2012-2015 State of Georgia Statewide Comprehensive HIV Services Plan

Georgia Department of Public Health
Division of Health Protection
HIV Office
Ryan White Part B

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Appendices

OFFICE OF THE COUNTY MANAGER
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RYAN WHITE PROGRAM

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June 5, 2012

RADM Deborah Parham Hopson, Ph.D., R.N., FAAN
Associate Administrator
HIV/AIDS Health Resources and Services Administration
U.S. Department of Health and Human Services
HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Hopson:

As a participant and contributor to the State of Georgia's 2012- 2015 Statewide Comprehensive Plan, the Atlanta EMA Ryan White Part A Program submits this letter of concurrence in support of the goals, objectives, and strategies of the Plan which will guide the development and monitoring of the state's HIV/AIDS system of care. The Plan includes discussions surrounding the local and national goals of HIV/AIDS healthcare, such as improving access to HIV-related core services, improving the quality of HIV core services and health outcomes, increasing linkage to care for individuals newly diagnosed with HIV infection, reducing health disparities, and enhancing collaboration and communication with partners statewide. All goals were established with emphasis given to the edicts of the National HIV/AIDS Strategy and the potential impact of the Affordable Care Act.

The Atlanta EMA is pleased to have been a part of the network that provided input to ensure that the needs of persons living with individuals with HIV/AIDS in the Atlanta EMA were considered in this regional and statewide process.

Sincerely,

Kandace F. Carty

Kandace F. Carty
Director
Ryan White Program

Grady Health System

Infectious Disease Program
341 Ponce De Leon Avenue
Atlanta, GA 30308
404-616-6230

June 4, 2012

RADM Deborah Parham Hopson, Ph.D., R.N., FAAN
Associate Administrator for HIV/AIDS
Health Resources and Services Administration
Us Department of Health and Human Services HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Parham Hopson:

On behalf of the Atlanta Family Circle Ryan White Part D Program, I am pleased to confirm: concurrence with the State of Georgia's 2012-2015 HIV/AIDS Comprehensive Plan to the Health Resources and Services Administration (HRSA). I believe that the document addresses the patient care and planning needs for priority populations that are being supported through the funding commitments of the Georgia Department of Human Resources as well as other Ryan White program funding sources, including Part D.

I worked with our cross-part planning group in preparing for the May 2 and 3 SCSN meeting and, during that meeting, Atlanta Family Circle Ryan White Part D project staff, sub-recipients and consumers were well-represented and provided the state with substantial feedback on the development of the plan. The meeting format provided a number of opportunities for providing input, including small breakout groups. We reached consensus that the priorities and strategies proposed in the plan reflect the priorities of clients served by the Atlanta Family Circle Ryan White Part D Program and we appreciate the excellent cooperative working relationship we have in Georgia across all parts of Ryan White programs.

Sincerely,

Jacqueline Mother
Interim Administrative Director;
HIV Policy, Contracts and Resource Manager;
Atlanta Family Circle Ryan White Part D Program Director
Grady Health System Infectious Disease Program

EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Southeast AIDS Training and Education Center
Department of Family and Preventive Medicine

June 4, 2012

RADM Deborah Parham Hopson, Ph.D., R.N., FAAN
Associate Administrator for HIV/AIDS
Health Resources and Services Administration
U.S. Department of Health and Human Services
HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Parham Hopson:

On behalf of the Southeast AIDS Training and Education Center (SEATEC), we are confirming our concurrence with the State of Georgia's 2012-2015 Statewide Comprehensive Plan to the Health Resources and Services Administration (HRSA) for the HIV/AIDS funds under Section 2617 (b) (6) of the Ryan White HIV/AIDS Treatment Extension Act of 2009. We believe that the document addresses the patient care planning needs and priority populations that are being supported through the funding commitments of the Georgia Department of Public Health, as well as other Ryan White program funding sources, including Part F.

In developing the plan, Georgia has updated the process for conducting or utilizing needs assessments, in concurrence with the legislative requirements. SEATEC contributed to the development of the 2012-2015 statewide comprehensive plan and reached consensus that the strategies and priorities proposed in the statewide comprehensive plan reflected the priorities of SEATEC. During the meeting held on May 2-3, 2012, SEATEC project staff provided the state with substantial feedback on the development of the 2012-2015 statewide comprehensive plan.

Sincerely,

Laura Donnelly

Laura Donnelly, MPH
Deputy Director
Southeast AIDS Training and Education Center

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Principal funding from the HIV/AIDS Bureau, Health Resources and Services Administration (DHHS).

Brenda Fitzgerald, M.D., Commissioner Nathan Deal, Governor

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June 5, 2012

RADM Deborah Parham Hopson, Ph.D., R.N., FAAN
Associate Administrator for HIV/AIDS
Health Resources and Services Administration
U.S. Department of Health and Human Services
HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Parham Hopson:

On behalf of the HIV Prevention Program, we are confirming our concurrence with the State of Georgia's 2012-2015 Statewide Comprehensive Plan to the Health Resources and Services Administration (HRSA) for the HIV/AIDS funds under Section 2617 (b) (6) of the Ryan White HIV/AIDS Treatment Extension Act of 2009. We believe that the document addresses the patient care planning needs and priority populations that are being supported through the funding commitments of the Georgia Department of Public Health.

In developing the plan, Georgia has updated the process for conducting or utilizing needs assessments, in concurrence with the legislative requirements. Key staff from Prevention contributed to the development of the 2012-2015 statewide comprehensive plan and reached consensus that the strategies and priorities proposed in the statewide comprehensive plan reflected the priorities expressed by Georgia's HIV Prevention Program. During the meeting held on May 2-3, 2012, HIV Prevention program staff provided the state with substantial feedback on the development of the 2012-2015 statewide comprehensive plan.

Sincerely,

Brandi L. Williams
HIV Prevention Program Manager

Contributors

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Introduction

Comprehensive HIV/AIDS services' planning is a central focus of the Ryan White HIV/AIDS Treatment Modernization legislation and an essential component of the Ryan White programs. Comprehensive planning is necessary to achieve the goals of the Ryan White HIV/AIDS Treatment Modernization: to develop, organize, coordinate, and implement more effective and cost-efficient systems of essential services to individuals and families with HIV disease.

Comprehensive planning guides decisions about services for people living with HIV disease and AIDS. Planning activities undertaken by the Georgia Department of Public Health Ryan White Part B state and local programs, the Metropolitan Atlanta Part A Planning Council, and Ryan White Part C, D and F programs across the state assist the decision-making process in the development and maintenance of a system of care and support for persons living with HIV and AIDS (PLWHA) in Georgia. This is especially important in light of the changing and increasingly complex health care environment.

The comprehensive HIV services planning process undertaken in Georgia required Ryan White providers, other HIV/AIDS providers, other public agency representatives, and PLWHA to ask four questions related to the state's HIV health service delivery system and to engage in a planning process that resulted in this written Comprehensive HIV Health Services Plan. The four questions addressed in the Plan are:

- ► Where are we now?
- ► Where do we need to go?
- ► How will we get there?
- ► How will we monitor our progress?

Executive Summary

According to the 2010 federal census population, Georgia ranked ninth among states in population size, with a total population of 9,687,653. Females comprise 51% of the population while males are 49% of the population. Among Georgians reporting one race, 60% were white, 31% were African American and 9% were Hispanic. About one-half of the population, 52% of the state's African American population, 66% of the Hispanic population 29% of the poor, live in the 20-county Atlanta Eligible Metropolitan Area (EMA). The other half of the state's population is widely dispersed among the remaining 139 counties which has historically presented challenges in healthcare resources and service.

Since the earliest days of the HIV/AIDS epidemic, Georgia has had a substantial number of reported cases of AIDS. Georgia ranked sixth highest in the nation for its reported rate of AIDS cases per 100,000 population in 2009. The HIV/AIDS epidemic continues to grow in Georgia. As of December 2010, there were 23,451 PLWA and 18,535 PLWH (non-AIDS). Seventy-two (72) percent of HIV (non-AIDS) cases were among African Americans, 22% among Whites, 4% among Hispanics and 2% among others.

The Georgia Department of Public Health (DPH), Division of Health Protection (DHP), Infectious Disease and Immunization (IDI) Program, HIV Office provides oversight and management of the state's HIV Care Grant Program Part B which serves 16 of the state's 18 public health districts. In addition, the Part B ADAP program covers all 18 districts and Part B provides funding to some HIV providers in the Part A service area. Ryan White Part A serves the 20-county metro Atlanta area, located in the remaining two districts.

The comprehensive HIV services planning process undertaken in Georgia required the State HIV Office to ask four questions related to the state's HIV/AIDS service delivery system and to engage in a planning process that resulted in this written Comprehensive HIV Health Services Plan. The four questions addressed in the Plan are:

- ► Where are we now?
- ► Where do we need to go?
- ► How will we get there?
- ► How will we monitor our progress?

Georgia's FY 2012-2015 Comprehensive HIV Health Services Plan provides the goals, objectives, and strategies that will be used to guide further development and monitoring of the state's HIV/AIDS health care delivery system. Identified needs and barriers have been incorporated into the plan goals and objectives. The plan includes five major goals:

Goal 1: Improve access to HIV-related core services.

1.1. Ensure continuity and availability of HIV primary care consistent with Public Health Services guidelines.
1.2. Evaluate and respond to the changing healthcare environment to assure HIV health and support services are available and accessible.
1.3. Assure health districts are aware of changes in the health and support service access and availability to help clients navigate the system of care.
1.4. Assure consumers are consistently informed about changes in health and support service access and availability, as well as aware of available supports/resources to respond to their changing needs.
1.5. Assess barriers to accessing core and support services to identify potential solutions and best practices.
1.6. Assess and enhance access to HIV medications.

Goal 2: Improve the quality of HIV core services and health outcomes.

2.1. Assure standards of care, including Public Health Services (PHS) guidelines and best practices, are consistently applied in the provision of HIV services.
2.2. Improve HIV/AIDS case management services throughout Georgia.
2.3. Implement statewide Ryan White Part B quality management plan.
2.4. Improve recruitment and retention of health care staff.
2.5. Adapt the Georgia Department of Public Health, HIV Office, practices and guidelines as needed to align with the National HIV/AIDS Strategy, Healthy People 2020, the HIV/AIDS Bureau (HAB) Measures, and other state and federal initiatives focused on reducing health disparities.

Goal 3: Increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment.

3.1. Identify individuals unaware of their status.
3.2. Collaborate with counseling and testing and prevention programs to facilitate identification of individuals unaware of their status and link them to care.
3.3. In collaboration with the HIV Prevention program in the Georgia Department of Public Health and federal Department of Health and Human Services (DHHS) directly funded entities (e.g., health departments, community based organizations) develop and implement strategies to facilitate integration of care, treatment and prevention.

Goal 4: Reduce health disparities.

4.1. Identify health disparities and barriers to care.
4.2. Improve cultural competency of service providers and programs.
4.3. Improve the utilization of interpretation and translation services for clients.
4.4. Maximize opportunities for clients to access affordable, stable and safe housing.
4.5. Advocate for policy change.

Goal 5: Enhance collaboration and communication with partners statewide

5.1. Engage key stakeholders, including but not limited to Program Collaboration Service Integration (PCSI), HIV Office, Prevention Section grantees, Early Identification of Individuals with HIV/AIDS (EIIHA), Substance Abuse and Mental Health Services Administration (SAMHSA), Community Planning Group (CPG), the AIDS Drug Assistance Program (ADAP), ADAP Contract Pharmacy Network (ACP), Health Insurance Continuation Program (HICP), Preexisting Condition Insurance Plan (PCIP), Test-Link-Care Network, private providers, all Ryan White Parts, and Medicaid.

