and care targets

Reducing New HIV Infections

- Use public health data to inform policy and optimize the allocation of resources
- Develop integrated approaches for increasing HIV testing and knowledge of serostatus
- Re-orient HIV prevention to better support linkage, engagement, and retention in care, and adherence to ART for people with HIV
- Effectively target services to gay men of all races and ethnicities
- Ensure broader access to effective comprehensive sexuality education

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

- Expand access to insurance and ensure that benefits and managed care contracts support continuous, coordinated, and quality HIV care

Reducing HIV-Related Disparities and Health Inequities

- Systematically track prevention and care metrics for key subpopulations
- Modernize state laws and policies to stop criminalizing people with HIV in order to better protect the health of the public

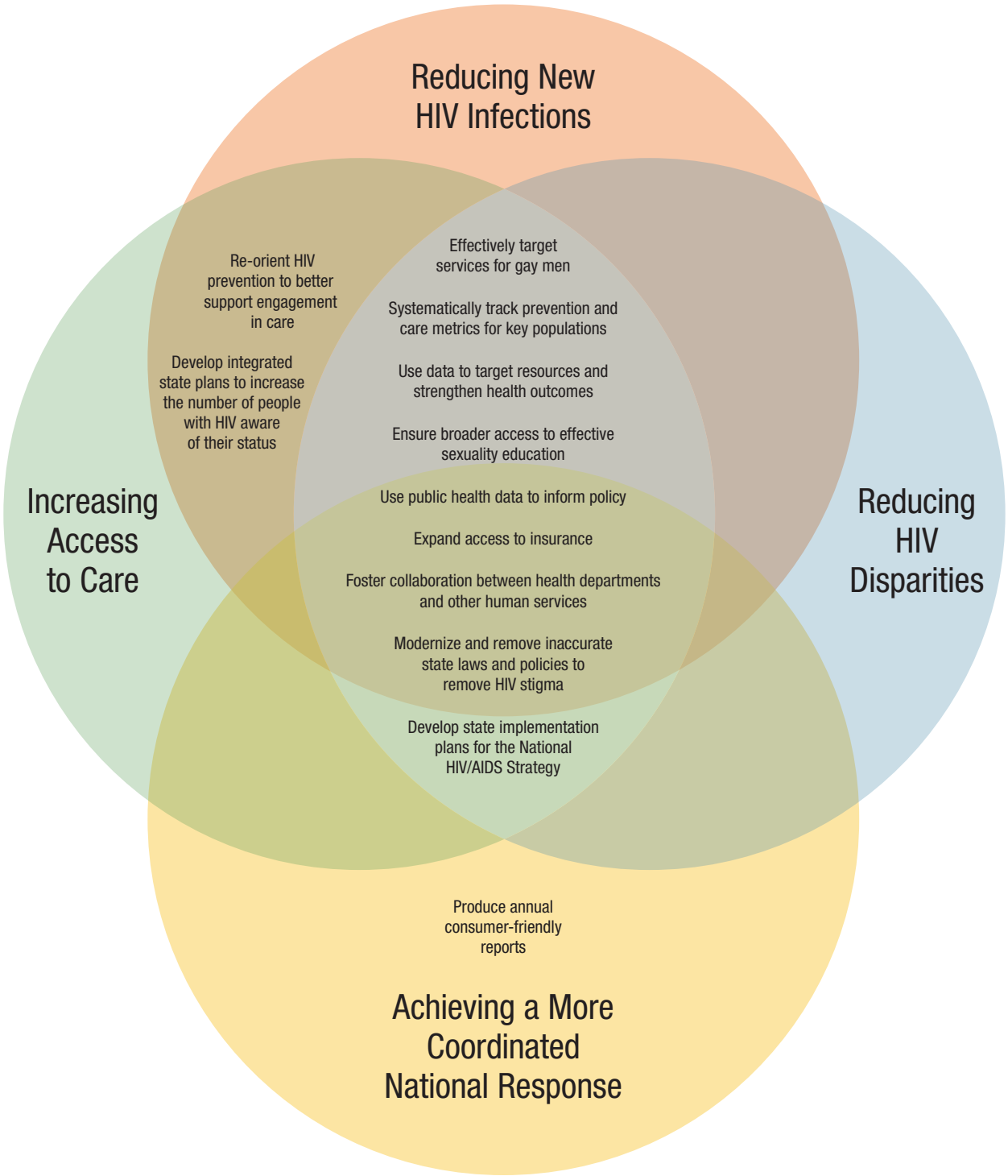
As shown in **Table 1**, there is substantial variance in how states are doing across these indicators. For Instance, states have made great progress in aligning HIV testing laws with CDC guidelines and requiring all CD4 and viral load tests to be reported. However, states are also doing poorly at including sexual orientation in sex and HIV education and are over-utilizing general criminal laws to prosecute HIV transmission or exposure.

Table 1: Progress of states across key indicators

Indicator	Number of states with each rating:		
	Yes	No	Mixed
Achieving a More Coordinated National Response to the HIV Epidemic			
States with integrated HIV planning groups and jurisdictional plans	23	**25**	3
Reducing New HIV Infections			
State HIV testing laws in alignment with the CDC's 2006 HIV testing recommendations	49	2	
States that require all CD4 and viral loads to be reported to public health authorities	43	8	
States that mandate HIV education	34	17	
States that cover routine HIV screening for adults under state Medicaid program	32	13	6
States that mandate sexual education	23	**28**	
States that estimate linkage to and retention in care by diagnosed population	21	**30**	
States that require that sexuality education includes sexual orientation	9	3	39
Increasing Access to Care and Improving Health Outcomes for People Living with HIV			
State ADAP covers prescription deductibles	41	5	5
State expanded Medicaid under the ACA	30	18	3
Percentage of ADAP budget contributed by the state (>10%, 0%, 1–10% or unknown)	23	15	13
State ADAP covers medical co-pays/ co-insurance	16	**31**	4
Reducing HIV-Related Disparities and Health Inequities			
States with scientifically accurate/plausible HIV laws	40	11	
State data reported to CDC mature for continuum of care analysis	21	**30**	
States without specific laws criminalizing HIV transmission or exposure	18	**33**	
States that do not use general criminal laws to prosecute HIV transmission or exposure	13	**38**	

Figure 1

Priority Actions Help to Achieve Multiple Goals of the National HIV/AIDS Strategy



While categorized as individual goals in the Strategy, the priority actions we identify are intertwined such that implementing the strategies necessary to achieve one helps to achieve all four.

ACHIEVING A MORE COORDINATED NATIONAL RESPONSE TO THE HIV EPIDEMIC

A central focus of the National HIV/AIDS Strategy is to better coordinate the actions of different governmental agencies, as well as a broad range of external stakeholders. One notable development has been the establishment of overlapping mechanisms at the federal level to strengthen coordination between federal agencies and collaboration with other levels of government. This includes the issuance of a Presidential Memorandum concurrent with the Strategy's release to delegate primary responsibility for operational coordination to the Secretary of Health and Human Services. Additionally, the President's 2013 Executive Order on the HIV Care Continuum Initiative focused cross-agency attention on high priority areas of collaboration.[4] Some states (as well as local and community partners) have built on these federal efforts to implement action steps in their own states. What was intended to encourage creative, individualized, and targeted responses in different states, however, has meant that too little systematic work has taken place in the absence of clear federal direction and funding.

