DELAWARE HIV PREVENTION JURISDICTIONAL PLAN 2016

Introduction

This document serves as a supplement to the already plentiful HIV/AIDS documents relative to Delaware HIV/AIDS Prevention and Treatment:

- The Delaware 2010-2014 Comprehensive HIV Prevention Plan and Statewide Coordinated Statement Of Need explicates the planning process, the needs assessment, the epidemiologic profile, most at-need populations, potential interventions approved, etc.
  http://www.delawarehiv.org/uploads/cmsfiles/2010-2014%20Comp%20Plan%20Final%20With%20Color%20.pdf
- The 2014 Delaware HIV/AIDS Surveillance Report provides a complete picture of Delaware's HIV/AIDS epidemic by as many variables possible and reasonable.
  http://www.dhss.delaware.gov/dhss/dph/dpc/files/2014hivepireport.pdf
- The Delaware Monthly HIV/AIDS Reports provide more real-time statistics for Delaware's epidemic.
  http://www.delawarehiv.org/uploads/PDF/Monthly%20Surveillance%20Report%20 (through%20July%202013).pdf
- The National HIV/AIDS Strategy
  http://www.whitehouse.gov/administration/eop/onap/nhas

In short, these documents are available online, kept up-to-date, and contain everything needed for the jurisdictional plan other than:

1. Delaware specific goals/objectives in a format matching the National HIV/AIDS Strategy
2. Short-term rationale for the goals as applied to Delaware
3. Explication of non-DEBI (diffusion of effective behavioral intervention) tactics for achieving the goals in Delaware.

A brief excerpt from the Surveillance Report is provided below for the reader's convenience. The reader is referred to the above listed documents if there are further questions about the most-at-risk populations, needs assessments, gaps analysis, or other items forming the basis of this document.

General Epidemic Overview

From 2008 through 2014, the HIV epidemic has remained relatively stable relative to proportionality of the epidemic among the most-at-risk populations by sexual orientation, sexual behavior, gender, race, ethnicity, geography and other demographic signifiers. Yearly incidence has ranged from a high of 161 to a low of 113, with an average of 133 cases per year. The below is excerpted from the 2014 Surveillance Report Executive Summary for the reader's convenience.

As of 2013, a total of 3,560 Delawareans were known to be living with Human Immunodeficiency Virus (HIV) of which 2,227 had progressed to Acquired Immune Deficiency Syndrome (AIDS). In that same year, the cumulative number of HIV/AIDS cases ever diagnosed in Delaware reached 5,650. As noted in the CDC, HIV/AIDS Surveillance Report of 2012, Delaware's HIV incidence rate (16.3 per 100,000) was the 11th highest in the United States and the AIDS incidence rate (11.8 per 100,000) ranked seventh highest in the nation. The five year average number of new infections diagnosed in Delaware currently stands at 131 cases per year (2009-2013).

The distribution HIV cases in Delaware mirrors county-level population distribution. New Castle County – the most populous of Delaware's three counties – has the largest number of cases with most confined to the densely populated Wilmington metropolitan area. There exists a disparity. While Wilmington comprises 14% of the New Castle County population, it accounts for 40% of the county's individuals living with HIV/AIDS.

Males account for the majority (71%) of HIV/AIDS cases diagnosed in Delaware.

African-Americans are disproportionately affected by the HIV/AIDS burden. Twenty-one percent of Delaware's total population is African-American but this group accounts for 66% of all HIV/AIDS cases ever diagnosed in the state. This racial disparity is more pronounced in Delaware compared to the general U.S population, and persists even when HIV and AIDS are considered separately. African-Americans account for 38% of all male AIDS cases living in the U.S., but 56% of all male AIDS cases living in Delaware. Similarly, African-American women comprise 61% of all female AIDS cases living in the U.S., but nearly 75% of all female AIDS cases living in Delaware.

Consistent with U.S. trends, the majority (62%) of HIV/AIDS cases ever reported in Delaware were among adults aged 30-49. Fewer than 4% were reported among adults age 60 and older.

Pediatric HIV/AIDS (defined as disease in children under 13 years of age) account for 1% of cases ever reported in Delaware (consistent with general U.S figures). Legislation requiring testing of all expectant mothers for HIV and active identification and referral for treatment of any HIV infected mothers has been effective. Only two infected infants have been born in Delaware in the past 10 years.