Ongoing monitoring, input, and adjustment are critical in continuing to ensure that available HIV/AIDS resources in Georgia are maximized and the use of these resources are prioritized when changes to the system are needed. Comprehensive Plan progress will be evaluated, and modifications made as needed, based on measures indicated in the plan, the development and implementation of detailed annual plans and regular progress reports.

Acronyms

AAOI	African American Outreach Initiative
ACA	Affordable Care Act
ACP	ADAP Contract Pharmacy
ADAP	AIDS Drug Assistance Program
ARTAS	Antiretroviral Treatment Access Study
ARV	Antiretroviral
ASO	AIDS Service Organization
BHDD	Behavioral Health and Developmental Disabilities
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CMS	Center for Medicare and Medicaid Services
CM	Case Manager/Case Management
CPG	Community Planning Group
CY	Calendar Year
DPH	Department of Public Health
ECHPP	Enhanced Comprehensive HIV Prevention Planning
eHARS	Electronic HIV/AIDS Reporting System
EIIHA	Early Identification of Individuals with HIV/AIDS
EIW	Early Identification Workgroup
EMA	Eligible Metropolitan Area
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
GIA	Grant-In-Aid
HAB	HIV/AIDS Bureau
HHS	Department of Health and Human Services
HICP	Health Insurance Continuation Program
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Resources and Services Administration
IDI	Infectious Disease and Immunization Program
IDP	Infectious Disease Program
IDU	Intravenous Drug Use
ISP	Individualized Service Plan
LGBT	Lesbian, Gay, Bisexual, Transgender
MSA	Metropolitan Statistical Area
MSM	Men Who Have Sex With Men
NHAS	National HIV/AIDS Strategy
NIR	No Identified Risk
OB/GYN	Obstetrics/Gynecology
PAP	Patient Assistance Program
PBM	Pharmacy Benefit Manager
PCIP	Preexisting Condition Insurance Plan
PCSI	Program Collaboration Service Integration
PHS	Public Health Services
PLWHA	People Living with HIV/AIDS
PS	Partner Services
QM	Quality Management
RFP	Request for Proposal
RN	Registered Nurse

RSR	Ryan White Services Report
RW	Ryan White
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Child Health Insurance Program
SCSN	Statewide Coordinated Statement of Need
SEATEC	Southeast AIDS Training and Education Center
SEHD	Southeast Health District
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
WICY	Women, Infants, Children, and Youth

Section I. Where are we now?

A. Description of Georgia – Local HIV/AIDS Epidemic

According to the 2010 federal census population, Georgia ranked ninth among states in population size, with a total population of 9,687,653. Females comprise 51% of the population while males are 49% of the population. Among Georgians reporting one race, 60% were white, 31% were African American and 9% were Hispanic. About one-half of the population, 52% of the state's African American population, 66% of the Hispanic population 29% of the poor, live in the 20-county Atlanta Eligible Metropolitan Area (EMA). The other half of the state's population is widely dispersed among the remaining 139 counties which has historically presented challenges in healthcare resources and service.

1. CY 2010 Epidemiological Profile

From 1981 to the end of 2009, the cumulative number of reported cases of AIDS in the United States (50 states and DC) was 1,142,714 (statistics for 2010 are not yet available from Centers for Disease Control and Prevention). This number reflected a case rate of 11.2 cases of AIDS/100,000 total population of the US. A total of 490,696(43%) were reported as living through 2009.[1]

Since the earliest days of the HIV/AIDS epidemic, Georgia has had a substantial number of reported cases of AIDS. Georgia ranked sixth highest in the nation for its reported rate of AIDS cases per 100,000 population in 2009. The HIV/AIDS epidemic continues to grow in Georgia. As of December 2010, there were 23,451 PLWA and 18,535 PLWH (non-AIDS). Seventy-two (72) percent of HIV (non-AIDS) cases were among African Americans, 22% among Whites, 4% among Hispanics and 2% among others.

Georgia's 2009-2010 AIDS Diagnoses, AIDS Prevalence, and HIV (not AIDS) Prevalence data by demographic group and exposure category is provided below followed by information on trends in Georgia's HIV prevalence for January 2009-December 2010.

[1]CDC. HIV/AIDS Surveillance Report Aug 11, 2011.

AIDS Diagnoses, AIDS Prevalence, and HIV Prevalence by Demographic Group and Exposure Category, Georgia, 2009-2010

	AIDS Diagnoses* 1/1/2009 - 12/31/10		AIDS Prevalence† 12/31/2010		HIV (not AIDS) Prevalence† 12/31/2010	
Race/Ethnicity	n	%	n	%	n	%
White, Non-Hispanic	247	15.2	5676	24.2	4143	22.4
Black, Non-Hispanic	1246	76.4	16217	69.2	13253	71.5
Hispanic	113	6.9	1110	4.7	779	4.2
Asian/Pacific Islander	11	0.7	78	0.3	82	0.4
American Indian/Alaska Native	1	0.1	26	0.1	28	0.2
Other/Multi-race/Unknown	12	0.7	344	1.5	250	1.4
Total	1630	100	23451	100	18535	100
Gender						
Male	1245	76.4	18007	76.8	13138	70.9
Female	385	23.6	5444	23.2	5397	29.1
Total	1630	100	23451	100	18535	100
Age‡						
0 - 15 years	0	0	155	0.7	309	1.7
15 - 24 years	161	9.9	1658	7.1	3757	20.3
25 - 34 years	416	25.5	7780	33.1	5924	32.1
35 - 44 years	509	31.2	8748	37.3	5108	27.6
45 - 54 years	394	24.2	3927	16.8	2567	13.9
55 - 64 years	125	7.7	989	4.2	678	3.7
65+ years	25	1.5	194	0.8	162	0.9
Total	1630	100	23451	100	18535	100
Transmission Categoryж						
Men who have sex with men (MSM)	572	35.1	9845	41.9	6713	36.2
Injection Drug Use (IDU)	37	2.3	2269	9.7	803	4.3
MSM and IDU	31	1.9	1117	4.8	441	2.4
High-Risk Heterosexual Contact¥	129	7.9	3192	13.6	1660	8.9
Other**	2	0.1	249	1.1	217	1.2
Risk not reported or identified††	859	52.7	6779	28.9	8701	46.9
Total	1630	100	23451	100	18535	100

Note: Source: Georgia Division of Public Health HIV/AIDS Reporting System (eHARS). Note: Numbers are based on cases entered.
Note: Numbers are based on cases entered through June 30, 2011.
*The number of AIDS cases diagnosed in the specified period.
†Prevalent cases are those persons living with AIDS or HIV and are based on current residence being in Georgia.
‡AIDS Diagnoses cases are based on age at diagnosis and prevalent cases are based on current age as of December 31, 2010.
ЖCases with unknown Transmission Categories are not included.
¥High risk heterosexual is defined as sexual contact with someone of the opposite sex with known risk such as injection drug use, bisexual male (applied to females only), persons with hemophilia/coagulation disorder, transfusion recipient with HIV documentation, person with AIDS or documented HIV.
††Cases with no reported exposure to HIV or AIDS through any of the routes listed above are classified as NIR (no identified risk) and those with no risk at all as NRR (no risk reported).

AIDS Diagnoses, AIDS Prevalence, and HIV Prevalence for Females by Demographic Group and Exposure Category, Georgia, 2009-2010

Females	AIDS Diagnoses* 1/1/2009 - 12/31/10		AIDS Prevalence† 12/31/2010		HIV (not AIDS) Prevalence† 12/31/2010	
Race/Ethnicity	n	%	n	%	n	%
White, Non-Hispanic	28	7.27	632	11.61	719	13.32
Black, Non-Hispanic	334	86.75	4537	83.33	4370	80.97
Hispanic	19	4.94	191	3.51	210	3.89
Asian/Pacific Islander	1	0.26	17	0.31	22	0.41
American Indian/Alaska Native	0	0	5	0.09	9	1.67
Other/Multi-race/Unknown	3	0.78	62	1.14	67	1.24
Total	385	100	5444	100	5397	100
Age‡						
0 - 15 years	0	0	20	0.37	91	1.69
15 - 24 years	23	5.97	104	1.91	374	6.93
25 - 34 years	86	22.34	606	11.13	1188	22.01
35 - 44 years	143	37.14	1619	29.74	1543	28.58
45 - 54 years	96	24.94	1928	35.42	1486	27.53
55 - 64 years	26	6.75	888	16.31	568	10.52
65+ years	11	2.86	279	5.12	147	2.72
Total	385	100	5444	100	5397	100
Transmission Category Ж						
Men who have sex with men (MSM)	0	0	0	0	0	0
Injection Drug Use (IDU)	14	3.64	752	13.81	354	6.56
MSM and IDU	0	0	0	0	0	0
High-Risk Heterosexual Contact¥	73	18.94	1964	36.07	1184	21.94
Other**	0	0	107	1.97	123	2.28
Risk not reported or identified††	298	77.40	2621	48.14	3736	69.22
Total	385	100	5444	100	5397	100

Note: Source: Georgia Division of Public Health HIV/AIDS Reporting System (eHARS). Note: Numbers are based on cases entered.
Note: Numbers are based on cases entered through June 30, 2011.
*The number of AIDS cases diagnosed in the specified period.
†Prevalent cases are those persons living with AIDS or HIV and are based on current residence being in Georgia.
‡AIDS Diagnoses cases are based on age at diagnosis and prevalent cases are based on current age as of December 31, 2010.
ЖCases with unknown Transmission Categories are not included.

¥High risk heterosexual is defined as sexual contact with someone of the opposite sex with known risk such as injection drug use, bisexual male (applied females only), persons with hemophilia/coagulation disorder, transfusion recipient with HIV documentation, person with AIDS or **Other includes hemophilia, blood transfusion, transplant, perinatal, and pediatric.
††Cases with no reported exposure to HIV or AIDS through any of the routes listed above are classified as NIR (no identified risk) and those with no risk at all as NRR (no risk reported).

AIDS Diagnoses, AIDS Prevalence, and HIV Prevalence for Males by Demographic Group and Exposure Category, Georgia 2009-2010

Males	AIDS Diagnoses* 1/1/2009 - 12/31/10		AIDS Prevalence† 12/31/2010		HIV (not AIDS) Prevalence† 12/31/2010	
Race/Ethnicity	n	%	n	%	n	%
White, non-hispanic	219	17.59	5044	28.01	3424	26.06
Black, non-hispanic	912	73.25	11680	64.86	8883	67.61
Hispanic	94	7.55	919	5.10	569	4.33
Asian/Pacific Islander	10	0.80	61	0.34	60	0.46
American Indian/Alaska Native	1	0.08	21	0.12	19	0.14
Other/Multi-race/Unknown	9	0.72	282	1.57	183	1.39
Total	1245	100	18007	100	13138	100
Age‡						
0 - 15 years	0	0	16	0.9	89	0.7
15 - 24 years	138	11.08	289	1.6	1005	7.7
25 - 34 years	330	26.51	1673	9.3	3102	23.6
35 - 44 years	366	29.40	4711	26.2	3672	27.9
45 - 54 years	298	23.94	7325	40.7	3662	27.9
55 - 64 years	99	7.95	3148	17.5	1268	10
65+ years	14	1.12	845	4.7	340	2.6
Total	1245	100	18007	100	13138	100
Transmission CategoryЖ						
Men who have sex with men (MSM)	572	45.94	9845	54.67	6713	51.10
Injection Drug Use (IDU)	23	1.85	1517	8.42	449	3.42
MSM and IDU	31	2.49	1117	6.20	441	3.36
High-Risk Heterosexual Contact¥	56	4.50	1228	6.82	476	3.62
Other**	2	0.16	142	0.79	94	0.72
Risk not reported or identified††	561	45.06	4158	23.09	4965	37.79
Total	1245	100	18007	100	13138	100

Note: Source: Georgia Division of Public Health HIV/AIDS Reporting System (eHARS). Note: Numbers are based on cases entered.
Note: Numbers are based on cases entered through June 30, 2011.
*The number of AIDS cases diagnosed in the specified period.
†Prevalent cases are those persons living with AIDS or HIV and are based on current residence being in Georgia.
‡AIDS Diagnoses cases are based on age at diagnosis and prevalent cases are based on current age as of December 31, 2010.
ЖCases with unknown Transmission Categories are not included.
¥High risk heterosexual is defined as sexual contact with someone of the opposite sex with known risk such as injection drug use, bisexual male (applied to females only), persons with hemophilia/coagulation disorder, transfusion recipient with HIV documentation, person with AIDS or documented HIV.
††Cases with no reported exposure to HIV or AIDS through any of the routes listed above are classified as NIR (no identified risk) and those with no risk at all as NRR (no risk reported).