Priority actions for states:

- **Develop integrated HIV prevention and care plans for each state that are consistent with the National HIV/AIDS Strategy**

Since the Strategy was released, there has been a dizzying period of change that has included implementation of the ACA, approval of effective regimens for pre-exposure prophylaxis (PrEP), and a new emphasis on improving population-level performance along the care continuum as both a treatment and prevention intervention. States often have been at the forefront of pioneering new models of service delivery in response to these developments. The CDC and the Health Resources and Services Administration (HRSA) have worked with states on guidance on integrated care and prevention plans that satisfy the requirements of both the Ryan White Part B program and CDC's HIV prevention program. The President's Budget for FY 2016 also includes a request for $2.5 million in new funding to support state efforts to develop integrated state plans, which may facilitate progress in this area. Nonetheless, **whether or not new federal resources are provided, states should be expected to take tangible steps to strengthen coordination even without federal involvement.**

Next Steps

- ➤ Just as the federal government published a federal implementation plan with the National HIV/AIDS Strategy's release, each state needs its own plan.
- ➤ Whereas the Strategy defines a common path for all states, each state is in a different place in responding to various Strategy action steps. Therefore, relative priorities will vary by state, and each state will have to establish and monitor its own baselines and targets to achieve the Strategy's quantitative targets.
- ➤ Such plans should be based on the full integration of HIV prevention and care planning along with HIV funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and, if feasible, from the Housing Opportunities for People with AIDS (HOPWA) program.

- **Foster collaboration between state and local health departments and other human services agencies**

An ever-present tension in the Strategy is how to focus on key services and interventions while also recognizing that people's lives are complicated and they often have overlapping and competing needs. The Strategy recognizes the need to support people with co-occurring health conditions and who experience challenges meeting basic needs, such as food and shelter. At the state level, fostering collaboration between the health department (and offices within the health department) and other parts of state government, as well as with community-based organizations, is critical. This is one of the biggest areas for potential progress, yet often one of the biggest challenges for state AIDS officials, who may desire a closer, more collaborative relationship but lack willing partners. In part this may be because of structural barriers that limit engagement across state agencies. In many cases, the HIV population is such a small share of the general population or the Medicaid population that it can be hard to get insurance commissioners or Medicaid directors to offer their sustained attention or to prioritize critical policies for people with HIV.

As the HIV care continuum amply demonstrates, even when health care services or insurance coverage are available, food insecurity, lack of housing, unmet mental health and substance abuse treatment, or lack of social support can become serious impediments to engagement in care. Therefore, devising new ways to engage other parts of state government is critical.

A first step in strengthening cross-agency collaboration is to ensure that state planning for HIV prevention and care is fully integrated. This includes conducting a single comprehensive needs assessment for prevention and care, working to align the flow of information across prevention and care programs, and sharing data, ensuring cross-representation on prevention and care planning bodies, and coordinated/combined projects and meetings. Ideally, planning bodies would be merged. **Table 2** shows whether current state HIV planning groups and HIV jurisdictional plans have been integrated to include prevention and care.

Next Steps

- States can do more to strengthen coordination between HIV programs within state and local health departments and other social services agencies. Key questions to ask include: Has the state established one-stop shops for accessing health care and other social services? Are program staff able to advise on the full range of HIV-related support available? If clients receiving ADAP services have an emerging housing need, are systems in place to triage and coordinate with the housing agency?
- Each state's unique organizational structure will determine how to establish these partnerships and what opportunities exist. In some cases, community stakeholders can play an important role in pushing for this type of collaboration, or in establishing cooperative relationships with other stakeholders around a common policy agenda that makes it easier for state agencies to engage with the state HIV/AIDS leadership.

Table 2: States with integrated HIV prevention and care plans, 2014.[5]

	Do both the state HIV planning group and state jurisdictional plans integrate prevention and care?
Alabama	No
Alaska	No
Arizona	No
Arkansas	No
California	Yes
Colorado	No
Connecticut	Yes
Delaware	Yes
District of Columbia	No
Florida	No
Georgia	No
Hawaii	Yes
Idaho	Yes
Illinois	No
Indiana	No
Iowa	Yes
Kansas	No
Kentucky	Inconclusive*
Louisiana	Yes
Maine	No
Maryland	Yes
Massachusetts	Yes
Michigan	Yes
Minnesota	No
Mississippi	Inconclusive*
Missouri	Inconclusive*
Montana	Yes
Nebraska	No
Nevada	No
New Hampshire	Yes
New Jersey	Yes
New Mexico	No
New York	Yes
North Carolina	Yes
North Dakota	No
Ohio	No
Oklahoma	Yes
Oregon	Yes
Pennsylvania	No
Rhode Island	No
South Carolina	Yes
South Dakota	No
Tennessee	Yes
Texas	Yes
Utah	No
Vermont	Yes
Virginia	No
Washington	No
West Virginia	No
Wisconsin	Yes
Wyoming	Yes

* Only the state HIV planning group or jurisdictional plan was integrated, not both.

- **Strengthen public engagement in HIV policy by producing annual consumer-friendly reports and dashboards on state progress**

The Strategy states that fighting HIV requires widespread public support to maintain a long-term effort. Thankfully, we are no longer in a period where there is extreme public fear of HIV; however, we have also lost some motivation among the public at large to rally around preventing and treating HIV. We need to take deliberate steps to keep the American people engaged in the fight against HIV. While we clearly face continuing challenges, by telling the story of our country's amazing success at responding to HIV and explaining the moment of opportunity available to us today, we can generate excitement and sustain support for HIV programs.

A promising development

On April 29, 2015, Governor Andrew Cuomo unveiled New York's Blueprint to End AIDS in the state. The long-term goal of the blueprint is to dramatically reduce the number of new HIV infections such that HIV prevalence will be reduced for the first time in the state. The blueprint aims to do this through three main interventions:

1. "Identify persons with HIV who remain undiagnosed and link them to health care;"
2. "Link and retain persons diagnosed with HIV to health care and get them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission;" and
3. "Facilitate access to pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk persons to keep them HIV-negative."[6]

Next Steps

- States can do more to keep the public invested in the fight against HIV. Virtually every state makes available epidemiological reports that are needed by policymakers and provide a lot of detailed information. What is especially important about these reports is that they provide metrics over years and decades. These types of reports, however, are not written for the general public and generally do not explain state programs and actions in the context of meeting specific goals or responding to exciting opportunities.
- States should explore ways to work with external partners including community stakeholders, foundations, and corporations to create consumer-friendly annual reports and dashboards of key metrics that enable the public to both monitor state progress and identify areas where further emphasis is needed.
- These reports should highlight subpopulations that are being reached by programs, those that require greater attention, and geographic hotspots where more focused interventions are needed.

REDUCING NEW HIV INFECTIONS

A key goal of the Strategy was to reduce the number of new HIV infections by 25% between 2010 and 2015. It set related goals of reducing the HIV transmission rate by 30%[7] (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV). Further, it set a goal of increasing the percentage of people living with HIV who know their serostatus from 79% to 90% by 2015. Since the Strategy was released, the CDC has revamped how it funds state and local health departments to better reflect the current distribution of the HIV epidemic. It has also begun to implement its vision for HIP to identify the range of effective tools available to health departments to prevent infections, identify priority interventions that all health departments must deploy, and give greater guidance on how to effectively balance and combine interventions to have the greatest impact. Because recent data show that more than 90% of new HIV transmissions each year are from people who are undiagnosed or diagnosed but not in care, testing and care for people living with HIV are integral to preventing new infections.[8]

Priority actions for states:

- Use public health data to inform policy and optimize allocation of resources

As of 2012, all states have implemented reporting of all HIV cases to the CDC's National HIV Surveillance System. The surveillance system has improved our ability to monitor the HIV epidemic nationally. Working with states and other grantees of the Ryan White HIV/AIDS program, HRSA implemented a client-level data system that enables monitoring of the care experience of people with HIV in the Ryan White program. The availability of this data system increases the possibility of making more real-time use of health and surveillance data to benefit individual patients and to improve population-level outcomes.