Among new HIV infections diagnosed in Delaware in 2013, the largest proportion (45%; N=53) were attributable to men who have sex with men (MSM). Heterosexual transmission and injection

drug use (IDU) accounted for 34% (N=40) and 8% (N=9), respectively while 4% (N=5) were attributable to both MSM and injection drug use. 10% (N=12) fell into the "Other Risk" or "No Risk Identified" behavioral categories. (*Delaware Health and Social Services, Division of Public Health 2014 Delaware HIV/AIDS Report* 2)

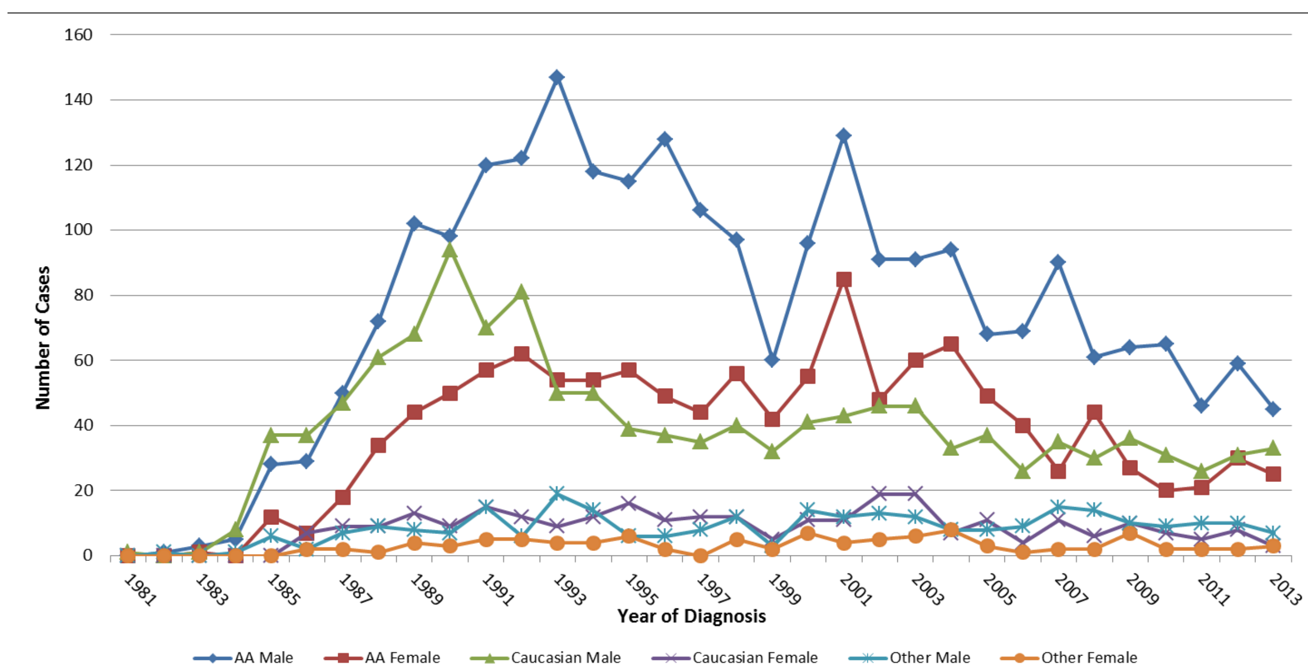
Exposure rates are similar in New Castle County between heterosexual (34%), MSM (31%) and IDU (26%). In Kent County the rates are heterosexual (38%), MSM (32%) and IDU (16%). In Sussex County exposure is predominantly MSM (51%)

From 1981 through December 2013, 2,346 Delawareans with AIDS died. In the past two decades, the survival of those living with AIDS has increased significantly as has the slowing of progression from HIV to AIDS. Earlier diagnoses of HIV infection and advances in medical management have all contributed to the marked improvements in HIV/AIDS quality of life and survival rates.

Race/Ethnicity

As stated above, Delaware's HIV/AIDS epidemic disproportionately affects the African-American population. Males account for most cases within each race category (i.e., Caucasian, African-American, Hispanic, and Other).

Figure 1: Delaware HIV/AIDS cases, by race and gender, 1981-2013 (N=5,650)



Mode of HIV Transmission

Patterns of HIV transmission may shift over time and the predominant mode of transmission in Delaware at the beginning of the HIV/AIDS epidemic (1981-1994) differs from current patterns of disease transmission.

In 1993, 49% of HIV/AIDS cases diagnosed among Delawareans were attributable to IDU. This percentage has fallen to 8% in 2013. Matter of fact, by 2007, cases of transmission via needle sharing was on par with the number of cases attributed to 'no identified risk' (under 10 cases/year) with slight increases in following years thought to be due to increased testing among highest-risk needle users enrolled in Delaware's Needle Exchange Program (implemented in 2007). New cases among IDU have remained relatively low post 2007.