Trends or Changes in HIV Disease Prevalence in Georgia for the Past Two Years (January 2009-December 2010)

Indicator	2008-2009	2009-2010	Percent change	Trend
AIDS Diagnoses	1,961	1,630	17%	Decrease
AIDS Prevalence	23,194	23,451	1%	Increase
HIV Prevalence	17,512	18,535	6%	Increase

Based on data from the Georgia Department of Public Health Electronic HIV/AIDS Reporting System (eHARS), Georgia reported 1,630 newly diagnosed AIDS cases during the period of January 1, 2009-December 31, 2010. This reflects a 17% decrease from the previous two-year period of 2008-2009. Approximately 76% (1,245) of diagnosed AIDS cases were males. In Georgia, there were 23,451 persons living with AIDS and 18,535 persons living with HIV (not AIDS) at the end of 2010.

Men who have sex with men (MSM) still represent the largest number of people living with AIDS in Georgia. They account for approximately 47% (42% MSM and 5% MSM who inject drugs) of the known cases of Georgians living with AIDS as of December 31, 2010. MSM represent the largest number of people living with HIV in Georgia. Based on HIV prevalence, as of December 31, 2010, MSM accounted for 36% of the HIV cases in Georgia.

Recent trends continue to indicate that HIV/AIDS is affecting African Americans, women, heterosexuals, and people living in rural areas at growing rates. In the United States, African-American males and females, ages 18-44, are the most disproportionately affected population. Although African Americans make up only 31% of Georgia's population, 76% of the new cases of AIDS in 2009-2010 were African Americans. As of December 31, 2010, 72% of Georgians living with HIV were African Americans, according to eHARS.

The HIV/AIDS epidemic in Georgia continues to affect a significant number of women. From 1984 to 2010, the cumulative proportion of AIDS cases among women increased from 4% to 23%. African American women are disproportionately affected. As of December 31, 2010, 83% of women living with AIDS in Georgia were African American, and 81% of women living with HIV (not AIDS) in Georgia were African American, according to eHARS data. Heterosexual contact remains the primary mode of transmission in women. Many women were sex partners of men who have used drugs or of MSM. Twenty-three percent (5,444) of the individuals living with AIDS and 29% (5,397) of the cases of HIV in Georgia at the end of 2010 were female.

According to eHARS data, Hispanics accounted for 5% of Georgians living with AIDS and 4% of the HIV cases reported as of December 31, 2010. There were more Hispanic males (919) than females (191) diagnosed with AIDS during the two-year reporting period. Hispanic males represented 8% of newly diagnosed AIDS cases in Georgia and 4% of the population living with

HIV (not AIDS) as of December 31, 2010. Hispanic females accounted for 5% of newly reported AIDS cases and 4% of reported cases of persons living with AIDS.

The epidemic is increasing in Georgia's rural areas and small cities and towns. In 2009, data indicated 33% of people living with HIV/AIDS were living outside the 20-county Atlanta Metropolitan Statistical Area (MSA). In rural areas of the state, resources are scarce. People and services are more dispersed and therefore harder to reach with treatment and prevention efforts. Geographic regions outside of the Atlanta MSA with a high HIV/AIDS morbidity include the East Central and West Central regions of the state.

2. Unmet need estimate for 2010 and Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware estimate

Using data from the HIV/AIDS reporting system (eHARS), the statewide laboratory database and the Georgia Department of Public Health, HIV Epidemiology Unit, it has been estimated that 55% (table below) of PLWHA in Georgia had not received primary health care services during 2010.

Quantified Estimate of Unmet Need for HIV Primary Care, Georgia
01/01/2010-12/31/2010

Quantified Estimate of Unmet Need for HIV Primary Care, Georgia, 2010				
Population		**Total**		**Data Source**
Row A.	Number of persons living with AIDS (PLWA) as of 12/31/2010	25,300		eHARS and Laboratory Database
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware as of 12/31/2010	19,676		C-A
Row C.	Total number of HIV+/aware as of 12/31/2010	44,976		eHARS and Laboratory Database
Care Patterns				**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period as of 12/31/2010	11,090		eHARS and Laboratory Database
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period as of 12/31/2010	9,312		F-D

Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period as of 12/31/2010	20,402		eHARS and Laboratory Database
Calculated Results		**Total**	**Percent**	**Calculations**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	14,210	56%	A-D
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	10,364	53%	B-E
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	24,574	55%	C-F

Note:

- Data sources were GA Laboratory Access Database and eHARS.
- Reported cases in eHARS were matched to reports in GA Lab Database
- All non-reported cases had documented positive Western Blot tests.
- Unmet need analyses performed on complete dataset as of December 31, 2010.
- eHARS may contain fewer cases than the actual count due to delayed case reporting by providers

The Unmet Need Estimate is updated utilizing the Georgia Laboratory Access Database and the Georgia eHARS database. The Georgia Laboratory Access Database captures lab reports such as CD4, viral load, and western blot (WB) while the eHARS database captures these same lab reports along with associated demographic information from HIV Case Report Forms. The eHARS database tracks over 200 indicators related to HIV/AIDS in Georgia. However, the eHARS laboratory data is not as comprehensive as the data from the Georgia Laboratory Access Database. For this reason, the reported cases in eHARS were matched to reports in the Georgia Laboratory Access Database to ensure data reliability.

The populations in the Unmet Need Estimate include Persons Living with AIDS (PLWA), Persons Living with HIV/non-AIDS (PLWH non-AIDS/aware), and PLWA In Care. These populations are defined as follows:

- Persons Living with AIDS (PLWA): the number of persons living with AIDS and reported in eHARS and/or GA Laboratory Access Database in the surveillance period of interest. It is presumed that all people living with AIDS are aware of their status.

- Persons Living with HIV/non-AIDS (PLWH non-AIDS/aware): the number of persons living with HIV/non-AIDS and reported in eHARS or the GA Laboratory Access Database in the report period.

- PLWA In Care: PLWA that have had at least one viral load or CD4 laboratory test reported in the GA Laboratory Access Database for the period of interest.

- PLWH non-AIDS/aware In Care: PLWH non-AIDS/aware that have had at least one viral load or CD4 laboratory test reported in the GA Laboratory Access Database for the period of interest.

These populations are then tabulated in the Unmet Need Framework to describe population sizes, care patterns and calculated results.

In FY2012, the Part B Program plans to further assess the unmet need data through collaboration with the statewide HIV Prevention Program and the Atlanta Eligible Metropolitan Area (EMA). An area of focus in the plan includes planning, implementing, and evaluating a statewide needs assessment. The next step toward achieving a needs assessment is to identify an academic partner. Over the past five years, the state of Georgia has seen a 78% increase in the number of PLWA who received care, as well as an 11% decrease in the number of PLWH/non AIDS who did not receive are. Conversely, the data show a 6% decrease in the number of PLWH/non-AIDS who received care and a 23% increase in the number of PLWA who did not receive care.

Indicator	2005	2010	Percent change	Trend
# of PLWA who received Care	6,213	11,090	78%	Increase
# of PLWH/non-AIDS who received Care	9,945	9,312	6%	Decrease
# of PLWA who did not receive Care	11,475	14,210	23%	Increase
# of PLWH/non-AIDS who did not receive Care	11,675	10,364	11%	Decrease

The gross number of PLWA has increased from 2005-2010; both those who are receiving care and those who did not receive care. This could be related to an increase in HIV testing efforts or better case-finding, although it would reflect testing late in the disease process. The gross number of PLWH/non-AIDS has not seen such a dramatic increase, although there have been slight decreases from 2005 compared to 2010 in those who are receiving care. In summary, the state has seen a large overall increase in PLWA as opposed to PLWH/non-AIDS.

An explanation for these trends may include the present state of the economy, the rapid expansion of the HIV/AIDS epidemic among low-income and uninsured populations, limited resources, and changes in data collection. When clients have insufficient financial resources or

have competing time demands such as finding and maintaining work, the ability to maintain consistent HIV care is bound to suffer. Likewise, the populations most likely to be HIV-infected are those with the least resources and tools to manage their disease. Limited resources to care for the large number of uninsured clients led several HIV clinics to be unable to accept new patients during various parts of the year. For those clients unable to persevere, this could have led to a failure to access HIV care.

Data collection methods have changed from 2005-2010 and may reflect better HIV/AIDS case reporting and improved data sources. In 2005, the number of PLWH/non-AIDS was calculated based on the midpoint of the Centers for Disease Control and Prevention (CDC) estimate instead of the real number for Georgia. The number of PLWH/non-AIDS receiving HIV primary care during CY 2005 was calculated based on this estimate. In contrast, the 2010 calculations are based on real numbers from the enhanced HIV/AIDS Reporting System (eHARS) and the Georgia Laboratory Report Database.

3. Early Identification of Individuals with HIV/AIDS (EIIHA)

The estimated number of living HIV positive individuals who were unaware of their status as of December 31, 2009.

a) Estimated Back Calculation

- National Proportion Undiagnosed HIV = .21
- Number of individuals in Georgia diagnosed with HIV and living as of December 31, 2009 = 17,307
- State of Georgia Undiagnosed= (0.21/0.79) x 17,307 = **4,601**

The table below provides information on EIIHA-HIV testing and awareness data for Georgia. A matrix follows of populations in Georgia who are unaware of their HIV status.

EIIHA-HIV Testing & Awareness Data (December 31st 2010)

*Total number of HIV **tests conducted**.*	126,645
*Total number **informed** of their HIV status (HIV positive and HIV negative).*	90,001
*Total number **NOT informed** of their HIV status (HIV positive and HIV negative).*	36,644
*Total number of HIV **positive** tests.*	1,237
*Total number of HIV **positive informed** of their HIV status.*	1,034
*Total number of HIV **positive referred** to medical care.*	943
*Total number of HIV **positive linked** to medical care.*	409
*Total number of HIV **positive NOT informed** of their HIV status.*	203
*Total number of **negative** tests.*	125,408
*Total number of HIV **negative informed** of their HIV status.*	88,967
*Total number of HIV **negative referred** to services.*	75,245
*Total number of HIV **negative NOT informed** of their HIV status.*	36,441

P1. All Individuals in Georgia who are Unaware of their HIV Status *(HIV Positive & HIV Negative)*																
P2. Tested in the Past 12 Months				P3. Not Tested in the Past 12 Months												
P4. Individuals Not Post-Test Counseled *(HIV positive & HIV negative)*		T3. Received Preliminary Positive Results Only – No Confirmatory Test	T4. Failure to Re-Test After High Risk Behavior	P5. High Risk Individuals											T5. Moderate & Low Risk Individuals 13-64 Years of Age	
T1. Tested Confidentially	T2. Tested Anonymously			P6. IDU		P7. MSM			P8. African Americans			P9. Hispanics				
				T6. MSM	T7. Women	T8. African Americans	T9. Age 13-25	T10. Transgender	T11. MSM	T12. Women	T13. Heterosexual Men	T14. Heterosexual Men	T15. Women	T16. MSM		

B. Description of the current continuum of care

HIV Prevention

HIV Counseling, Testing, and Linkage (HIV CTL) services provide the foundation for Georgia's comprehensive HIV prevention activities. The program supports testing in healthcare and non-healthcare settings. Currently, there are 18 public health districts (HD), and their satellite programs, substance abuse programs, jails, detention centers, and university health clinics that provide HIV CTL.