A starting point for states is to require reporting of all lab-based CD4 and viral load tests. This is essential for building a robust continuum of care in each state. These data enable policy makers to make more informed decisions based on the epidemiology in the state. Most states have updated their regulations to require such reporting, yet several continue to lag **(Table 3)**.

Table 3: States requiring all CD4 and viral loads to be reported to public health authorities, 2014

CD4 and Viral Load Reporting Requirements		
Require ALL tests be reported to state health authority[12]		
	CD4	Viral Load
Alabama	Yes	Yes
Alaska	Yes	Yes
Arizona	CD4<200 only	No
Arkansas*	Yes	Yes
California*	Yes	Yes
Colorado	Yes	Yes
Connecticut	Yes	Yes
Delaware	Yes	Yes
District of Columbia	Yes	Yes
Florida	Yes	Yes
Georgia	Yes	Yes
Hawaii	Yes	Yes
Idaho	CD4<200 only	No
Illinois	Yes	Yes
Indiana	Yes	Yes
Iowa	Yes	Yes
Kansas	CD4<500 only	Yes
Kentucky	Yes	Detectable only
Louisiana	Yes	Yes
Maine	Yes	Yes
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	Yes
Minnesota	Yes	Yes
Mississippi	Yes	Yes
Missouri	Yes	Yes
Montana	Yes	Yes
Nebraska	Yes	Yes
Nevada	CD4<500 only	No
New Hampshire	Yes	Yes
New Jersey	CD4<200 only	Yes
New Mexico	Yes	Yes
New York	Yes	Yes
North Carolina	Yes	Yes
North Dakota	Yes	Yes
Ohio	Yes	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	CD4<200 only	No
Rhode Island	Yes	Yes
South Carolina	Yes	Yes
South Dakota	Yes	Yes
Tennessee	Yes	Yes
Texas	Yes	Yes
Utah	Yes	Yes
Vermont	CD4<200 only	Yes
Virginia	Yes	Yes
Washington	Yes	Yes
West Virginia	Yes	Yes
Wisconsin*	Yes	Yes
Wyoming	Yes	Yes

*Arkansas, California, and Wisconsin are reporting all CD4 and VL tests despite regulatory requirements remaining unclear in those states.[13]

Next Steps

- HIV prevention can be improved by strengthening states' use of strategic data initiatives to improve decision making.
- Key actions include:
  - integrating HIV surveillance data with HIV program and STI (sexually transmitted infections) surveillance data, actively using HIV surveillance data, claims data, and pharmacy data to strengthen engagement and re-engagement in care;
  - tracking community viral load and other population-level metrics that can help to better target resources to heavily impacted populations and geographic hotspots;
  - and streamlining agency decision-making procedures so that programmatic initiatives and resource allocations are driven predominantly by careful population monitoring within a state or community.
- Federal action needed: The CDC, HRSA, SAMHSA and other federal agencies should consider new approaches to helping states build their capacity to collect and use data.
- Specifically, the CDC should consider expanding the Medical Monitoring Project (MMP) to support data collection in all states.[9] MMP is an important data set for providing information about engagement in HIV care nationwide. Due to funding constraints, only 16 states and one territory participate in MMP. Expanding this data set to include all states, while requiring a new prioritization of resources, would improve the value and representativeness of these data and would assist states in building their own capacity to collect and use surveillance and other data in strategic ways.

Additionally, such HIV surveillance systems could be a tool for supporting linkage, engagement (and re-engagement), and retention in care, as well as monitoring viral suppression. Doing so may require political will to use existing public health authorities, state regulatory changes, and amending state laws. Project Inform, a national HIV policy and advocacy organization, has already led a dialogue among key stakeholders including states, people with HIV, CDC surveillance staff, and others to examine the potential for using surveillance data to improve engagement in care, identify challenges, and articulate areas of consensus over whether and how to use such data appropriately.[10] This process needs to be continued.

Louisiana Public Health Information Exchange (LaPHIE)

Louisiana's public health system, with grant funds from HRSA, has developed a statewide HIV electronic medical records (EMR) system that notifies clinicians when they are seeing patients who have fallen out of care based on public health surveillance data. The system automatically identifies patients who are missing recent expected lab test results that indicate they have fallen out of care, and notifies authorized clinicians that patients require HIV follow-up assessments.

The LaPHIE system was designed with input from physicians, nurses, people with HIV, and with ethical and legal reviews to ensure proper safeguards were in place, confidentiality was respected, and the acceptability of the program.

By incorporating public health surveillance data as a tool for engaging patients in care, as of April 2013 more than 1,000 people were identified as out-of-care by the system. Of 854 alerts sent out by the system to clinicians, 69% of those individuals were linked back into care within 90 days.[11]

Develop integrated approaches for increasing knowledge of serostatus

The CDC estimates that 86% of people with HIV in the U.S. are aware of their HIV status, up from 79% when the Strategy was released, which shows we're making progress in increasing serostatus awareness.[14] The CDC's Expanded Testing Initiative that targeted groups at high risk for HIV infection has demonstrated its effectiveness.[15] Further, states and local jurisdictions have increased their investments in community-based testing over the past decade and many also have tested new approaches to HIV screening such as routinely screening all people who come for care in emergency rooms (voluntarily with opt-out provisions).

What is needed now is thoughtful planning on how to leverage testing resources for the greatest impact, considering issues such as relative investments in clinical versus community testing, the deployment of new technologies, better screening within social and sexual networks, and resources required for timely and systematic linkage to effective care for those newly diagnosed.

Next Steps

- States should consult with the Centers for AIDS Research (CFARs) and other researchers and stakeholders to engage in modeling and other exercises to maximize their ability to diagnose new cases of HIV infection and ensure strong linkages to HIV medical care.
- States should explore how to integrate network-based testing and testing in STI clinics and reproductive health settings as more prominent parts of such a plan. Expanding support for health centers to routinely screen all patients without regard to identified risk factors may be an important step, as well as ensuring that individual providers are appropriately screening patients for HIV infection, consistent with current guidelines. The CDC has issued guidance to promote the adoption of 4th generation testing.
- States also should take active steps to support the adoption of this technology and to fund targeted approaches to diagnose cases of acute infection among high prevalence populations.