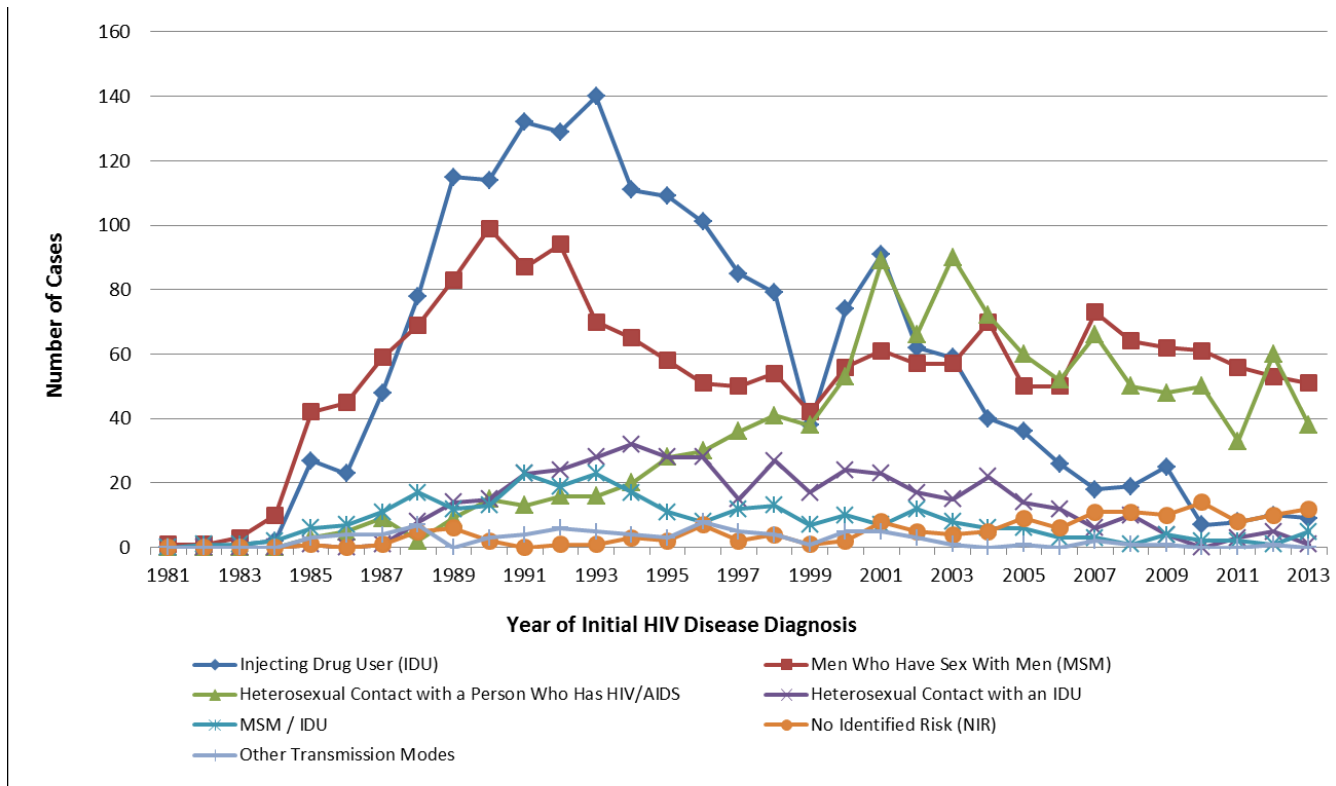
The proportion of Delaware's HIV/AIDS cases diagnosed among men who have sex with men (MSM) in 2013 is 44%. MSM as a risk factor has been resurgent since 1999 and is currently the highest ranking risk factor for HIV infection in Delaware.

In Delaware, the percentage of cases attributable to heterosexual contact increased from 1985 until 2004. Since 2004, HIV infections attributable to heterosexual contact has decreased significantly.

It is not unusual for cases that were attributable to one risk factor to be later re-assigned to a different risk category if it is determined that the sexual partner who has HIV/AIDS is also an IDU and/or a bisexual.

Cases attributable to "other modes of transmission" include perinatal exposure, transfusion recipients, and those infected from working in a healthcare or laboratory setting. Cases representing "other modes of transmission" account for a very small percentage of all HIV/AIDS cases in the state.

Figure 2: Delaware HIV/AIDS cases, by mode of transmission, 1981-2013 (N=5,650)



Though there have been fluctuations in actual number of new cases in each risk category/ population, the most at-risk populations for HIV infection in Delaware have remained stable for the last 10 years and have remained overwhelmingly:

1. African American Men that share needles and/or have sex with men.
2. Caucasian MSM
3. African American Women heterosexual partners of 1 & 2 above.

Geographically, the distribution remains stable as well. In order of prevalence and incidence:

1. New Castle County (Wilmington) represents ~65% of the epidemic in any given year.
2. Sussex County (~20%)
3. Kent County (~15%)

Further specificity about Delaware's epidemic may be found in the documents referenced on page 2.

NOTE: As Delaware's epidemic has remained relatively stable relative to populations affected, we engage in a 5-year planning process with yearly updates. The next Comprehensive HIV Prevention

Plan and Statewide Coordinated Statement of Need will be for the years 2017-2021. The Jurisdiction Plan will be updated to match.