The program works closely with Community Based Organizations (CBOs) to conduct Opt-out HIV testing. Special emphasis is placed on areas with high co-morbidities of STD infections, substance abuse, and teen pregnancy rates. CBOs invited to participate in HIV testing have to demonstrate their ability to implement rapid testing based on specified criteria such as: access to the identified target population, previous counseling and testing experience, and Sexually Transmitted Disease (STD) and Tuberculosis (TB) testing referral protocol.

HIV Care

Georgia's system of health care is largely dependent upon the existing public health structure of 18 health districts and 159 county health departments, with community health centers, universities, hospitals, and community organizations playing a variety of roles in different parts of the state. All levels of Ryan White funding are distributed throughout the state. These funding streams have enabled Georgia to expand the resources available to PLWHA. As resources vary in different regions of the state, so does the scope of available services. Statewide planning and involvement on different planning bodies, as well as collaboration and coordination locally and regionally have assisted in service delivery development in Georgia. The Ryan White Part B program has a service delivery system which includes a comprehensive range of core medical services and essential support services for individuals infected with and affected.

The HIV Office contracts with 16 Ryan White Part B consortia and several agencies to deliver HIV/AIDS services throughout the state. The consortia are responsible for planning and prioritizing the delivery of HIV services in their respective geographic areas. The District Health Offices administer Ryan White Part B funds and are the lead agencies in the respective consortia. All consortia provide primary care services. Support services are prioritized by the consortia, using needs assessment data, and funded based on the availability of resources. The delivery of HIV care and support services are provided either directly by Part B funded public health districts or indirectly through sub-contractual agreements with local service providers. Part B funds also fund the Georgia AIDS Drug Assistance Program (ADAP) and Health Insurance Continuation Program (HICP), which provide medications and health insurance coverage.

To receive Ryan White Part B services, a client must be a Georgia resident, HIV positive or affected, have no other payer source, and an income below 300% of the Federal Poverty Level. Georgia Part B contractors screen clients for eligibility through a financial screening process that requires the client to present verification of documents. Documentation of the client's available resources is assessed at the initial clinic visit and documented in the client's record and is reviewed every six (6) months. The Ryan White HIV/AIDS Program requires that Ryan White funds are the payor of last resort.

Public Health Districts: The Georgia Department of Public Health (DPH), Division of Health Protection (DHP), Infectious Disease and Immunization (IDI) Program, HIV Office provides oversight and management of the state's HIV Care Grant Program Part B which serves 16 of the state's 18 public health districts. In addition, the Part B ADAP programs covers all 18 districts and Part B provides funding to some HIV providers in the Part A service area. Ryan White Part A serves the 20-county metro Atlanta area, located in the remaining two districts.

The HIV Office disburses funds to 16 public health districts, through a contractual process known as Grant-in-Aid (GIA), to provide Part B services. The Part B Program Team Lead and Public Health Office of Budgets monitor and track funds and expenditures on a monthly basis. The state of Georgia does not provide services through consortia. Funding is provided directly to local health districts. Each district maintains a consortium that functions as a community and client advisory body. All 16 Part B funded public health districts receive administrative, fiscal, and programmatic monitoring via monthly desk audits and annual on-site monitoring.

ADAP: The Georgia AIDS Drug Assistance Program (ADAP) is the state administered program that provides HIV/AIDS medication to low-income individuals living with HIV disease who have little or no coverage from private or third party insurance. Georgia ADAP provides services to all eligible residents of Georgia. As a cost containment measure, Georgia ADAP only provides those medications listed on the ADAP formulary. The Georgia ADAP formulary includes all Food and Drug Administration (FDA) approved antiretroviral agents and a limited number of medications used to treat/prevent opportunistic infections related to HIV disease. Effective April 1, 2011, all three (3) phases of ADAP Contract Pharmacy (ACP) Network were implemented throughout all enrollment sites and all ADAP clients were able to receive their medications via the ACP Network.

Due to limited funding, a growing demand for ADAP services and increased enrollment, a waiting list was implemented on July 1, 2010. The duration of the waiting list is unknown. However, based on attrition rates of approximately 150 clients monthly and Emergency Relief Funding, limited enrollment of new clients from the waiting list into the ADAP is now possible. ADAP staff continues to monitor attrition of ineligible, non-compliant or those persons with other payers to determine the eligibility of current ADAP clients. Liaisons now combine the

annual Grant–In-Aid and ADAP site visits to Part B health clinics to ensure a more comprehensive and time effective means of measuring district activities. The monitoring process for other designated ADAP enrollment sites within the Eligible Metropolitan Area (EMA) and not included in Grant –In-Aid site visits are conducted by ADAP staff and/or the ADAP/HICP Manager.

ADAP Contract Pharmacy (ACP) Network: The main objective of the ACP is to provide comprehensive and convenient pharmacy services while maintaining cost saving to the AIDS Drug Assistance Program. The ACP allows ADAP clients the ability to fill monthly ADAP prescriptions at a contract pharmacy of their choice. Currently, there are 26 pharmacies in the ACP network that provide medications in convenient locations statewide with several pharmacies that offers statewide delivery. The ADAP replenishes contract pharmacies with all approved formulary medications dispensed to the ADAP clients. These medications are provided through the state pharmaceutical wholesaler Cardinal Health with the assistance of a Pharmacy Benefit Manager (PBM).

HICP: The HIV Office manages the Health Insurance Continuation Program (HICP) which pays health insurance premiums for eligible clients with health coverage. The payment of health insurance premiums has proven to be a more cost effective way to meet the needs of clients in comparison to providing expensive HIV/AIDS medications at a much higher cost. The HICP allows clients the opportunity and flexibility to continue to access their doctors, maintain a continuum of primary health care and sustain an improved quality of life.

Resource Inventory: A resource inventory describing Ryan White funded and non Ryan White funded HIV/AIDS care resources and services in Georgia are provided in Appendix 1. The Southeast AIDS Training and Education Center's (SEATEC) *Key Contacts – Metro Atlanta/Georgia Resources for HIV/AIDS* 15th edition May 2011 telephone list of helping agencies and organizations served as the baseline for the inventory. Copies of the inventory are provided at no cost to service agencies and individuals A searchable digital version of *Key Contacts* is available at http://content.yudu.com/A1ujp0/SEATECMay2011/resources/index.htm. *Key Contacts* includes an alphabetical listing by agency/organization as well as identification of resources by the following categories:

- Metro Assistance: advocacy, case management, clothing/furniture, financial/public assistance, food, funerals, housing/low income/homeless, legal, peer counseling, spiritual support, and transportation
- Metro Education Services: AIDS information lines, education resources, education courses, hotlines and general information – not HIV/AIDS, medical treatment information, prevention education and outreach, and speakers' bureaus

- Internet Resources: national AIDS service organizations, governmental agencies, access to treatment/health maintenance, medical, speakers of languages other than English, and substance abuse
- Metro Medical Services: access to treatment, clinical trials, counseling/mental health care, dental, health departments/testing/medical care, HIV test sites – other, home health care/hospice, medical care, nursing home/long term care, and wellness
- Prevention and Care Planning Councils: Georgia HIV/AIDS prevention and care planning councils
- Metro Services for Specific Populations: adolescents, alcohol and substance users, children, deaf and hard of hearing, family/friends, health care providers – HIV caregivers, Hispanic, Hispanos, inmates/parolees/probationers/ex-offenders, low literacy, people living with hemophilia, people of color, speakers of languages other than English or Spanish, tuberculosis patients and caregivers, women, and lesbian, gay, bisexual and transgendered (LGBT) individuals.
- Metro Support Groups: caregivers, people living with HIV/AIDS, and other
- Statewide Organizations
- Georgia Agencies Outside Metro Area
- Ryan White Program in Georgia

1. Ryan White funded – HIV care and service inventory (by service category, organized by core and support services)

Individuals are eligible for services paid for by the Ryan White Part B Program if they are a person living with HIV/AIDS and their annual income is below 300% of the federal poverty level. HIV/AIDS care services vary among the state's public health districts. The table below highlights services provided by each district.

Part B Funded District/Contract Agency	Funded Core Services	Funded Support Services
Rome Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Medical Nutritional Therapy	Medical Transportation Services
	Medical Case Management (including Treatment Adherence)	Psychosocial Support Services
Dalton Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)

	Dental Care/Oral Health	Emergency Financial Assistance
	Health Insurance Premium & Cost Sharing Assistance	Food Bank/Home Delivered Meals
	Mental Health Services	Health Education/Risk Reduction
	Medical Nutritional Therapy	Housing Services
	Substance Abuse Services Outpatient	Linguistics Services
		Medical Transportation Services
Gainesville Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Mental Health Services	Food Bank/Home Delivered Meals
	Medical Nutritional Therapy	Linguistics Services
	Medical Case Management (including Treatment Adherence)	Medical Transportation Services
Cobb Health District		
	Ambulatory/ Outpatient Medical Care	Emergency Financial Assistance
	Medical Case Management (including Treatment Adherence)	
Clayton Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
		Medical Transportation Services
Gwinnett Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Medical Case Management (including Treatment Adherence)	
LaGrange Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance

	Medical Nutritional Therapy	Health Education/Risk Reduction
	Medical Case Management (including Treatment Adherence)	Linguistics Services
		Medical Transportation Services
Dublin Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Health Insurance Premium & Cost Sharing Assistance	Housing Services
	Medical Nutritional Therapy	Medical Transportation Services
	Medical Case Management (including Treatment Adherence)	
Macon Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Medical Nutritional Therapy	Food Bank/Home Delivered Meals
	Medical Case Management (including Treatment Adherence)	Housing Services
		Medical Transportation Services
		Treatment Adherence Counseling
Augusta Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Medical Case Management (including Treatment Adherence)	Emergency Financial Assistance
		Housing Services
Columbus Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Medical Case Management	Linguistics Services

	(including Treatment Adherence	
Valdosta Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Medical Case Management (including Treatment Adherence	Food Bank/Home Delivered Meals
		Health Education/Risk Reduction
		Medical Transportation Services
		Psychosocial Support Services
		Treatment Adherence Counseling
Albany Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Health Insurance Premium & Cost Sharing Assistance	Food Bank/Home Delivered Meals
	Medical Nutritional Therapy	Health Education/Risk Reduction
	Medical Case Management (including Treatment Adherence	Housing Services
	Substance Abuse Services Outpatient	Medical Transportation Services
		Psychosocial Support Services
		Treatment Adherence Counseling
Coastal Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Mental Health Services	Health Education/Risk Reduction
	Medical Nutritional Therapy	Medical Transportation Services
	Medical Case Management	

	(including Treatment Adherence	
	Substance Abuse Services Outpatient	
Waycross Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Health Insurance Premium & Cost Sharing Assistance	Health Education/Risk Reduction
		Medical Transportation Services
Athens Health District		
	Ambulatory/ Outpatient Medical Care	Case management (non-Medical)
	Dental Care/Oral Health	Emergency Financial Assistance
	Health Insurance Premium & Cost Sharing Assistance	Food Bank/Home Delivered Meals
	Medical Nutritional Therapy	Linguistics Services
	Medical Case Management (including Treatment Adherence	Medical Transportation Service

See the resource inventory provided in Appendix 1 for additional information on Ryan White funded services in Georgia, including the 20 county metro Atlanta EMA (Part A).