Table 4: State policies to promote more routine HIV screening, 2013

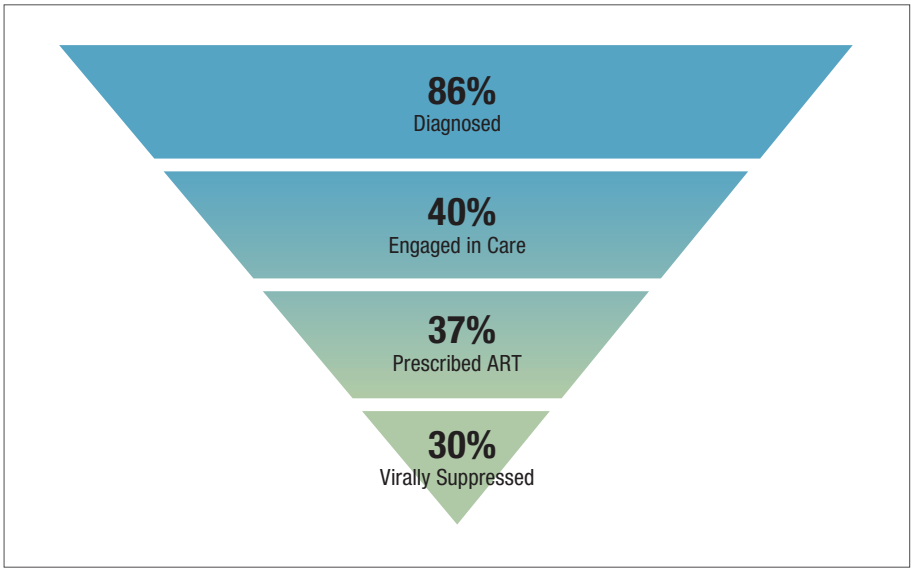
Medicaid coverage of HIV screening and compliance with CDC guidelines for consent and counseling[17]		
	Is Routine HIV screening for adults covered under state Medicaid program?	State HIV testing laws in alignment with CDC's 2006 HIV testing recommendations
Alabama	No	Yes
Alaska	Yes	Yes
Arizona	No	Yes
Arkansas	No	Yes
California	Yes	Yes
Colorado	Yes	Yes
Connecticut	Yes	Yes
Delaware	Yes	Yes
District of Columbia	Yes	Yes
Florida	No Response	Yes
Georgia	No Response	Yes
Hawaii	Yes	Yes
Idaho	Yes	Yes
Illinois	Yes	Yes
Indiana	No	Yes
Iowa	No	Yes
Kansas	No Response	Yes
Kentucky	Yes	Yes
Louisiana	Yes	Yes
Maine	No	Yes
Maryland	No	Yes
Massachusetts	Yes	Yes
Michigan	No	Yes
Minnesota	Yes	Yes
Mississippi	No	Yes
Missouri	Yes	Yes
Montana	Yes	Yes
Nebraska	No Response	No
Nevada	Yes	Yes
New Hampshire	Yes	Yes
New Jersey	No Response	Yes
New Mexico	Yes	Yes
New York	Yes	No
North Carolina	Yes	Yes
North Dakota	Yes	Yes
Ohio	No Response	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	Yes
Rhode Island	Yes	Yes
South Carolina	No	Yes
South Dakota	No	Yes
Tennessee	Yes	Yes
Texas	Yes	Yes
Utah	No	Yes
Vermont	Yes	Yes
Virginia	No	Yes
Washington	Yes	Yes
West Virginia	Yes	Yes
Wisconsin	Yes	Yes
Wyoming	Yes	Yes

In 2013, the United States Preventive Services Task Force (USPSTF) issued an A rating for population-based HIV screening in clinical settings for persons aged 15–64.[16] Under the ACA, this rating means that health care providers can implement routine HIV screening and receive insurance payment for such services, yet it does not guarantee that any expanded HIV screening will take place. Some hospitals and institutions have signed contracts for bundled payments for diagnostic services that cover HIV testing, but did not factor in or require routine HIV screening. Therefore, updating such contracts and addressing reimbursement barriers will need to be taken into account to effectively utilize this new funding resource for population-based screening.

- ### Re-orient HIV prevention to better support engagement in care for people with HIV

An important aspect of the CDC's HIP initiative is to help states and other jurisdictions more effectively allocate resources to increase impact.[18] It emphasizes the need to consider concepts such as scalability, durability, and impact, across a variety of interventions. While it is sometimes politically difficult, this framework calls for states to de-emphasize interventions that are not easily offered to large numbers of at-risk people or whose effectiveness is less clear. One area where federal policymakers are encouraging scaled up investment is prevention for people with HIV and encouraging them to initiate and maintain adherence to HIV treatment. Consideration of specific sub-populations is also important. Studies suggest that retention in care is worse for young people, women, transgender populations, and racial minorities and that factors such as a lack of health insurance and supportive services, including housing, case management, mental health and substance abuse services correlate to poor retention in care.[19]

Figure 2: Estimated percentage of persons living with HIV infection, by outcome along the HIV care continuum — United States, 2011[20]



Next Steps

- States should develop cascades to estimate engagement in care along the care continuum, as well as cascades for key populations including gay men, women, youth, and other groups.
- States should use these cascades to inform and integrate prevention and care programming. This includes focusing resources on effective interventions that support engagement at multiple stages of the continuum and emphasizing interventions that target the stages with the greatest drop-offs. It also includes enacting specific policies to identify HIV infection among people in care, but undiagnosed.
- States should implement Data to Care initiatives and should build on model efforts such as LaPHIE (see page 11) to integrate HIV surveillance and clinical care data to improve engagement in care and actively re-engage people in care where necessary.
- States should seek out new partnerships to use and communicate data in innovative ways, such as engaging technology and/or online media experts with expertise not typically found in state government.
- The CDC, HRSA and other parts of HHS should work with state and local jurisdictions to provide unified guidance to standardize the methodologies by which care continuum estimates are generated.

Table 5: States that estimate linkage to and retention in care by diagnosed population

	Percentage of newly diagnosed HIV-positive individuals actively linked to care, 2011[21]	Percentage of diagnosed HIV-positive individuals retained in care, 2010[22]
Alabama		
Alaska		
Arizona		
Arkansas		
California	81%	58%
Colorado		
Connecticut		
Delaware	80%	28%
District of Columbia	82%	44%
Florida		
Georgia	72%	44%
Hawaii	88%	35%
Idaho		
Illinois	74%	25%
Indiana	78%	53%
Iowa	88%	59%
Kansas		
Kentucky		
Louisiana	75%	50%
Maine		
Maryland		
Massachusetts[23]	72%	73%
Michigan	82%	51%
Minnesota	80%	30%
Mississippi		
Missouri	77%	47%
Montana		
Nebraska	87%	57%
Nevada		
New Hampshire	85%	48%
New Jersey		
New Mexico		
New York	84%	58%
North Carolina		
North Dakota	100%	42%
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island		
South Carolina	92%	57%
South Dakota		
Tennessee		
Texas		
Utah		
Vermont		
Virginia		
Washington		
West Virginia	79%	33%
Wisconsin[24]	81%	51%
Wyoming	93%	50%

Table 5 shows the percentage of people with HIV who are actively linked to and retained in care. Estimates are not available for many states. For states that only recently have modified their CD4 and viral load reporting requirements to include all tests, these data will come online soon. For states that have not yet begun reporting all CD4 and viral load tests, these data will not become available for some time even after adopting new reporting requirements. Therefore, it is imperative that every state immediately take steps to report all CD4 and viral load tests and actively monitor linkage and retention in care. Importantly, protecting individuals with HIV from harm, including the threat of criminal prosecution, must go hand in hand with using surveillance data to support linkage and engagement in care.

• Effectively target services to gay men and other men who have sex with men (MSM)

The HIV epidemic in the U.S. always has been concentrated among gay and bisexual men and other men who have sex with men (MSM). While we have made progress at lowering infection rates among other groups, the epidemic today is actually increasing its concentration among gay and bisexual men. Gay and bisexual men represent the greatest percentage of all new HIV infections in each state **(Table 6)**. According to the most recent CDC data, HIV rates are stable or falling for all groups in this country, except young gay men of all races. Among young gay men, infections rates have been highest among young Black gay men.

Historically, despite the concentration of HIV among gay and bisexual men, neither federal programs nor state health departments have adequately targeted funding and other resources to this population.[25] While funding needn't match epidemiological data with precision, generally programs targeting the population with the heaviest burden of new infections should receive the largest amount of money. States have typically done better at targeting resources to other risk groups, and the federal government has been overly passive when requiring state and local jurisdictions to allocate resources to this population.

The intention is not to focus solely on gay men, and we are sensitive to the perception that other groups may be inappropriately marginalized in the HIV response due to the overwhelming burden of the epidemic borne by gay men. Nonetheless, experience suggests that when recommendations are made for a variety of populations without calling specific attention to gay men, other groups are prioritized. Therefore, a special emphasis on the group with the largest number of HIV infections in the U.S. is warranted.