National HIV/AIDS Strategy (NHAS)

There are three primary goals for the NHAS:

- Reducing HIV incidence
- Increasing access to care and optimizing health outcomes
- Reducing HIV-related health disparities

These three goals are addressed at a high-level emphasizing the following themes familiar to anyone working in HIV/AIDS for any length of time. Paraphrased, they are:

1. Get services to those that need them most (Proper Targeting of Services)
2. Use the most cost effective interventions reaching the greatest number of people for the least amount of money to the greatest effect. (Scalability, Research-based and/or Evaluated, Culturally Sensitive)
3. Ensure everyone in need has the same, high-quality access to needed services. (Eliminate Disparities)

Recommended strategies include (those relevant to CDC Funded HIV Prevention Cooperative Agreement in Delaware are bolded):

- **Abstinence from [high-risk] sex or drug use**

  Drug treatment programs are underfunded on the national and state levels. Wait times for enrollment are excessive in most jurisdictions and available services are well below demand, as incarceration of addicts is a higher priority than treatment, both nationally and locally. This is beyond the scope of the HIV Prevention Cooperative Agreement and the funding provided through it. Referral to existing programs that are enrolling new clients will remain a high priority – as they exist.

- **HIV Screening Programs**

  This is a priority service of Delaware HIV Prevention. However, as funding continues to decrease, supporting this activity will pose challenges (i.e. decrease existing contracts with CBO's, decrease the number of HIV testing kits provided to Title X agencies).

- **Condom Availability**

  This is less evidence-based than other recommended interventions, but it seems rational

and morally appropriate to provide those at highest-risk with free access to the tools to modify sexual behaviors in the recommended ways.

This is a priority activity of Delaware HIV Prevention and is possible within current budget levels.

- **Access to sterile needles and syringes**

  This is not permitted with federal funds at present and has no relevance to the HIV Prevention Cooperative Agreement. However, the HIV Prevention office manages the contract with Brandywine Counseling for syringe exchange services.

  Delaware State funding supports Needle Exchange for Wilmington and those able to access the service in Wilmington.

  HIV Treatment

  Connection of HIV infected individuals discovered through HIV Prevention Cooperative Agreement programs is a priority of those programs and will remain a high priority.

  Connection of those discovered outside of programs funded by the Delaware HIV Cooperative Agreement remains a cooperative effort between HIV prevention, HIV surveillance, and DE STD program – and will remain a priority activity.

  Provision of treatment services remains the domain of Ryan White.

- **Educate all Americans about the threat of HIV and how to prevent it.**
  - Utilize evidence-based social marketing and education campaigns

    Delaware HIV Prevention Program has made this a priority in past years and will retain it as a primary function of the program to the extent that shrinking funding allows.
  - Promote age-appropriate HIV and STI prevention education for all Americans

    This remains a priority activity for all funded intervention of the HIV Prevention Program.

    It is recommended that HIV education be integrated into all educational environments, but it is out of the scope of the funding available and the effective actionable sphere of influence of the HIV Prevention Program to influence school curricula choices in DE. This will remain the purview of the DOE (Department of Education) and individual school districts and the School-based Wellness Center Programs.

- **Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV**.

  This is and will continue to be a priority activity of the HIV prevention interventions funded under the HIV Prevention Cooperative Agreement.

  - Promoting quality referral services among all other venues in which diagnosis of HIV may occur remains a high priority of the HIV Prevention program.

    This is actualized as a cooperative effort between HIV surveillance, HIV treatment, HIV Prevention and STD services.
  - Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.

    This is the domain of Ryan White and private service providers and out of the scope of HIV Prevention Cooperative funding.
- Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

  This is the domain of Ryan White and private service providers and out of the scope of HIV Prevention Cooperative funding.
- Reduce HIV-related mortality in communities at high risk for HIV infection.
  - Ensure that high-risk groups have access to regular viral load and CD4 tests.

    This is a function of treatment and not in the scope of HIV Prevention Cooperative Agreement or the funding it provides to Delaware.
- Adopt community-level approaches to reduce HIV infection in high-risk communities.
  - **Establish pilot programs that utilize community models**.

    This has been and remains a priority activity for Delaware HIV Prevention.
  - Measure and utilize community viral load

    This is a function of treatment and not in the scope of HIV Prevention Cooperative Agreement or the funding it provides to Delaware.
  - **Promote a more holistic approach to health**

    This remains a routine part of HIV Prevention Programs.
- **Reduce stigma and discrimination against people living with HIV.**
  - Engage communities to affirm support for people living with HIV

    This is not implementable or measurable as defined as 'encouraging communities to

take responsibility for having a nonjudgmental support for those with HIV'. This crossed too many lines of religious, social, cultural, moral, and legal thought and feeling to be addressed by the funding provided for HIV Prevention in DE.