Part B clients receive services from other Ryan White funded and non funded programs that enhance and augment the comprehensive range of services required by individuals and families. For example, Part B clients receive housing assistance through the Housing Opportunities for People With AIDS (HOPWA) program; Women, Infants, Children, and Youth receive assistance through Part D funds (Waycross and metro Atlanta); and Primary Care and Counseling & Testing are provided through Part C funds; and Part A allocates funding to help with clients on the ADAP waiting list. In this environment of limited funding for HIV/AIDS and the increased prevalence among emerging populations, integration and coordination of services ensures timely, uninterrupted care.

2. Non Ryan White funded – HIV care and service inventory (organizations and services)

See the resource inventory provided in Appendix 6.

3. How Ryan White funded care/services interact with Non-Ryan White funded services to ensure continuity of care

Ryan White Part B services are coordinated with other programs and funding streams. Coordination examples include coordination of services with the Housing Opportunities for Persons with AIDS (HOPWA) program; participation in needs assessments, consumer surveys, focus groups and other activities, including the Georgia Oral Health Coalition Strategic Planning Committee; participation of other programs and funding streams in the HIV Prevention Community Planning Group; and sharing of treatment sites with prevention and counseling sites.

4. How the service system/continuum of care has been affected by state and local budget cuts, as well as how the Ryan White Program has adapted

According to an analysis by the Georgia Budget and Policy Institute in its June 15, 2010 article *"Deep Cuts to Government Mark Fiscal Year 2011, Budget May Yet Be in the Red"* Georgia's financial safety and structure continues to erode.

The "Great Recession" has resulted in Georgia facing the worst fiscal crisis in more than 70 years. State revenues have dropped dramatically over the past two years, resulting in multi-billion dollar budget deficits. Although federal Recovery Act funds have helped Georgia avoid cuts to Medicaid and limited somewhat cuts to education and public safety, most state agencies have seen their budgets reduced by 15 percent or more.

Beyond FY12, Georgia is facing additional structural deficit. Due to projected sluggish economic growth, normal budget growth due to a growing population resulting in an increased demand for state services, and the importance of growing the Revenue Shortfall Reserve, the existing tax base may be inadequate to balance the state budget in the long-term.

The number of persons being served through the Ryan White Program continues to increase as jobs and insurance coverage have been lost particularly for primary care, medications, and medical transportation services. The Part B providers work diligently to assure access to patient assistance programs for medications and routinely review eligibility for Medicare and/or Medicaid enrollment so that Ryan White funds continue to be the payer of last resort.

5. **For jurisdictions that lost a TGA, describe the impact on services (Only Puerto Rico, New York, New Jersey and California grantees should respond)**

N/A. Georgia did not lose a Transitional Grant Area.

C. Description of need

1. Care needs

Georgia employs several different mechanisms to assess the need for primary medical care and other core medical services and barriers among PLWHA in the state. The primary method of collecting data regarding needs, unmet needs, and barriers to care has been through collaborative relationships with other entities, including the HIV/AIDS Epidemiology Surveillance Section, the Southeast AIDS Education and Training Center (SEATEC), district-level Ryan White Part B Consortia, other Ryan White programs such as the Atlanta EMA Part A Program, and the Prevention Program in the HIV Office. The process of updating the Statewide Coordinated Statement of Need (SCSN) also provides critical information regarding client needs.

Needs assessments conducted by the 16 health districts show that, in order of importance, the five most needed services are: Primary Care, Medical Case Management, Oral Health, Emergency Financial Services, and Non Medical Case Management. These five needs are identified across the state regardless of where HIV positive individuals reside (urban, suburban, or rural) as priorities by the consortia. Other needs identified by rank mirror the overall lack of services in the communities where HIV positive clients reside. Rural populations identify transportation as a higher ranked need while suburban and urban regions ranked mental health and substance abuse services as a greater need.

2. Capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities

Public health and community clinics serve as the foundation for the provision of primary care services in Georgia and enable disenfranchised populations to access care by providing services in clinics that are geographically located in communities where the majority of persons are minorities, indigent, and uninsured, and who represent the populations least likely to have access to care. The need for increased access to non-Ryan White funded oral health, mental health and substance abuse services have been identified, particularly for underserved communities and populations.

Part B providers assist clients in enrolling in AIDS Pharmaceutical Assistance Programs (PAP) in primary care sites which allows timely access to therapies and prophylaxis for opportunistic infections as a stop-gap measure until enrollment in ADAP or pharmaceutical PAP has been completed, and for long-term clients who are ineligible for ADAP due to the state requirement that a patient must be on HAART. However, Georgia has had an ADAP waiting list since July 2010. Pharmaceutical PAPs are currently available to provide access to needed medications; however, it is not known how long pharmaceutical companies will continue to offer PAP given demand.

A training needs assessment was conducted in 2010 by the Southeast AIDS Education and Training Center of persons working with the state's Ryan White-funded program sites. The top clinical training topics requested included mental illness and HIV, substance abuse and HIV, and ART therapy. The top requested care-related training topics included chaotic patients, staff team building, and medical case management. Results from the assessment have guided statewide training and the inclusion of topics at the November 2011 Georgia Ryan White Meeting.

D. Description of priorities for the allocation of funds based on a) size, demographics, and location of people who know their status but are not in care and b) needs of individuals with HIV/AIDS.

Through health districts, state direct services, home and community-based care, and ADAP, Georgia's HIV Office allocates funds to the Health Resources and Services Administration (HRSA) defined core medical services and support services for People Living with HIV/AIDS (PLWHA). The HIV Office allocates funds to the core medical services in all state direct services and contracts. The yearly guidance to the 16 public health districts includes language from HRSA regarding how funds should be allocated at the local level to the core medical and support service areas. The public health districts submit yearly budgets that are reviewed and approved by the HIV Office to ensure funds are allocated to core medical service.

Georgia's planned services and implementation plan are reflective of HRSA's 75/25 core medical services requirement. Eighty-seven percent of Georgia's proposed Part B funds will be allocated to core medical services.

Statewide, there are 16 Part B public health districts that work collaboratively with consortia, which serve as advisory bodies and are charged with conducting regional needs assessments and gap analyses, making recommendations on how to prioritize Part B funds in their respective districts. Local Part B consortia membership includes people living with HIV/AIDS (PLWHA), district health staff, community based organizations, medical and social service providers, and other interested community members. Consortia meetings are open to the public.

E. Description of gaps in care

Service gaps have been documented in a number of specific needs assessments/consumer surveys. Planning is underway to conduct a statewide consumer survey in 2013 to identify needs and gaps in care. In addition, an across Ryan White Parts statewide client satisfaction survey is planned for Fall 2012. In the interim, a recent consumer survey conducted by the Metropolitan Atlanta HIV Health Services Planning Council has yielded valuable information for both the EMA and applicable statewide. Survey findings from the 2011 Atlanta EMA HIV/AIDS

Consumer Survey (715 completed surveys), presented at the May 2-3, 2012 SCSN meeting identified the following top ten gaps in core services and in support services.

Top Gaps in Core Services

1. Treatment for dental problems (specialty)
2. Emergency dental care
3. Prevention dental care
4. Session with mental health doctor
5. One to one or group mental health counseling
6. Pharmaceutical assistance
7. Soft meals
8. Residential substance abuse treatment
9. Case management
10. One to one or group substance abuse counseling

Top Gaps in Support Services

1. Food vouchers
2. Emergency financial assistance for utilities
3. Food pantry
4. Legal services
5. Benefits counseling
6. Home delivered meals
7. Nutrition education/counseling
8. Housing information services
9. Peer navigator
10. Peer counseling

Top Gaps in Services: Gender

Males: Food vouchers, nutrition supplements, treatment for dental problems

Females: Food vouchers, treatment for dental problems, emergency dental care, preventive dental care

Transgenders: Treatment for dental problems, food pantry, emergency dental care, preventive dental care

Top Gaps in Services: Race/Ethnicity

African American: Food vouchers, treatment for dental problems, nutritional supplements

Latino: Nutritional supplements, food vouchers, emergency dental care

White: Food vouchers, preventive dental care, legal services

Top Gaps in Services: Special Populations

Young Heterosexuals: Emergency financial assistance for utilities, preventive dental care, nutritional supplements
Young MSM: Emergency financial assistance for utilities, food vouchers, nutritional supplements
Women, children and adolescents: Food vouchers, nutritional supplements, emergency financial assistance, treatment for dental problems, emergency dental care
Persons 50 years of age and older: Food vouchers, emergency financial assistance for utilities, treatment for dental problems, emergency dental care, preventive dental care

F. Description of prevention and service needs

Unmet need data indicate that there are 14,210 PLWA and 10,364 PLWH (non-AIDS) who are aware of their status but are not in care in the public or private health care system.[2] Combined, these figures total 24,574 individuals with HIV/AIDS who are in need of regular primary care in either the public or private health system. To this total needs to be added those individuals who are infected but unaware of their status (EIIHA data, 5,230) for a grand total of 29,804. Based upon historical utilization patterns, an estimated 1/3 of the population access the public health system, 1/3 access the private health system, and 1/3 do not access any health system for the treatment of HIV disease. Applying this utilization figure, it is estimated that 1/3 of the 29,804 (or 9,934) would access the public health system. In addition, there are currently 8,140 individuals receiving HIV care through the Part B continuum. Thus, it could be crudely estimated that 18,074 individuals (9,934+8,140) are in need of services through the Part B continuum at the present time.

However, there has been a 6% increase in the number of PLWH (non-AIDS), and a 1% increase in PLWA in Georgia in 2009-2010 compared to 2008-2009, for a total increase of 7%. The number accessing primary care in 2012 (assuming another increase in the number of clients of 7%) can be estimated to be 19,339 (18,074 + (18,074*7%). These individuals will require additional Part B core services and essential support services as well.

Part B will continue to collaborate with the State's Enhanced Comprehensive HIV Prevention Planning (ECHPP) to support the current prevention activities targeting the populations included below as outlined in the ECHPP plan.

Emerging Trends That Impact Service Needs in Georgia:

(*1*) Population Group: Men who Have Sex with Men

[2] GA/DPH/HIVEU, September 2011.

Since the onset of the HIV/AIDS epidemic in the United States, AIDS incidence and prevalence has been the highest among men who have sex with men. The term "men who have sex with men (MSM)" refers to all men who have ever had sex with men regardless of how they identify themselves (gay, bisexual, or heterosexual).

Men who have sex with men (MSM) still represent the largest number of people living with AIDS in Georgia. They account for approximately 47% (42% MSM and 5% MSM who inject drugs) of the known cases of Georgians living with AIDS as of December 31, 2010. MSM represent the largest number of people living with HIV in Georgia. Based on HIV prevalence, as of December 31, 2010, MSM accounted for 36% of the HIV cases in Georgia. Seventy-eight percent of PLWHA in Georgia are MSM.

Unique Challenges Presented – MSM are members of all communities, all races and ethnicities and all strata of society. The unique challenges presented to this segment of the population include social and economic factors such as racism, homophobia, poverty, and lack of access to health care services. African American and Hispanic males are more likely than White males to receive a diagnosis of HIV infection in the late stages, often when the infection has progressed to AIDS, which suggests that they are not accessing testing or health care services early in their infection when treatments might be more effective. The stigma associated with homosexuality may inhibit some men from identifying themselves as gay or bisexual, even though they have sex with other men. Some men who have sex with men and with women do not identify themselves as gay or bisexual. Research suggests that elevated rates of Sexually Transmitted Infections (STIs) and undetected or late diagnosis of HIV infection may contribute to higher rates of HIV infection among African American MSM.[3]

Data from the 2008 National HIV Behavioral survey found that not only were 19% of MSM HIV infected but that half did not know they were infected. When analyzed by race, 59% of African American MSM did not know their status compared to 26% of White MSM. Not surprisingly it was also found that HIV prevalence increased as education and income decreased.[4]

People with HIV infection are now living much longer and healthier lives than previously tends to portray it as less of a threatening disease and more like a regular infection that can be cured with treatment. It is also noteworthy that among older PLWHA, there is a greater proportion of White MSM than African American MSM again suggesting that the

[3] Ibid.