Next Steps

- All states should do more to respond to HIV among gay and bisexual men. This should start with assessing both funding levels and programmatic activities to determine whether gay and bisexual men (and gay men of color and young gay men in particular) are receiving the proportionate level of services needed to effectively reduce the number of HIV infections in their communities. In some cases, significant resource alignments are needed.
- States should support the appropriate uptake of pre-exposure prophylaxis (PrEP) among gay men. While we view PrEP's role as to complement, not supplant, other prevention interventions, there is an important role for state leadership in ensuring PrEP is available and affordable, training both medical providers and health plans on CDC clinical guidelines for PrEP, and working with communities to better understand PrEP and to de-stigmatize it.
- The federal government can do more to achieve greater targeting of resources and more effective tailoring of programs for gay and bisexual men. CDC, HRSA, SAMHSA and other agencies should assess and publicly release information on resource and programmatic alignment of state programs, and provide individualized technical assistance and guidance to achieve funding allocations and programs that appropriately match their epidemics.

Table 6: Gay men as a share of new HIV infections and HIV deaths, by state, 2008–2010

HIV Diagnoses and Deaths Among MSM[26]	MSM as a percentage of total HIV diagnoses (2008–2012)*	MSM as a percentage of total HIV deaths (2008–2011)*
Alabama	64%	48%
Alaska	55%	40%
Arizona	74%	70%
Arkansas	74%	56%
California	81%	71%
Colorado	78%	72%
Connecticut	51%	22%
Delaware	49%	32%
District of Columbia	54%	36%
Florida	54%	41%
Georgia	62%	48%
Hawaii	76%	72%
Idaho	76%	60%
Illinois	69%	49%
Indiana	67%	62%
Iowa	71%	61%
Kansas	71%	69%
Kentucky	72%	60%
Louisiana	52%	44%
Maine	65%	57%
Maryland	47%	26%
Massachusetts	55%	31%
Michigan	71%	54%
Minnesota	69%	64%
Mississippi	61%	46%
Missouri	77%	70%
Montana	72%	59%
Nebraska	65%	57%
Nevada	78%	69%
New Hampshire	66%	40%
New Jersey	50%	25%
New Mexico	73%	74%
New York	58%	30%
North Carolina	60%	38%
North Dakota	70%	71%
Ohio	71%	61%
Oklahoma	72%	66%
Oregon	81%	69%
Pennsylvania	47%	31%
Rhode Island	59%	37%
South Carolina	60%	40%
South Dakota	48%	58%
Tennessee	62%	52%
Texas	66%	54%
Utah	79%	65%
Vermont	63%	67%
Virginia	64%	47%
Washington	77%	68%
West Virginia	63%	55%
Wisconsin	70%	59%
Wyoming	71%	79%

* MSM includes those reported as MSM/IDU.

- Ensure broader access to effective sexuality education

There are actions that states can take that may be beyond the traditional purview of health departments, yet could contribute to a strengthened prevention response. All people need access to current, medically accurate information about HIV transmission and steps they can take to protect themselves. Ideally, such information is provided before people become sexually active and is integrated into a comprehensive health education curriculum that includes exemplary sexual health education (ESHE). ESHE is provided universally to all students from kindergarten through twelfth grade. It is scoped and sequenced in an age-appropriate way, with information about HIV included at appropriate times throughout the curriculum.[27]

In addition to universally applied ESHE, many young people at disproportionate risk of HIV will benefit from targeted programs that bolster lessons provided by parents, families, and schools. These programs are often offered within a broader school-based curriculum or in community settings that serve young people. Such programs have been shown to delay sexual debut, reduce the number of sex partners, decrease the number of times young people have unprotected sex, and increase condom use.[28] Yet, despite our knowledge of what works, as a nation we continue to be limited by our inability to ensure that all young people receive age-appropriate sexuality education in all school districts and in all communities throughout the country.

A number of components contribute to effective HIV and sexuality education programs. **Table 7** relies on an assessment by the Guttmacher Institute of a range of state policies that can contribute to an effective overall HIV and sexuality education program.

Next Steps

- Preventing HIV in young people begins with ensuring a uniform base of functional sexual health knowledge. It continues with providing complete and accurate information about STIs and how to reduce risk. More must be done to get this information to young people in every state and community in the country.
- While abstinence is the preferred message and approach to disease prevention of many parents, research shows that more comprehensive approaches that include an emphasis on abstaining from sex, but also include information on condoms and other risk reduction strategies lead to better STI and teen pregnancy health outcomes.
- While health departments may view decisions about sexuality education and whether, when, and what to teach young people as falling within the purview of the education department, health department staff have expertise about HIV and STI prevention that should inform state decision making in this critical area. Therefore, health departments are encouraged to engage with education leaders, legislators, and parents in order to build consensus on expanding uniform and consistent access to exemplary sexual health education that includes medically accurate risk reduction information.
- Health departments also can assist with identifying communities that would benefit from programs for young people at disproportionate risk, helping those communities select and implement programs, and assuring that targeted programs complement the overall sexual education curriculum in that community's schools.

Table 7: State policies that support HIV and sexuality education[29]

	Sex education mandated	HIV education mandated	Sex or HIV education must be medically accurate	Sex education must include sexual orientation	HIV education must include condoms	HIV education must include abstinence*
Alabama		Yes		No	Yes	Stress
Alaska						
Arizona						Stress
Arkansas						Stress
California		Yes	Yes	Yes	Yes	Cover
Colorado			Yes	Yes	Yes	Cover
Connecticut		Yes				
Delaware	Yes	Yes		Yes	Yes	Stress
District of Columbia	Yes	Yes				
Florida						Stress
Georgia	Yes	Yes				Cover
Hawaii			Yes		Yes	Stress
Idaho						
Illinois		Yes	Yes		Yes	Stress
Indiana		Yes				Stress
Iowa	Yes	Yes	Yes	Yes		
Kansas						
Kentucky	Yes	Yes				Cover
Louisiana						Stress
Maine	Yes	Yes	Yes		Yes	Stress
Maryland	Yes	Yes			Yes	Cover
Massachusetts						
Michigan		Yes	Yes			Stress
Minnesota	Yes	Yes				Cover
Mississippi	Yes					Stress
Missouri		Yes				Stress
Montana	Yes	Yes				Cover
Nebraska						
Nevada	Yes	Yes				
New Hampshire		Yes				Cover
New Jersey	Yes	Yes	Yes	Yes	Yes	Stress
New Mexico	Yes	Yes		Yes	Yes	Stress
New York		Yes			Yes	Stress
North Carolina	Yes	Yes	Yes		Yes	Stress
North Dakota	Yes					
Ohio	Yes	Yes				Stress
Oklahoma		Yes			Yes	Cover
Oregon	Yes	Yes	Yes	Yes	Yes	Stress
Pennsylvania		Yes				Stress
Rhode Island	Yes	Yes	Yes	Yes	Yes	Stress
South Carolina	Yes	Yes		No		Stress
South Dakota						
Tennessee	Yes	Yes				Stress
Texas				No	Yes	Stress
Utah	Yes	Yes	Yes			Stress
Vermont	Yes	Yes			Yes	Cover
Virginia					Yes	Cover
Washington		Yes	Yes	Yes	Yes	Stress
West Virginia	Yes	Yes			Yes	Cover
Wisconsin		Yes				Stress
Wyoming						

Note: Blank spaces indicate that there is no statewide policy in place.