- **Promote public leadership of people living with HIV**
  The program routinely works with Delaware HIV Consortium, community entities, cooperative programs, etc. to include those with HIV that wish to and have capacity to participate in leadership roles and this will remain a priority.
- **Promote public health approaches to HIV prevention and care**
  HIV Prevention routinely works with community groups, interested individuals, legislators, etc. to pass laws supporting HIV prevention/treatment work. This will remain a priority.
- Strengthen enforcement of civil rights laws
  Defined as a function of the federal government and not in the scope of the Cooperative Agreement.

PLAN OF ACTION, GOALS AND OBJECTIVES BASED ON THE PRECEDING

While the National HIV/AIDS Strategy (NHAS) does not take into account individual jurisdictional funding levels or parse out which activities might be most appropriate for the local funding reality, this document must do so. Additionally, the Funding Opportunity Announcement (FOA) for the HIV Prevention Cooperative Agreement has very specific guidelines relative to how CDC wants to implement programs relative to their interpretation of the guidance.

The following section of this document addresses program activities that are supported by NHAS, are included in the FOA, and are possible, scalable and sustainable within the funding levels provided to Delaware to fight HIV. This leads to the following programs in Delaware, in order of priority:

1. HIV Screening Services
2. Prevention for Positives
3. Condom Distribution
4. Policy/legislative efforts
5. Planning

HIV SCREENING SERVICES

The services are funded solely through the HIV Prevention Cooperative Agreement (HPCA) are provided by several CBOs and public health clinics throughout the state. In all cases other than CBOs, the services are provided by collaboration with other programs that fund the services to a much greater extent than the HPCA. In Sexual Wellness Clinics (STD/FP), Women's Health Clinics, Federally Qualified Health Centers, Drug and Alcohol Treatment Centers and other cooperative programs, the funding for personnel, space, record keeping, etc. are provided by other funding sources: Title X, OPA, SAMHSA, STD and other federal grants. Funds from the CDC HPCA have typically funded training, kit supplies, problem solving/QA, program objective/performance management and database access for HIV CTR services.

As funds have been reduced in the CDC HPCA, most routine quality assurance, services management, kit purchase/ inventory control and almost all other functions needed to continue the service has been assumed by the primary funding agency/program staff. CDC HPCA funded prevention program staff retain training of counselors, database access and QA for CTR services, non-routine quality event assistance, counselor skills assessments and general SOP guidance.

As the funding continues to be cut through 2016, as the Affordable Care Act is implemented and as the move to encourage HIV screening throughout routine care – the HIV CTR system will have to adapt to support these transitions as much as possible. It must not be forgotten, however, that the ACA will still not reach all of those at greatest need/risk or provide them a medical home. So, dwindling HIV prevention funding must focus services most on those vulnerable populations, neighborhoods, and programs that may not see immediate benefit from ACA implementation.

HIV screening numbers that are reported directly to (are funded by in whole or in part by) the HIV Prevention Program/HPCA have remained relatively steady for nearly a decade – sometime ranging by +-1,000 tests year to year, despite significant investment in statewide cable TV advertising/Social marketing. In recent years, despite this relative steady testing rates, the majority of new positives have been reported from private medical providers – and 50%+ of those newly diagnosed for HIV still are AIDS defined within 24 months. This is not necessarily bad news or indication that the programs are not working. In fact the opposite might be true.

The success of specialized screening programs at reaching their high-risk populations with screening services, diagnosing HIV infection, and connecting the clients to care may have accounted for the majority of the decline in cases since 2001, leaving the private sector to assume a larger portion of reported new cases by default. It is not possible to know, unequivocally, what has led to the current situation. However, it would be remiss of the program to not capitalize on it and boost the transition to routine medical testing while maintaining services to the most-at-risk without medical homes.

It is also necessary, due to predicted continuing funding cuts, to find ways to save funds while accomplishing this.

HIV TESTING IN NON MEDICAL SETTINGS

GOAL 1: Maintain current levels of HIV screening among highest-need populations throughout 2016 (goal: 3,000 tests)

Objective	Rationale/Strategy	Responsible	Potential Partners	Date	Progress
Continue to collaborate with Community-Based Organizations under contract with DPH on HIV Counseling and Testing protocols and data submission. Maintain 2015 testing goals for each agency	Funding for HIV Prevention services has decreased 52% over the last five years. Testing goals will remain at current levels	DPH	AIDS Delaware Camp Rehoboth Beautiful Gate Outreach Center	By December 31, 2016	Contracts and testing goals are in place for 2015. Renegotiate contracts in late 2015 for next calendar year
Collaborate with the Bureau of Health Equity and the Ryan White program on HIV testing in the City of Wilmington	The city has the highest prevalence and incidence of HIV in the State and the majority of its population is racial minorities. Delaware's HIV Prevention Program (HPP) will partner with the Bureau of Health Equity and the Ryan White Program to address the high prevalence of HIV/AIDS in the City of Wilmington.	DPH	Bureau of Health Equity Ryan White program	By December 31, 2016	The Bureau of Health Equity submitted a grant application on 5/20/2015. Within the application, funding will be allocated to contract with two agencies to offer HIV testing. HIV Prevention is prepared to offer HIV CTR training, technical assistance, and quality assurance to the CBOs and capture testing data in Evaluation Web. The Ryan White program is also seeking approval from HRSA to fund one agency to offer HIV testing in Wilmington. The HIV Prevention program will assist as stated above. Data will be captured in Evaluation Web.