[4] Prevalence and Awareness of HIV Infection Among Men Who Have Sex With Men --- 21 Cities, United States, 2008, September 24, 2010 / 59(37);1201-1207.

African American PLWHA are not receiving the same level of medical care as White PLWHA.

African American and Hispanic males are less likely than White MSM to live in gay-identified neighborhoods. Therefore, prevention and treatment programs directed to gay-identified neighborhoods may not reach these MSM. For Hispanic MSM, cultural factors may discourage openness about homosexuality, the importance of non-confrontational relationships, and the importance of a close family relationship.[5]

*Service Gaps***:** Service gaps include insufficient outreach initiatives that create awareness and educate MSM about HIV/AIDS and safer sex practices, social support groups that address substance abuse and mental health issues and the stigma associated with the complexity of multiple health problems. Other gaps in services identified by MSM through the HIV Consumer Survey include primary prevention services for oral health, transportation, and emergency assistance for paying household utilities.

(*2*) Population Group: Women

In 2010 women accounted for 24% of newly diagnosed AIDS cases and 29% of people living with HIV in Georgia. The HIV/AIDS epidemic in Georgia continues to affect a significant number of women. From 1984 to 2010, the cumulative proportion of AIDS cases among women increased from 4% to 23%.

African American women are disproportionately affected. As of December 31, 2010, 83% of women living with AIDS in Georgia were African American, and 81% of women living with HIV (not AIDS) in Georgia were African American, according to eHARS data.

Heterosexual contact remains the primary mode of transmission in women. Many women were sex partners of men who have used drugs or of MSM. Twenty-three percent (5,444) of the individuals living with AIDS and 29% (5,397) of the cases of HIV in Georgia at the end of 2010 were female.

In 2010 African American women accounted for 81% of HIV-NA and 83% of women with AIDS. Hispanic women accounted for 4% of female PLWHA. African American women are 19 times more likely to be infected than White women and nearly 4 times as likely as Hispanic women.[6]

[5] Ibid.
[6]National HIV/AID Strategy for the United States, The White House Office of National AIDS Policy, July 2010.

Sexually transmitted infections (STIs) are the most common co-morbidities of HIV and can facilitate exposure to, and progression of, HIV disease. Studies have shown that people who are dually infected with HIV and STIs are much more infectious than those who are infected only with HIV. Since most STIs can be asymptomatic, diagnosis and treatment of infection can be delayed.

According to the 2010 Georgia Annual STD Report, there were 44,612 reported cases of chlamydia and 15,652 reported cases of gonorrhea in Georgia. Women and African-Americans were disproportionately affected by both diseases. Women accounted for 32,863 (74%) of reported chlamydia cases and had a case rate of 658.1/100,000, while African-Americans accounted for 20,553 (46%) of chlamydia cases with a case rate of 601.3/100,000. African-Americans accounted for 61% (9,516) of reported gonorrhea cases with a case rate of 324.7/100,000, while women accounted for 52% (8,297) of reported gonorrhea cases and had a case rate of 166.1/100,000.

*Unique Challenges Presented***:** The challenges presented to women include discrimination, low socioeconomic status, poverty, and lack of insurance. In addition to the challenge of living with HIV, women also face challenges of domestic abuse, maternal health issues, and are often the primary caregivers for children and aging parents. HRSA's HIV/AIDS Bureau's Client Demonstration Project found that among women, receipt of medical care services, emergency financial assistance, housing assistance, or transportation services was predictive of continuing receipt of services in the following year. This finding indicates that many women are living in poverty and have a continuing need for support services. Among HIV positive women, psychological distress poses a significant barrier to care. In one study, 31% of women who tested positive for HIV delayed accessing care for three months or longer because of fear, depression, and anxiety about their serostatus. Of the 2,000 women enrolled in the National Institutes of Health Women's Interagency HIV Study nearly 50% reported a history of sexual abuse and 60% were victims of domestic violence.[7]

Since most female HIV infections are transmitted through heterosexual activities, women are at additional risk based on the activities of the men with whom they are having sex since most female HIV infections are transmitted through heterosexual activities. African American women are more at risk than White due to the higher drug use by their partners. This also applies to Hispanic women.[8,9]

*Service Gaps***:** Services including outpatient ambulatory care, oral health care, mental health counseling, and family case management are needed for adult and adolescent women. The 2008 HIV Consumer Survey reports a high rate of primary care usage (80%)

[7] HRSA Fact Sheet: Women & HIV/AIDS.
[8] National HIV/AID Strategy for the United States, The White House Office of National AIDS Policy, July 2010.
[9]CDC, HIV/AIDS Surveillance in Injection Drug Users (through 2007) Slide set.

among women, yet only 69% use antiretroviral medications. The top services needed but not received were: oral health care, food, transportation assistance, home-delivered meals, and referrals to services.

(*3*) Population Group: Hispanics

Hispanics include any person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[10]According to the 2010 US Census Bureau population estimate, there are roughly 50.5 million Hispanics living in the United States representing 16% of the population in 2010.[11]Georgia has the third fastest growing Hispanic populations in the nation over the last 10 years. In 2010 it was estimated that Hispanics of any race accounted for 9% of the Georgia population.

Georgia eHARS data shows that Hispanics constituted 5% (1,110) of those living with AIDS and 4% (779) of those living with HIV (not-AIDS) as of December 31, 2010. The HRSA Fact Sheet: Hispanics and HIV/AIDS, reports that Hispanics tend to be tested for HIV late in their illness. They are more likely than non-Hispanic Whites to have AIDS-defining conditions at the time of their first test or within the first year after diagnosis.

Hispanics accounted for 7% of all newly reported cases of AIDS in the state of Georgia during 2010, an increase from 6% in 2009. (It is thought that this decline may be a result of recent state immigration legislation and persons may have chosen not to seek care for fear of imprisonment or deportation. Many Hispanics either declined or were very hesitant to participate in the recent Consumer Survey.) Among the 26,886 PLWHA, 5% are Hispanics. In the last year, the number of Hispanic PLWHA has increased from 1,319 to 1,351, an increase of 2%.

Unique Challenges Presented: Hispanics shoulder a disproportionate burden of AIDS in the United States. Study results show that 27% of Hispanic adults in the US do not have regular health care providers. Those who do seek treatment are getting into care late and are not getting diagnosed early. Thirty-two percent of HIV-positive Hispanics are diagnosed with AIDS within 30 days after testing positive for HIV, compared with 24% of both HIV-positive African Americans and Whites. Many face significant barriers to health information, HIV counseling, testing and care. Challenges for the Hispanic population include: poverty; language difficulty; lack of health insurance; availability of quality health services in their communities; distrust of the American health care system; citizenship status; and cultural perceptions, beliefs, attitudes and practices.[12]

*Services Gaps***:** Service gaps include lack of culturally competent and bilingual prevention education and outreach initiatives, limited availability of bilingual healthcare services, lack of access to culturally competent sub-specialty care, limited access to

[10]HRSA Fact Sheet: Hispanics & HIV/AIDS.
[11]The Hispanic Population 2010, US Census Bureau, 2010 Census Summary File 1, May 2011.
[12] HRSA Fact Sheet: Hispanics & HIV/AIDS.

pharmaceuticals, mental health, and substance abuse services, and lack of culturally sensitive health care providers**.**

(*4*) Population Group: African-Americans

Although African-Americans make up only 31% of Georgia's population, 76% of all new cases of AIDS in 2009-2010 were among African-Americans. As of December 31, 2010, 72% of Georgians living with HIV were African-Americans, according to Georgia's eHARS.

Unique Challenges Presented: African-Americans present unique challenges that impact services delivery and access to care. Challenges for the African-American population include fear of stigma in community, reluctance to seek services, education and literacy rate, lack of insurance and availability of services in local communities, lack of adherence to medications, poverty, distrust of practitioners and social services providers, and limited access to healthcare.

Service Gaps: Gaps include population specific prevention education and outreach initiatives that educate African-Americans about HIV/AIDS, shortages of health professionals located in primarily African-American communities, and mental health counseling that deals with not only mental health concerns but also self-esteem and stigma.

G. Description of barriers to care

1) Routine testing (including any state or local legislation barriers)

There are no legal barriers to routine testing. However, information provided by the State's Prevention Program indicates that some physicians are not aware of the CDC's recommendation for routine testing for HIV. Additional efforts are required to educate providers on the CDC recommendations.

In addition, a current law categorizes hypodermic needles as illegal drug paraphernalia, which is the barrier to implementing programs and activities that address prevention of persons who inject drugs.

2) Program related barriers

According to a 2006 article in the American Journal of Public Health, "data document substantial increases in AIDS cases in the Deep South… In contrast, other US regions are experiencing stable rates or small increases in new AIDS cases. Furthermore, the AIDS epidemic in the Deep South is more concentrated than in other regions among African Americans, women and rural residents. The Deep South also has some of the highest levels of poverty and uninsured

individuals, factors that complicate the prevention and treatment of HIV infection."[13]In 2010, a report criticized the response to the AIDS epidemic in the 17 states in "the South".[14] This report concludes that a combination of socioeconomic conditions and state laws and policies means that this region is disproportionately affected by the epidemic; half of all people living with HIV live in the South although this region is home to just over a third of the population. Poverty, poor access to healthcare relative to the rest of the country, a focus on abstinence based on sex education and laws that criminalize HIV transmission and restrict harm reduction programs for IDUs are some of the factors which explain why the risk of becoming infecting with HIV and dying from AIDS is highest in the South. A study examining data from across the country also found that, for socioeconomic reasons, nonwhite men and particularly nonwhite women residing in the South experience the worst clinical outcomes after being diagnosed with HIV.[15]AIDS continues to be a profound medical, psychosocial, and economic crisis in Georgia. In the context of a burgeoning diverse population base, overburdened public health care, social service systems, and economic recession, each year the number of AIDS and HIV cases increases. The basic service needs of the existing population of persons living with HIV/AIDS are barely being met, and acute information and capacity gaps are being increasingly noted. There also exist subgroups among PLWA who present further challenges to the system and specific needs for care, notably youth, with high rates of STIs; the homeless and recently incarcerated "hidden" populations; women, especially single mothers barely living above the poverty level; and the increasing rate of AIDS cases among MSM, notably men of color. Failure to meet the primary care, substance use, and mental health needs of these populations of PLWA will lead to increased cost as physical, social, and personal wellbeing are jeopardized. This could in turn lead to reduced capacity for, and access to, care. When complications related to housing, income, health, or personal wellbeing are present, the system is strained. The Georgia Ryan White system of health care and psychosocial services must continue to accommodate these client challenges and the increased demand for services as the epidemic continues to grow in the present economic environment.

3) Provider related barriers

The cost and complexity of care for persons living with HIV infection is significantly increased with the presence of one or more co-morbid diseases, such as Sexually Transmitted Infections (STIs), including Hepatitis B or C, tuberculosis (TB); homelessness; lack of medical insurance; poverty; and the release of infected incarcerated individuals.

Factors that compound the high rates of STIs and prevalence of poverty among PLWHA in the are the lack of adequate medical insurance coverage, which further disenfranchises PLWHA from receiving adequate care; the presence of other complicating medical problems, such as *TB*

[13] Reif, et al., American Journal of Public Health, June 2006.
[14]Human Rights Watch: Southern Exposure, Human Rights and HIV in the Southern United States, November 2010.
[15]Journal of Infectious Diseases, Sex, Race, and Geographic Region Influence Clinical Outcomes Following Primary HIV-1 Infection, February, 2011, 203(4):442-51.

(Tuberculosis)*;* and cofactors such as homelessness, poverty, substance use, or severe mental illness. Each additional complication creates further complex care and care coordination, and correspondingly drives up health care costs for treating the individual client.