*For abstinence education, "Stress" indicates that HIV education must emphasize the importance of abstinence until marriage, while "Cover" indicates that HIV education must cover abstinence as an option that must be discussed.

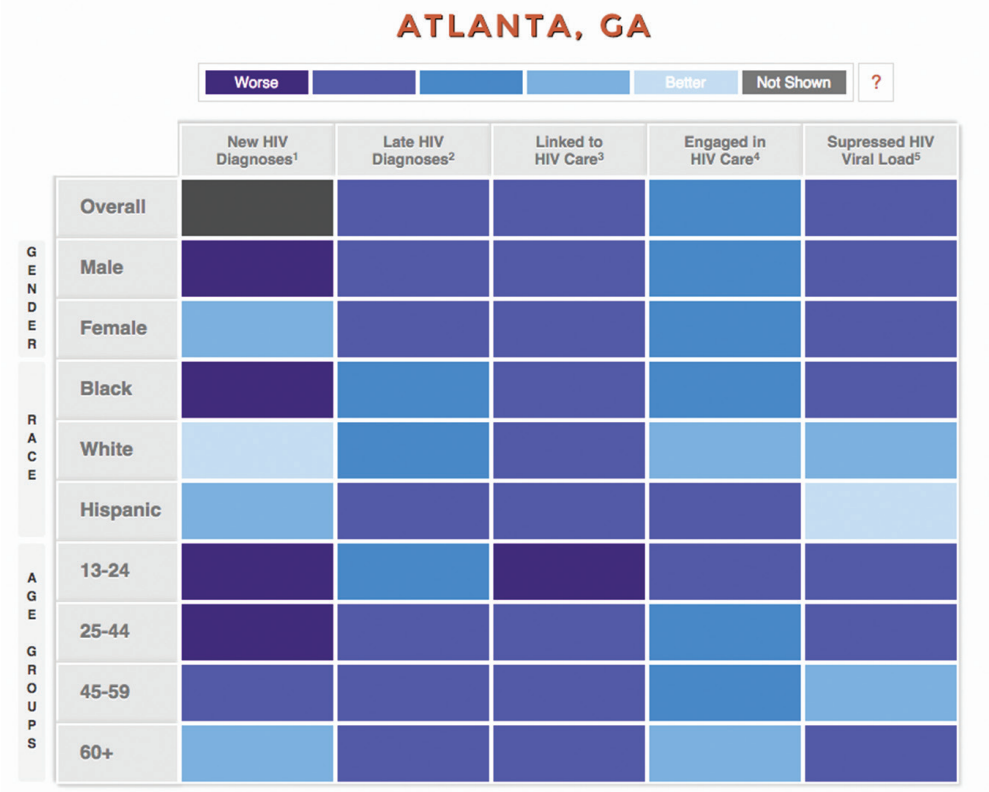
INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV

The Strategy was predicated on supporting the effective implementation of the ACA as a primary mechanism for increasing health security for people living with HIV. Further, the Strategy explicitly stated that even once the ACA was fully implemented, the Ryan White HIV/AIDS Program and other federal and state programs would continue to be necessary to address gaps in essential services for people with HIV. As the growing use of the HIV care continuum demonstrates, however, ensuring a source of insurance coverage or payment for critical health care and supportive services is often insufficient to engage people with HIV in care and keep them engaged over the long term.

Since the Strategy was released, the HIV care continuum has been popularized by the work of Ed Gardner and others who developed a model for determining population-level estimates of engagement in care at each step of the care continuum, from HIV diagnosis to effective viral suppression with treatment. The CDC subsequently created its own estimates of engagement in care **(Figure 2)**. States and communities have begun to develop and publish care continuum estimates, too, as well as similar estimates for sub-populations within states.[30] This work is potentially very significant if it leads to smarter and more targeted investments in services for key populations and services and interventions that reach people at stages of the care continuum when they are at greatest risk of falling out of care.

Our increased understanding of the benefits of treatment comes as we learn how challenging it can be to build systems of care that effectively support all people with HIV in remaining engaged in care for an extended period of time.

Figure 3: An estimate of the HIV continuum of care in Atlanta, Georgia



HIVContinuum, part of the Rollins School of Public Health at Emory University, has published HIV care continuum data on Washington, D.C., Atlanta, Georgia, and Philadelphia, Pennsylvania, and intends to continue adding more cities as data becomes available. Available at: www.hivcontinuum.org.

Priority action for states:

- Expand access to insurance in order to support continuous, coordinated, and quality HIV care

The Strategy was released a few months after enactment of the ACA. Subsequently, the Supreme Court significantly altered the program by upholding the law, but effectively making Medicaid expansion—the source of coverage for the majority of uninsured people living with HIV—optional for the states. Clearly, this has only elevated the importance of state-based decisions.

The policies that states enact to support the implementation of health reform matter. While expanding Medicaid and insurance access through the ACA does not solve all patient access problems such as lack of transportation, mental health services, or substance abuse treatment, it is a first and necessary condition for expanding HIV services. **Table 8** identifies actions taken by states in light of the ACA's implementation. Please note that HRSA guidance states that Ryan White funds under Parts A, B, C, and D may be used to support programs that pay premiums, deductibles, and cost sharing. While ADAP is a primary mechanism by which states have provided such assistance, and data are available on state ADAP policies, other part B funds and other Ryan White programs may also assist with financial costs associated with accessing health insurance benefits. States also may wish to explore providing incentives or developing metrics that incentivize retention of people in care by clinics and individual providers and the achievement and maintenance of viral suppression.

Next Steps

- ➤ Increasing engagement in care requires taking active steps to leverage the ACA, including making the decision to expand Medicaid. Giving people an insurance card, however, is but the initial step in making insurance work for people.
- ➤ State HIV leaders should work with insurance regulators and Medicaid program staff to assess benefit design issues and other policies to ensure that people with HIV have meaningful access to covered services.
- ➤ Changes in HIV treatment standards and the increased focus on engagement in care at each stage of the care continuum demand that states reflect on how their Ryan White programs can better supplement insurance coverage to reduce financial and other barriers to care.

Table 8: State policies to maximize the impact of the ACA

State Actions to Leverage the ACA to Increase Engagement in Care				
	Has state expanded Medicaid under the ACA? (as of May 2015)[31]	ADAP covers medical co-pays/co-insurance[32]	ADAP covers prescription deductibles[33]	Percentage of ADAP budget contributed by the state[34]
Alabama	No	No	No	22%
Alaska	Debate	Yes	Yes	0%
Arizona	Yes	Yes	Yes	4%
Arkansas	Yes	Planning	Planning	0%
California	Yes	No	Yes	8%
Colorado	Yes	Yes	Yes	22%
Connecticut	Yes	No	Yes	0%
Delaware	Yes	No Response	No Response	Unknown
District of Columbia	Yes	No	Yes	0%
Florida	Debate	No	Yes	10%
Georgia	No	Yes	Yes	16%
Hawaii	Yes	No	Yes	13%
Idaho	No	No	Yes	14%
Illinois	Yes	No	Yes	27%
Indiana	Yes	Yes	Yes	0%
Iowa	Yes	No	Yes	13%
Kansas	No	No	Yes	22%
Kentucky	Yes	Yes	Yes	0%
Louisiana	No	Yes	Yes	0%
Maine	No	No	Yes	2%
Maryland	Yes	No	Yes	0%
Massachusetts	Yes	No	No	8%
Michigan	Yes	No	Yes	0%
Minnesota	Yes	No Response	No Response	10%
Mississippi	No	No	Planning	9%
Missouri	No	Yes	Yes	19%
Montana	Yes	No	Yes	7%
Nebraska	No	No	Yes	Unknown
Nevada	Yes	No	Yes	14%
New Hampshire	Yes	Yes	Yes	4%
New Jersey	Yes	No	Yes	0%
New Mexico	Yes	No	No	22%
New York	Yes	Yes	Yes	10%
North Carolina	No	No	Yes	37%
North Dakota	Yes	No	Yes	0%
Ohio	Yes	Yes	Yes	0%
Oklahoma	No	No	Yes	11%
Oregon	Yes	Yes	Yes	0.20%
Pennsylvania	Yes	No	Yes	13%
Rhode Island	Yes	Yes	Yes	1%
South Carolina	No	No	Yes	19%
South Dakota	No	Yes	Yes	0%
Tennessee	No	No Response	No Response	23%
Texas	No	No	No	27%
Utah	Debate	No	Yes	0%
Vermont	Yes	No	Yes	0%
Virginia	No	No	No	24%
Washington	Yes	Yes	Yes	19%
West Virginia	Yes	No	Yes	Unknown
Wisconsin	No	No	Yes	6%
Wyoming	No	Yes	Yes	32%

REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

Access to health care in the U.S. is very unequal and there are significant disparities in health outcomes. A health condition such as HIV, which is concentrated among specific communities and unequally dispersed throughout the country, yields even higher disparities. State laws and policies can both magnify or minimize such inequities. The Strategy set a goal of increasing the proportion of gay and bisexual men, Blacks, and Latinos with undetectable viral load by 20 percent by 2015.

Because of the marginalization of many communities heavily impacted by HIV, taking action to focus on communities and populations at greatest risk may require strong leadership and a willingness to ignore resistance to change.

Priority action for states:

- Systematically track prevention and care metrics for key subpopulations

While there is a broad understanding that HIV is concentrated in key groups, many members of the public may misunderstand which populations are most heavily impacted. Further, while regional disparities are fairly well understood, with broad recognition that the U.S. South and Northeast are disproportionately affected, the significant HIV-related disparities within states and communities are less well appreciated. Nearly every state professes to target resources to key populations, but few effective tools or indicators exist to accurately measure whether those allocations effectively follow the epidemic or support interventions likely to have the largest public health impact. The CDC, working in partnership with the HHS Office of HIV/AIDS and Infectious Diseases Policy (OHAIDP), pilot tested a resource allocation modeling project (RAMP) that could guide state and local jurisdictions in maximizing effective allocations of HIV prevention resources. This type of tool must be available and utilized in each state or, at the very least, in those states that comprise the largest number of new HIV infections each year.

Table 9 provides estimates of viral suppression, presenting these data as percentages of all people diagnosed with HIV and the smaller subset of people who have been retained in care.

Next Steps

- ➤ All states should have the capacity to produce population-level estimates of the care continuum broken down by key populations (using standardized population definitions), including gay men, heterosexuals, injection drug users, youth, Blacks, Latinos, and other racial/ethnic minorities.
- ➤ States should monitor and report on measures of health disparities, both in terms of access to care and disparities in achieving clinical outcomes including viral suppression. These data also should form part of annual consumer-friendly reports, as discussed earlier.
- ➤ Over time, each state should increase its capacity and sophistication in developing and using estimates of linkage, engagement, and retention in care, and achieving viral suppression.
- ➤ More must be asked of states to show that prevention and care services targeted to key populations are being funded roughly commensurate with their share of the epidemic.

Table 9: State-level estimates of viral suppression among all persons living with HIV and among those in medical care.

State Retention in Care Policies and Results			
	State data reported to CDC mature for continuum of care analysis as of December 2012[35]	Percentage of diagnosed patients achieving viral suppression (VL <200), 2010[36]	Percentage of patients in care achieving viral suppression (VL <200), 2010[37]
Alabama	No		
Alaska	No		
Arizona	No		
Arkansas	No		
California	Yes	56%	78%
Colorado	No		
Connecticut	No		
Delaware	Yes	14%	33%
District of Columbia	Yes	40%	67%
Florida	No		
Georgia	Yes	32%	55%
Hawaii	Yes	33%	61%
Idaho	No		
Illinois	Yes	25%	60%
Indiana	Yes	48%	70%
Iowa	Yes	53%	72%
Kansas	No		
Kentucky	No		
Louisiana	Yes	39%	61%
Maine	No		
Maryland	No		
Massachusetts[38]	No*	64%	84%
Michigan	Yes	44%	64%
Minnesota	Yes	36%	75%
Mississippi	No		
Missouri	Yes	43%	69%
Montana	No		
Nebraska	Yes	50%	72%
Nevada	No		
New Hampshire	Yes	45%	77%
New Jersey	No		
New Mexico	No		
New York	Yes	47%	70%
North Carolina	No		
North Dakota	Yes	50%	81%
Ohio	No		
Oklahoma	No		
Oregon	No		
Pennsylvania	No		
Rhode Island	No		
South Carolina	Yes	47%	70%
South Dakota	No		
Tennessee	No		
Texas	No		
Utah	No		
Vermont	No		
Virginia	No		
Washington	No		
West Virginia	Yes	39%	71%
Wisconsin[39]	No*	46%	82%
Wyoming	Yes	45%	71%

* Massachusetts and Wisconsin data were not reported by the CDC, but these states subsequently published their own continuum of care data, which are included here.

Having continuum of care data tied to health surveillance systems will be essential for HIV programming in the future. States shaded in orange that have yet to amend state reporting requirements for CD4 and viral load will lag behind other states in their capacity to respond to their epidemics.

- ## Modernize state laws and policies to stop criminalizing people with HIV in order to better protect the health of the public

Despite significant progress in responding to the domestic HIV epidemic and the existence of comprehensive civil rights protections for people with HIV through the Americans with Disabilities Act and other laws, HIV-related stigma and discrimination persist. In many cases, such stigma is entrenched in state civil and criminal laws that single out people living with HIV for sanctions and selective prosecution. Many of these laws were passed in the early days of the HIV epidemic in response to fear of reckless behavior that would spread HIV to unsuspecting individuals and fuel the growth of the epidemic across the general population. In the decades that have followed, these fears have proven to be unfounded and many of the specific behaviors criminalized are now known not to be effective modes of transmission. As such, continued prosecutions under these laws go against American principles of equality and fairness.

Thirty-three states have laws that make it a criminal offense for people with HIV to fail to disclose their HIV status before engaging in sexual activity, and 38 states use those or general criminal laws to prosecute people with HIV for failure to disclose their status. Eleven states still have laws that enable prosecutions of people living with HIV for behaviors that do not pose meaningful risks for HIV transmission—such as spitting, biting, or throwing of bodily fluids. These laws are out of step with science and send inaccurate messages about how HIV is (and is not) transmitted. There is no medical basis for legal distinctions between people with and without HIV for such behaviors.

Some laws also proscribe sexual behavior in a manner that many find problematic. They shift responsibility for sexual decision-making from a shared responsibility between two consenting adults and place full responsibility on the person with HIV. To protect the population, our public health messages should tell the public that it is not reasonable

for sexually active adults to make any assumptions about the health status of a partner outside of a well-established mutually monogamous relationship. Individuals have primary responsibility for taking active steps to prevent themselves from becoming infected with HIV and other sexually transmitted infections through the consistent use of condoms, PrEP, or engaging in less risky behaviors. For this public health approach to be effective, it must be consistent with the law. With treatment advances, individuals living with HIV also can make themselves extremely unlikely to transmit infection once they achieve and maintain effective viral suppression through the use of ART, and state laws should reflect this reality.