GOAL 2: Assist CBOs with targeted testing methodologies and adherence to CDC's mandated 1% positivity rate

Objective	Rationale/Strategy	Responsible	Potential Partners	Date	Progress
Request Capacity Building Assistance (CBA) for those CBOs that fail to reach 1% positivity goals for 2015	Achieving a 1% positivity rate can be challenging for our CBOs. Requesting technical assistance from CDC is highly recommended if an agency is struggling to reach this goal	DPH	AIDS Delaware Beautiful Gate Outreach Center Camp Rehoboth	By December 31, 2016	Will request CBA through CDC's CRIS system if warranted in early 2016
Analyze HIV targeted testing data in Evaluation Web	Evaluation Web captures risk information for all clients being tested. This data needs to be evaluated to ensure CBOs are targeting the appropriate clients	DPH	AIDS Delaware Beautiful Gate Outreach Center Camp Rehoboth	By December 31, 2016	Data analysis will start in the fall of 2015 and extend into 2016

HIV TESTING IN MEDICAL SETTINGS

Goal 3: Maintain current levels of HIV screening among contracted providers of CTR services for DPH, Title X, School Based Health Centers, or any of DPH's other service partners under contract or MOU throughout 2016 (goal: 6,000 tests)

Objective	Rationale/Strategy	Method	Responsible	Potential Partners	Date	Progress
Align kit funding with agencies who identify HIV+ clients	HIV Prevention allocates roughly 10% of its funding for HIV testing kits. Kits are provided to various medical agencies for HIV testing and referral. Kits should be provided to those agencies that identify HIV+ clients	Give priority to those testing agencies that consistently identify HIV+ clients	DPH	DPH Title X	By December 31, 2016	In June 2015, the program no longer provides HIV kits to the Univ. of DE. That program has never identified a HIV+ client in 5 years
Implement testing of Delaware's migrant seasonal workers	DPH does not contract with any agencies to specifically target Delaware's migrant farm worker population	Establish a MOU with Westside Health in Dover	DPH	Westside Health	By December 31, 2016	A MOU will be established between DPH and Westside Health to offer HIV rapid testing to the migrant seasonal workers within 25 camps throughout Kent and Sussex Counties

Implement targeted testing in Western Sussex County	HIV testing is available at the State Service Center in Seaford however DPH feels that there is a need for a more targeted approach towards HIV testing in Western Sussex County to include the areas of 19933, 19973 and 19956	Partner CTR services with a DPH service provider under contract or MOU to provide targeted HIV testing in Western Sussex County	DPH	To be announced	By December 31, 2016	Negotiate CTR partner in late 2015 for next calendar year
Collect HIV testing data from agency performing outreach utilizing a mobile van sponsored by SAMHSA	SAMHSA is currently contracting with Brandywine Counseling to medically screen individuals for HIV and other STDs using a mobile van. Brandywine has agreed to enter testing data in Evaluation Web	Collaborate with Brandywine Counseling on HIV data submission	DPH	Brandywine Counseling --Impact Pgm --Cope Pgm --Wish Pgm --Reach Pgm	By December 31, 2016	Agreements are in place and Brandywine employees will be trained by November 2015

GOAL 4: Increase the proportion of HIV diagnosed gay and bisexual men, African Americans and Latinos with undetectable viral load by 5%

Objective	Rationale/Strategy	Responsible	Potential Partners	Date	Progress
Gather the viral load of Delaware's African American and Latino MSMs who are accessing care in DE	Assess those who are virally suppressed by race and transmission mode to gather a baseline	DPH	HIV Surveillance and the Ryan White Program	12/31/2016	Collaborated with HIV Surveillance on the creation of a treatment cascade. Establish a baseline of viral suppression

Increase engagement in continuous HIV care and medical compliance with HIV+ AA and Latino patients	Studies show that those retained in care have the greatest chance of viral suppression. Key to this goal will be the continued funding of the "Lost to Care" project. See specific program below	DPH	HIV Surveillance, Ryan White, Christiana Care and Private doctors' offices	12/31/2016	Collaborate with the Medical Monitoring Project personnel. During client interviews, educate patients on the benefits of viral suppression. Also, collaborate with AIDS Delaware and the "Lost to Care" project

PREVENTION FOR POSITIVES AND HIGH RISK NEGATIVES

The Program maintains small scale Comprehensive Risk Counseling Services (CRCS) for HIV positives and negatives that are at high-risk for passing or obtaining HIV. CRCS is concentrated in Wilmington and clients are enrolled via treatment provider assessment and referral. The service is highly successful in reducing risk behaviors for those that enroll. A similar, but shorter duration service is provided in Rehoboth Beach. It is a variation of the Mpowerment model of sexual wellness counseling (SWC). Again, for those that enroll, the service is very effective.