At primary care sites, any of these co-morbidities increases the time spent by any health provider with a client. A medical follow-up visit for a patient adherent to treatment is approximately 45 minutes.[16] Clients who have one or more co-morbidity factors require over an hour, and with acute illness, up to 4 hours. This reflects the need for more in-depth evaluation, laboratory tests, radiological exams, and even hospitalization. The presence of co-morbid factors presents barriers to routine and preventive care, and their attention is necessary to facilitate HIV treatment and increase survival rates. As people access routine health services with less regularity or encounter barriers to service access, they develop more urgent health and social service needs. Effectively addressing any of these problems can decrease cost and treatment complexity. For example, studies have documented that addressing the impact of STIs through early intervention can potentially reduce new HIV cases and associated treatment costs. One study documented how preventing syphilis-related new cases of HIV can result in savings of $833 million nationally in direct medical cost for HIV treatment.[17]

With respect to health infrastructure, Georgia is facing problems as the growing demand for Registered Nurses (RNs) outpaces the supply of the nursing workforce.[18] Key factors driving these concerns are that Georgia continues to be one of the fastest growing states in the nation, and one that is aging. As the 9th most populous state in 2009, Georgia continues to attract new residents. Between 2000 and 2030, Georgia is projected to have a population increase of 46.8%, growing to over 12 million residents from 8.1 million in 2000. This will make Georgia the 8thfastest growing state between this time period, growing at a rate well above the national average growth rate of 29.2%. Not only is Georgia's population increasing, the state is also experiencing a rapid growth in the number and percentage of residents age 65 and older. Older populations typically place increased demand on healthcare services. Between 2000 and 2030, Georgia is projected to add 1.1 million people age 65 and older, an increase of 143%, which more than doubles the current population in this age group. This growth rate is the 8thlargest of the 50 states and District of Columbia and is nearly 40 percentage points higher than the national average. This rate of growth will mean that the state will change from having 9.6% of the population being 65 and older in 2000 to 15.9% of Georgia residents being age 65 and older in 2030. As a result of total population growth and change in the number of residents age 65 and over, Georgia must expect to face a substantial increase in demand for healthcare services. This is occurring at a time when the supply of RNs in Georgia is already too low to meet existing demand.

[16] Grady Infectious Disease Program: Clinical data and chart review 2005.
[17] Chesson, et al., American Journal of Public Health, 2003.
[18] Policy Brief, University of Georgia Board of Regents, Center for Health Workforce Planning and Analysis: The Registered Nurse Workforce in Georgia, September 2009.

4) Client related barriers

In addition to the challenges described above, client related barriers include the following:

Uninsured Persons: The South is home to the greatest number of uninsured persons (estimated at 21 million or 19%). Nationally, 17% of the population is without insurance. In Georgia, 19% of residents reported no health insurance coverage in 2009, including no Medicaid or Medicare (11th highest uninsured rate of all States).[19,20] This is a marked increase from the 16% just 5 years earlier.[21] This figure increases to 25% among those aged 19-64 years.[22]

Georgia's difficult economic situation has also resulted in high unemployment. In July 2008, the state's unemployment rate was 6.2%. With the economic downturn experienced by the state, the rate increased to a high of 10.4% in 2011.[23]The state's unemployment rate has decreased to 8.9% in 2012, but still remains higher than the national rate of 8.1%. Loss of employment or inability to find employment has led to an increased number of uninsured PLWHA. Similarly, the proportion of individuals on Medicare/Medicaid will also likely rise at the same time as a decline in State funding for Medicaid of $43 million,[24] which will result in fewer individuals on Medicaid and result in a larger number of individuals without any insurance coverage at all. Georgia is 6th worst in economic measures that include foreclosures, food stamps and unemployment levels.[25]

In Georgia, African Americans represent 69% of the total HIV/AIDS prevalence. According to a national assessment by the Kaiser Commission, access to health services by African Americans is compromised by an uninsured rate that is one and one-half times that of Whites. With half of all African Americans living in families with incomes below 200% of poverty, this rate would be much higher were it not for Medicaid coverage.[26] Medicaid provides an important safety net for one in five African Americans, underscoring the role that Medicaid plays for low-income families with children. Medicaid covers one-half of African Americans with incomes below poverty and 17% of those between 100-199% of poverty. However, Medicaid's protection is incomplete leaving 30% of African Americans below 200% of poverty and uninsured.

Homelessness: Homelessness is a psychosocial, as well as an economic and health crisis. However, documenting the number of homeless persons at any given time remains a significant challenge. Data on the number of homeless in Georgia is limited; however a 2010 HUD

[19]US Census Bureau, Current Population Survey, 2005-2007, Update 2008.
[20] Kaiser Commission on Medicaid and the Uninsured, April 2011.
[21] Georgia Budget and Policy Institute, September 2009.
[22]Kaiser Family Foundation, 2011.
[23] Atlanta Journal and Constitution, August 2011.
[24] Georgia Budget and Policy Institute, Budget Primer 2012, August 2011.
[25] Bureau of Labor and Statistics, August 2009.
[26]Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2011.

homeless census count identified sheltered (n=8,746) and unsheltered (n=11,090) homeless persons totaling 19,836 homeless individuals on any given night. From the 2010 statewide homeless census count, it is estimated that 75,000 people experience homelessness in Georgia at some time during one year. It is estimated that within the US, 3.4% of the homeless population is infected with HIV or 3 times the rate found in the general population.

Education and Health Literacy**:** Healthy People 2010, the federal government's public health policy initiative, addresses the connection between health literacy and health disparities. It states, "Equitably distributed health communication resources and skills, and a robust communication infrastructure can contribute to the closing of the digital divide and the overarching goal of *Healthy People 2010* – to eliminate health disparities."[27] According to Healthy People 2020, the emphasis on the importance of health literacy is in its overarching goal "to achieve health equity, eliminate disparities, and improve the health of all groups."

Health literacy is one of the tools individuals need to access, understand, and act on health information. It enables consumers to navigate our complex health system, to seek and receive higher quality health care, and to be fully involved in self-management and maintaining good health.[28] Although low health literacy affects individuals of every age, race, education and income level, the elderly, minorities, immigrants, poor, homeless, prisoners, and persons with limited education are more likely to have low health literacy skills. People who are managing multiple chronic diseases and/or multiple insurance systems are also likely to have greater difficulty understanding health messages. Recent studies demonstrate a higher rate of hospitalization and use of emergency services among patients with limited literacy. Patients with low literacy skills are twice as likely to be hospitalized and twice as likely to report poor health.[29] A 2002 study indicated that, nationally, low health literacy was estimated to cost $73 billion annually in excess hospitalization days alone.[30]

Many Georgians have low health literacy because of low English proficiency. According to a 2007 report, Georgia is 49th in the country in high school completion and has the fastest growing immigrant population in the nation, having more than doubled in five years.[31]. In a large health literacy study in 1996,[32] one-third of English speaking patients at two public hospitals were unable to read basic health materials. Forty-two percent of patients could not comprehend directions for taking medication on an empty stomach, 6% were unable to understand information on an appointment slip, 43% did not understand the rights and responsibilities

[27] US Department of Health and Human Services, 2000.
[28] HealthVoices, Health Literacy – A Key to Better Health for Georgians, Issue 2, 2007.
[29] Ibid.
[30] "Low Health Literacy: What Do Your Patients Really Understand?," Nursing Economic$, May-June 2002/Volume 20/No.3, Joanne G. Schwartzberg.
[31] HealthVoices.
[32] Parikh, NS., et al., "Shame and Health Literacy: The Unspoken Connection." Patient Educ. Couns. 1996 Jan; 27(1): 33-9.

section of a Medicaid application, and 60% did not understand a standard informed consent document. In a separate study, patients who presented for acute care at a large public hospital in Atlanta were interviewed.[33] A total of 202 predominately African American patients completed a demographic survey (The Test of Functional Health Literacy in Adults) and answered questions about difficulty reading. Of the 202 interviewed, 42.6% had inadequate or marginal functional health literacy. This study found that about 1 of 4 people living with HIV/AIDS demonstrated difficulty comprehending simple medical instructions indicating low health literacy rates. HIV-infected people with lower health literacy rates had lower CD4 cell counts, higher viral loads, were less likely to be taking antiretroviral (ARV) medications, reported a greater number of hospitalizations, and reported poorer health than those with higher health literacy.[34]

The 2011 Atlanta EMA HIV/AIDS Consumer Survey (715 completed surveys) offers valuable information about client related barriers, including individual, organizational and structural barriers. Individual barriers refer to an individual's knowledge, physical and mental health. Organizational barriers include access (such as transportation or access to a specialist), sensitivity (how clients feel they are treated by providers) and expertise (quality of care by organization and individual provider) barriers. Structural barriers relate to insurance, cost, red tape, rules and regulations, and problems navigating the system. The top five barriers for each category are provided in the table below.

Top Five Barriers					
Individual	**%**	**Structural**	**%**	**Organizational**	**%**
I did not know a service was available to me	59%	Lack of health insurance coverage	37%	Lack of privacy by the organization to protect my medical chart	27%
I did not know where to go to get the service	56%	Reduced services due to funding cuts	36%	Person providing services to me did not seem to know enough	23%
I did not know what medical services I needed	45%	No transportation or access to adequate transportation	36%	Cultural sensitivity of the organization and person providing services to me	20%
My state of mind or ability to deal with the treatment	41%	The amount of time I had to wait for an appointment	35%	The organization did not refer me to the services I needed	20%
My physical health has not allowed me to travel to where the service is	41%	There is too much paperwork and/or red tape	32%	I did not get along with the people providing the services	20%

[33] Williams, MV, et. al., "Inadequate Functional Health Literacy among Patients at Two Public Hospitals," JAMA 1995; 274:1667-82.
[34] Parikh, NS, et al.

H. Evaluation of 2009 Comprehensive Plan

Progress, successes and challenges in implementing Georgia's 2009-2012 Comprehensive Plan's goals, objectives, and strategies are described in the goal tables on the following pages.

Georgia's 2009-2012 Statewide Comprehensive HIV Services Plan

Goal 1: Improve access to HIV-related core services.

Objectives	Strategies	Progress, Successes and Challenges
1.1 Ensure continuity and availability of HIV primary care consistent with Public Health Services guidelines.	1.1.1 Identify and assure points of entry for services exist in each health district. 1.1.2 Establish system to regularly disseminate current contact information on all identified access points to providers throughout state. 1.1.3 Assure transitional discharge planning for incarcerated individuals. 1.1.4 Establish standardized referral form and documentation requirements throughout the state.	1.1.1 Clinics are located in each of the health districts and in the EMA. 1.1.2 Clinic and contact info is on the HIV Office website. 1.1.3 482 received an encounter with a CM (Had a referral with at least a onetime contact with the CM). 99 were active members (Were enrolled and received an Individual Service Plan) in 2011. Of the 99 active members, 55 are still in care. 1.1.4 Due to the variation in referral forms in the health districts, it is not necessary to develop this form or documentation at this time.
1.2 Provide essential comprehensive oral health care.	1.2.1 In collaboration with the State Chief Dentist, establish an oral health workgroup to develop state oral health plan. 1.2.2 Provide continuing education opportunities for oral health providers. 1.2.3 Develop and implement strategies to integrate oral health care education in clinic settings. 1.2.4 Develop relationships with dental schools and oral hygiene programs.	1.2.1 The Oral Health Coalition developed a State Oral Health Plan. 1.2.2 Ten trainings targeted specifically to oral health providers were conducted. 1.2.3 Fifty-four trainings conducted that included oral health care/HIV as a training topic. 1.2.4 Georgia Health Science University receives Part F funding and provides dental services for HIV-infected clients. A list of dental

Objectives	Strategies	Progress, Successes and Challenges
		hygiene school was sent out to HIV Coordinators in December and January; one district currently has an MOU.
1.3 Improve access to mental health and substance abuse services.	1.3.1 Increase linkages and collaboration at the state and local level with public and private mental health and substance abuse providers. 1.3.2 Evaluate current availability of mental health and substance abuse services at the local level. 1.3.3 Train local clinic staff to screen mental health and substance abuse status on clients.	1.3.1 Current linkages have been maintained. 1.3.2 Several districts are funded to provide mental health and substance abuse services. 1.3.3 One hundred and twelve trainings conducted that included mental health and/or substance abuse as a topic in training.
1.4 Ensure access to care for newly identified HIV positives.	1.4.1 Improve linkages between HIV counseling and testing and HIV care. 1.4.2 Coordinate outreach with early intervention services and HIV care. 1.4.3 Encourage clinic sites to dedicate a specific time/date for new patient evaluations. 1.4.4 Utilize trained peer advocates to facilitate new client enrollment in HIV Clinics	1.4.1-2 The HIV Prevention Section was funded through the new CDC cooperative agreement to implement a 2 years demonstration project that focuses on retention to care using linkage case managers, HIV Service Providers, and a network of stakeholders. HIV Prevention continues to move toward routinizing HIV testing. The program aims to fund more clinical settings. All agencies must have documented linkages. HIV Prevention Program continues to work with EIHAA to identify gaps in services and trends. 1.4.3 All Ryan White Part B HIV clinics accept new patients. 1.4.4 Five districts currently utilize peers for client support activities.