The best course for curbing HIV transmission is to eliminate barriers that deter people with HIV from learning their status and initiating and staying on treatment. While these laws were intended to provide protection to the public, they may in fact be doing the opposite. One study in Canada, for example, looking at stigma and criminalization laws found that 18% of respondents felt the law created an environment in which it was better not to know one's HIV status, and 7% were less likely to get tested because of the law.[40] Further, many of these laws were enacted under the premise that their existence would deter risky behavior, yet studies have shown that knowledge of these laws has no effect on disclosure, number of sexual partners, or condom use.[41,42] HIV-specific criminal statutes also are not needed to prosecute the extremely rare case of intentional transmission of HIV.

A related policy challenge is that many states' prosecutors utilize general criminal laws—including common law crimes—to prosecute cases of HIV exposure. There are no data to support the idea that the prosecutorial discretion to focus on these cases has a positive impact on changing the behavior of people with HIV or protecting public health. The Strategy urges states to evaluate the public health justification for their laws, and there is a growing realization in the U.S. and around the world that such laws and their use to prosecute people with HIV constitute both bad policy and bad practice.[43]

State laws and prosecution histories provide a tangible indicator of state policies that stigmatize people with HIV. **Table 10** presents data on state HIV criminal laws and recent (2008–2014) prosecutions on the basis of HIV status.

Next Steps

- ➤ All states should examine their laws related to exposure to HIV to ensure that these laws are updated to support current public health approaches to fighting HIV.
- ➤ All laws that allow for the differential prosecution of people with HIV for spitting and biting should be repealed.
- ➤ State legislators, health departments, and prosecutors should engage in a constructive dialogue with medical providers, disease control specialists, and people living with HIV to update HIV criminal statutes, common laws, and disclosure requirements regarding consensual sexual activity to ensure that they are non-discriminatory and respect the autonomy and privacy of people with HIV, in order to reduce HIV transmission.

Not Just an Issue of the Past

The prosecution of people living with HIV for failing to disclose their HIV status is not a relic of the past. Twenty-nine states have had at least one prosecution in the last two years.

State public health leaders have a critical role to play in helping prosecutors, judges, and the public to understand the risks of HIV acquisition when engaging in specific behaviors and the scientifically-validated effectiveness of condom use and antiretroviral therapy (ART)—as both treatment and as pre-exposure prophylaxis (PrEP)—in preventing HIV transmission.

Table 10: State criminal laws and prosecutions relating to HIV transmission or exposure, 2014

HIV-related Criminalization Statutes and Prosecutions				
	Does state have specific laws criminalizing HIV transmission or exposure?[44]	Does state use general criminal laws to prosecute HIV transmission or exposure?[45]	Does state have scientifically inaccurate/implausible laws (spitting, biting, throwing)?[46]	Number of state prosecutions relating to HIV transmission or exposure (2008–2014)[47]
Alabama	No	Yes	No	1
Alaska	No	No	No	
Arizona	Yes	No	No	5
Arkansas	Yes	No	No	
California	Yes	Yes	No	3
Colorado	Yes	Yes	No	3
Connecticut	No	No	No	
Delaware	No	No	No	
District of Columbia	No	No	No	
Florida	Yes	Yes	No	24
Georgia	Yes	Yes	Yes	15
Hawaii	No	No	No	
Idaho	Yes	Yes	No	6
Illinois	Yes	No	No	7
Indiana	Yes	Yes	Yes	7
Iowa	Yes	Yes	No	6
Kansas	Yes	Yes	No	2
Kentucky	Yes	Yes	No	2
Louisiana	Yes	Yes	Yes	2
Maine	No	No	No	
Maryland	Yes	Yes	No	5
Massachusetts	No	Yes	No	1
Michigan	Yes	Yes	No	12
Minnesota	Yes	Yes	No	2
Mississippi	Yes	No	Yes	2
Missouri	Yes	No	Yes	13
Montana	No	Yes	No	1
Nebraska	Yes	No	Yes	1
Nevada	Yes	Yes	No	1
New Hampshire	No	Yes	No	1
New Jersey	Yes	Yes	No	2
New Mexico	No	No	No	
New York	No	Yes	No	3
North Carolina	Yes	Yes	No	3
North Dakota	Yes	Yes	No	
Ohio	Yes	Yes	Yes	15
Oklahoma	Yes	Yes	No	5
Oregon	No	Yes	No	1
Pennsylvania	Yes	Yes	Yes	4
Rhode Island	No	Yes	No	
South Carolina	Yes	Yes	Yes	6
South Dakota	Yes	Yes	Yes	1
Tennessee	Yes	Yes	No	14
Texas	No	Yes	No	9
Utah	Yes	Yes	Yes	2
Vermont	No	Yes	No	1
Virginia	Yes	Yes	No	4
Washington	Yes	Yes	No	3
West Virginia	No	Yes	No	
Wisconsin	Yes	Yes	No	1
Wyoming	No	Yes	No	

CONCLUSIONS AND RECOMMENDATIONS

This report is intended to highlight critical priorities for states, both to clarify areas of focus and to help them assess their performance relative to other states. It is also intended to be a useful tool for community stakeholders to work with and, when necessary, push state policymakers to strengthen HIV prevention and care programs. The purpose is not to critique, but to prioritize needed actions.

It must be noted that the priority areas we have highlighted are not sufficient in and of themselves. These indicators are necessary measures that will enable states to embark on the next steps toward ending their epidemics. As has been highlighted throughout this report, this will mainly be accomplished through improving planning and resource allocation processes to more effectively prioritize populations and communities with the most acute need for HIV prevention, care, and treatment services. Some localities and states are clearly already moving in this direction.[48] If successfully implemented, these efforts could dramatically reduce HIV infections and mortality and greatly diminish the cost burden on health systems over the long term.

For states: The priorities identified here are intended to highlight areas where all states should focus attention. We recognize that many activities already are taking place and that persistent staffing and resource challenges complicate state efforts. Additionally, we recognize that individual states have shown important leadership in supporting the Strategy's major goals. Therefore, we recommend not only that states assess their own environments and develop innovative and specific solutions, but also that they look to their peers and build on the successes of other states.

For community stakeholders: An important role for community stakeholders, including people with HIV and others who advocate with and for them, is to identify shortcomings and push for both new resources and changed policies. A critical way to advance our common goals and broaden support for an increased commitment to fighting HIV is to educate and remind the public of our major successes—and the role of state leadership in achieving many of these successes. At the same time, no state is getting everything right and all states can benefit from engaged stakeholders. We recommend that community advocates use the indicators in this report as a starting point for a renewed dialogue with state leaders toward establishing aggressive, yet realistic targets for progress and then systematically taking steps to achieve these goals.

For the federal government: The focus of this report is on bolstering state action, yet there is an important role for the federal government to play in supporting state efforts. We recommend that federal agencies consider how they can create new opportunities for collaboration across states and between state policymakers and relevant stakeholders.

In preparing this report, it was striking to discover how limited the available indicators were to measure some of the types of policy actions that we believe are most needed. An appropriate role for the federal government is to work with states and other stakeholders to collaboratively develop a small number of meaningful indicators that can be used to effectively assess the extent to which individual states are taking the steps outlined here.

Additionally, while federal agencies have recently strengthened collaboration across agencies, conflicting and duplicative guidance from different federal agencies can significantly burden state efforts. Federal agencies should redouble their commitment to joint/blended funding initiatives, issuing program guidance that applies consistently across federal programs, and providing technical assistance and training initiatives that apply across different federal agencies. Federal officials also should consider new partnerships across agencies and with external partners (such as AIDSVu) to expand the availability of accurate, timely, and understandable data that is comparable across states and regions.

Information from this report is presented in state profiles accessible online at **www.amfar.org/key-indicators**.

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