These are the only two programs able to reach those most likely to pass or obtain HIV with meaningful counseling and it has proven efficacy in reducing risks. For these reasons and as CRCS and SWC remain a small investment (relative to the program total), total return on investment is likely to be relatively high. We will continue these two critical programs in 2016.

P4P services include Partner Notification (PN) Services provided by DE DPH STD program. PN is part of Delaware state code and DPH regulation, policy and procedure. It is not funded in any way by HIV Prevention funds – with the exception of process and outcome evaluation services provided by DPH HIV Prevention administration. The HIV Prevention evaluator tracks every new HIV+ case reported from any source (private lab, hospital, PCP, surveillance, etc.) to assure successful referral to care and provision/disposition of PN cases. The system has a very high efficacy, is run economically, and of all screening strategies produces the highest yield of HIV+/screenings. There is no plan to change this system, given current funding resources.

CRCS and SWC

Goal 5: Maintain the number of clients enrolled in CRCS and SWC by December 31, 2016 (Baseline: CRCS 60 clients; SWC 50 clients)

Objective	Rationale	Method	Responsible	Potential Partners	Date	Progress
Continue CRCS and SWC intervention at current levels	These services has reduced the risk for transmission among those completing the interventions.	Contract with Service Providers	DPH	AIDS Delaware	12/31/2016	A contract for these services is currently in place. CRCS and SWC services are included in the 2015 RFP.

LOST TO CARE

In 2014, the Prevention Office fully implemented a pilot program to locate HIV+ clients considered "lost to care." This program uses a contracted database provider typically used by creditors to locate debtors. Successes in 2014: A total of 862 HIV+ clients were initially included as "lost to care." That is 25% of Delaware's total living cases. Through the lost to care program, we discovered that 450 clients (52%) left our state. HIV Surveillance further confirmed this fact by contacting the applicable state health departments. Twenty-nine clients were deceased and there was no information on 37. Of the 346 clients believed to be residing in Delaware, 37 re-engaged themselves into care after telephone contact was made. Three were reconnected to care after a counseling session with the staff at AIDS Delaware, one of our contractors. This highly successful program was continued in 2015.

In 2016, we will be focusing our efforts to reconnect additional clients to care.

GOAL 6: Reduce number of HIV+ 'lost-to-care' statewide by 50% by December 31, 2016, (Baseline: statewide number of Lost-to-Care: 810)

GOAL 7: Reduce number of HIV+ 'lost-to-care' in Kent and Sussex Counties by 25% by December 31, 2016 (Baseline 245 clients).

GOAL 8: Reconnect 8 clients to care by December 31, 2016 (Baseline: 3 clients in 2014).

Objective	Rationale/Strategy	Method	Responsible	Potential Partners	Date	Progress
Continue with the pilot program to use subscription electronic databases and social media to locate lost to care clients	• Enrollment in care improves health and longevity of most HIV+ • Enrollment in TX reduces risk behaviors. • Achievement of viral suppression greatly reduces likelihood of transmitting HIV even when safer practices fail.	Contract provider will use online, subscription location services to find LTC and initiate contact to reconnect to care or document reasons why that is not possible.	DPH	AIDS Delaware	12/31/2016	AIDS Delaware will be provided with a lost to care list of clients residing in all three counties by November 2015
Determine if approach is successful and scalable statewide.	See above	Monthly contracting reports and standard evaluation methods, as possible. TBD	DPH	AIDS Delaware	12/31/2016	Pending
Evaluate outcomes of re-enrollment of clients in Tx services relative to retention, viral suppression, etc.	Evaluation of services is vital to maintenance of positive aspect and improvements of negative aspects of the services, revision of SOPs, CQI…	TBD. Evaluation SOP to be developed.	DPH	TDB	12/31/2016	Pending

CONDOM (risk reduction resources) DISTRIBUTION

One of the focuses of the NHAS and current prevention activities is a return to ensuring easy access to risk reduction supplies and information: condoms, lubricants, and other materials useful for assisting successful condom use and/or increasing likelihood and consistency of condom use. In order to ensure ease of access for those most at risk for passing or attaining HIV, Delaware has designed a program of automatic, home delivery of condoms and other supplies. The system will allow for easy sign-up, periodic assessment of client satisfaction and sexual behaviors, and selection from a greater variety of items that include those meant to enhance the experience of using condoms- not just reduce the risk of disease. The excessive and often exclusive focus of prevention programs on 'avoiding the negative consequences of sex' has ultimately associated the negative feelings relative to disease to condom use. It is hoped that an effort to focus on the pleasurable benefits of proper protection, lubrication and other enhancing aides will help reconnect a more positive set of feeling to condom use and safer practices in general.

The program will be implemented first among known HIV+ clients in treatment, then expand to partners of PLWHA, then expand to high-risk negatives enrolled in CRCS/Sexual Wellness Counseling, then (funding permitting) to the general public. Materials will be mailed bi-monthly to clients enrolled in discrete packaging also containing information about how to use the items in the package, where to get more information and/or screening, counseling, or treatment. To our knowledge, no other jurisdiction has implemented a program like this.

GOAL 9: Distribute 250,000 condoms to CBOs, State Service Centers and other collaborative agencies across Delaware in 2016

GOAL 10: Enroll at least 75 new HIV+ clients into the mail order condom distribution service by 12/31/2016

Objective	Rationale	Method	Responsible	Potential Partners	Date	Progress
Distribute condoms to organizations throughout Delaware	Condom use significantly reduces the spread of HIV nationwide	Free condoms will be distributed throughout DPH's clinic system and through the contracted provider network of CBOs and collaborating agencies at their sites. DPH provides additional condoms for churches, student organizations and other community partners with a focus on those especially in high-prevalence areas. Contractors use evaluation web to track condom distribution.	DPH	DPH Title X agencies DSAMH	12/31/2016	Each June, HIV Prevention staff place orders for condoms to be distributed

Continue with the mail order condom distribution program	This program is designed to help curb HIV infection and is intended for: 1) those who are HIV positive 2) sexual partners of those who are HIV positive 3) those who are at higher risk of contracting HIV (including IV drug users and people with multiple sex partners who currently do not use condoms).	Individuals will enroll through a link on the HIV Consortium's Website. After a short survey, enrollees will receive a supply of condoms and lubricants every other month	DPH	HIV Consortium	12/31/2016	Evaluate data in October 2015 and create new contract

POLICY/LEGISLATIVE EFFORTS

Objective	Rationale	Method	Responsible	Potential Partners	Date	Progress
Increase awareness of pre-exposure prophylaxis (PrEP), including who they are appropriate for, among the provider populations	When used consistently, PrEP has been shown to greatly reduce the risk of HIV infection in people who are at substantial risk	Contract with a HIV educational organization to inform providers on the benefits of PrEP	DPH	HIV Consortium Christina Care Health System	12/31/2016	In July, 2015, requested technical assistance from San Francisco's PrEP team

PLANNING

The Delaware HIV Consortium was recently awarded a contract from DPH to re-establish the HIV community planning process in our state. The revision was needed to maximize return while minimizing the burden on members and partners of the HIV Planning Group (HPG). The re-organization was prompted by the new requirements issued by CDC, funding limitations, and a technical assistance visit from HRSA in 2014.

On June 2, 2015, the HIV Planning Group (HPG) met for the first time in six months. The HPG goals are to create a robust conversation to assess Delaware's HIV care continuum, and to make recommendations as a group to help end the spread of the disease. In addition, the group wants to reach, educate and engage with members of our community that haven't previously interacted with our planning body. The group will meet six times annually and participates in subcommittee meetings, as needed, to address issues specific to stakeholders in Delaware.

As the characteristics of the epidemic in Delaware has been stable for well over a decade (relative to populations affected, etc.), Delaware will retain the 5-year planning cycle, with annual updates.

GOAL 11: Produce new 5-year Plan for 2017-2021 by August 1, 2016.

GOAL 12: Formally document the new CPG process by March 1, 2016 for inclusion in the new 5-year Plan (2017-2021).

GOAL 13: Produce and get concurrence on new HIV Prevention Jurisdictional Plan by July 1, 2016

Objective	Rationale	Method	Responsible	Potential Partners	Date	Progress
Review and update one chapter per month in the existing Plan	There are 6 chapters and this allows sufficient time for repeated review and revision.	Identify key players with expertise needed for each chapter and host in-person and/or teleconferences to facilitate update and revision of each chapter.	DPH	DPH DHC CBOs CPG	To be completed by 5/1/ 2016.	
New 5-Year Plan assembled into final form and checked for congruency, accuracy and edited into final form.	Self-explanatory	DPH administration will assemble and submit to small review editing group formed as a sub group of the CPG.	DPH	DPH DHC	To be completed by 6/1/ 2016	
New 5-year Plan submitted to CPG for review	To fully inform and provide up-to-date context for review of the Jurisdictional Plan for 2016-2020	Send out via email/web link prior to CPG meeting and review at following meeting.	DPH DHC	DPH DHC CPG	To be completed by 7/1/ 2016	
Develop draft Jurisdictional Plan 2016	To allow for a month for review and comment	Send out via email/web link prior to CPG meeting and review at following meeting	DPH	DPH DHC CPG	To be completed by 6/1 /2016	

Present 2017-2021 Jurisdiction Plan to CPG for concurrence	CDC grant requirement	Present at regular meeting one month after release of the draft.	DPH	DPH DHC CPG	To be completed by 8/1/ 2016	