Objectives	Strategies	Progress, Successes and Challenges
1.5 Ensure HIV clinics provide clients with medical visits two or more times at least three months apart annually.	1.5.1 Monitor clinic utilization data. 1.5.2 Work with providers to develop and implement strategies to ensure clients are accessing care on a regular basis, as defined in PHS.	1.5.1-2 According to the HAB Performance measures, as of 12/31/11 80% of Part B clients met this objective.
1.6 Ensure mechanisms to maximize utilization of Medicaid and Medicare.	1.6.1 Improve the linkages and collaboration between all Parts and Medicaid/Medicare. 1.6.2 Monitor the effects of Medicaid and Medicare policy changes on clients. 1.6.3 Monitor the impact of Medicare Part D and ADAP on clients. 1.6.4 Monitor the effects of reductions in standard Medicare and Medicaid reimbursement rates.	1.6.1 We are collaborating with CMS to provide assistance with Medicare Part D. We have received approval from Office of Pharmacy Affairs (OPA) to become a rebate/hybrid state and adjudicate claims that count towards True out of pocket (TrOOP). Attempts to link with Medicaid are ongoing. 1.6.2-4 Monitoring will occur pending implementation of Medicare Part D co-payments on behalf of clients by June 30, 2012.
1.7 Identify and address client transportation barriers.	1.7.1 Assess transportation barriers and resources by health districts. 1.7.2 Identify and implement possible solutions to key transportation barriers	1.7.1 This has not yet been completed, although funding was provided. Plan to complete in FY2012. 1.7.2 Payments for public transportation, gas vouchers and arranging third party transportation have been implemented.
1.8 Improve efficiency of the Georgia Health Insurance Continuation Program (HICP) and the AIDS Drug Assistance Program (ADAP).	1.8.1 Maintain HICP and ADAP workgroup. 1.8.2 Collaborate with Medical Advisory Committee to ensure newly FDA approved medications are added to the ADAP formulary. 1.8.3 Improve HICP and ADAP application process (e.g., web-based application process). 1.8.4 Revise and disseminate HICP and ADAP policies and procedures. 1.8.5 Conduct internal audits of up to five percent	1.8.1 The ADAP/HICP QM Workgroup has met quarterly; the last meeting was Feb. 23, 2012. 1.8.2 The ADAP in collaboration with the Medical Advisory Committee ensures that newly FDA approved medications are added to the ADAP formulary. 1.8.3 A web based application process for ADAP and HICP will be implemented by Dec. 2012.

Objectives	Strategies	Progress, Successes and Challenges
	of HICP and ADAP new client applications and or recertification forms quarterly 1.8.6 Establish and implement a policy to allow Advance Practice Registered Nurses (APRN) ADAP and HICP signature authority. 1.8.7 Explore options to assist clients with health insurance co-payments for medications	1.8.4 The ADAP and HICP Policies have been revised and will be disseminated by June 30, 2012. 1.8.5 A five percent audit of the ADAP applications/files will be performed annually; A five percent audit of the HICP applications/files will be performed quarterly. 1.8.6 A policy has been implemented to allow Advance Practice Registered Nurses (APRN) and Physician Assistance (PA) signature authority on ADAP applications and prescriptions. 1.8.7 ADAP currently assists clients with PCIP co-payments for premiums and other out-of-pocket expenses, and is collaborating with CMS to pay Medicare Part D Co-payments.

Goal 2: Improve the quality of health care and health outcomes.

Objectives	Strategies	Progress, Successes and Challenges
2.1 Ensure Ryan White providers are meeting standards included in the Public Health Services guidelines.	2.1.1 Collaborate with SEATEC to provide education and training as needed to providers. 2.1.2 Monitor HAB performance measures. 2.1.3 Mentor HIV inexperienced providers. 2.1.4 Notify providers of revised PHS guidelines.	2.1.1 Two hundred six trainings were conducted. 2.1.2 There are 25 HAB Performance Measures monitored on a quarterly basis through Ryan White Part B. 2.1.3 Fifty individualized clinical preceptorship trainings were provided 2.1.4 Revised PHS Guidelines are disseminated to providers via the HIV Coordinators by the Part B HIV Nurse Consultants.
2.2 Improve HIV/AIDS case management services throughout Georgia.	2.2.1 Provide case management training. 2.2.2 Develop, test, and implement a case management client Acuity Scale. 2.2.3 Develop and implement Women and Children specific case management standards. 2.2.4 Implement standardized case management intake forms. 2.2.5 Develop standardized referral form. 2.2.6 Monitor HAB case management performance measures 2.2.7 Maintain Case Management Sub-Committee.	2.2.1 A total of 28 trainings occurred from 2009-2012 on a variety of CM topics via state office staff. In addition, 337 trainings were conducted by SEATEC that addressed case management activities. 472 case managers were trained. 2.2.2 Acuity Scale and Self Management Model was implemented in 11 districts to date. 2.2.3 Development of the Women's and Children's Case Management Standards will begin after the revision of the CM Standards. 2.2.4 Completed in 2009 2.2.5 Due to the variation in referral forms in the health districts, it is not necessary to develop this form at this time. 2.2.6 HAB CM Performance Measures were monitored via district quarterly

Objectives	Strategies	Progress, Successes and Challenges
		reports; at present through CM chart review and attempting to track in CAREWare. 2.2.7 The Case Management Sub-Committee continues to meet monthly.
2.3 Implement statewide Ryan White Part B quality management plan.	2.3.1 Provide quality improvement workshops. 2.3.2 Assure quality improvement projects occur at state and local levels. 2.3.3 Communicate findings to key stakeholders at least biannually. 2.3.4 Update the QM plan at least annually and the QM work plan at least quarterly. 2.3.5 Require that all Ryan White Part B funded-sites revise written QM plans annually, and submit quarterly QM progress reports. 2.3.6 Maintain QM Core Team.	2.3.1 RW Part B QM staff averaged 2 training sessions per year. 2.3.2 QM reports are reviewed quarterly to capture and highlight quality improvement projects. Technical assistance (TA) is provided as needed. 2.3.3 Blinded Part B HAB Measure data is disseminated to district HIV coordinators quarterly, as well as other relevant quality data. Additionally, the Part B QM Plan is shared internally within DPH and with district HIV Coordinators. 2.3.4 Completed as scheduled. 2.3.5 Complete. TA provided as needed. 2.3.6 Complete. The QM Core Team meets quarterly and is composed of a variety of Part B stakeholders.
2.4 Reduce the number of newly diagnosed individuals entering into care with an AIDS diagnosis.	2.4.1 Work with HIV/AIDS Surveillance to establish process to collect and report data. 2.4.2 Monitor the percentage of new clients entering into care with an AIDS diagnosis. 2.4.3 Work with HIV prevention provider agencies to develop and implement subpopulation strategies to identify HIV positive individuals and get them in care.	2.4.1 The HIV Office continues to meet quarterly with the Surveillance team in order to obtain data and establish a process for data collection. 2.4.2 Monitored via CAREWare, but CAREWare system unable to determine if client is new to care or transfer from another agency. Utilizing the In Care Campaign data to further define this

Objectives	Strategies	Progress, Successes and Challenges
		population. 2.4.3 The HIV Office has secured Part C Funds from CDC to Link and retain clients in care.
2.5 Enhance efforts to retain clients in care and treatment.	2.5.1 Provide clients with treatment and care adherence education. 2.5.2 Train and utilize peer advocates to provide outreach, education, advocacy and retention services. 2.5.3 Identify and implement client self management and adherence approaches (e.g., client/provider contracts).	2.5.1 The HIV Office continues to meet twice yearly with the Surveillance team looking specifically at Enhanced HIV/AIDS Reporting System (eHARS) in order to obtain data. 2.5.2 Five districts currently train and utilize peer advocates to provide services. MAI was funded through 2010. 2.5.3 A Self Management Model was implemented in 11 districts to date.
2.6 Improve recruitment and retention of health care staff.	2.6.1 Mentor HIV inexperienced providers. 2.6.2 Collaborate with SEATEC to provide training and onsite technical assistance. 2.6.3 Collaborate with the Public Health Nursing (PHN) Section to address workforce crisis. 2.6.4 Reduce the time that staff positions are vacant.	2.6.1 Fifty individualized clinical preceptorship trainings provided 2.6.2 Collaborative efforts with SEATEC to provide training to health districts. 156 training and/or technical assistance events provided 2.6.3 Collaborated with PHN to develop a career ladder 2.6.4 Collaborated with HR to reduce vacant positions.

Goal 3: Eliminate health disparities and barriers to care.

Objectives	Strategies	Progress, Successes and Challenges
3.1 Identify health disparities and barriers to care.	3.1.1 Identify an academic partner to assist with the needs assessment process. 3.1.2 Develop the statewide needs assessment. 3.1.3 Implement the statewide needs assessment 3.1.4 Analyze findings and prepare a written report	3.1.1-4 SEATEC has been identified to work collaboratively on developing, implementing and analyzing a consumer needs assessment in 2013.
3.2 Improve cultural competency of service providers and programs.	3.2.1 Coordinate training and education on cultural competence issues (i.e., language, race/ethnicity, literacy, religion, sexual orientation, gender identity, physical challenges). 3.2.2 Improve client involvement in planning and implementation of programs. 3.2.3 Encourage the use of culturally and linguistically materials and resources.	3.2.2 Client representation is required on each districts' Consortia Planning Committee. Clients are also represented on many other committees. 3.2.3 Several districts are funded for language services.
3.3 Increase the number of clients with affordable, stable and safe housing.	3.3.1 Assess clients for housing needs and eligibility for housing resources, (e.g., HOPWA, Section 8, public housing). 3.3.2 Ensure clinic sites, community-based organizations, and other providers have current housing resource information for their area. 3.3.3 Establish linkages at local level between case managers and housing resources. 3.3.4 Improve collaboration between Part B Grantee and HOPWA.	3.3.1 Clients are assessed for housing needs through the Case Management intake process 3.3.2-3 Resource information is disseminated to clinics and organizations via resource guides (ie, Key Contacts). 3.3.4 Collaboration is ongoing.

Objectives	Strategies	Progress, Successes and Challenges
3.4 Improve the utilization of interpretation and translation services for clients.	3.4.1 Encourage Part B providers to budget funds for interpretation services where needed. 3.4.2 Collaborate with DHR Limited English Proficiency and Sensory Impairment program to ensure clients have access to all interpreter services as needed.	3.4.1 Four districts are currently Part B funded to provide linguistic services.
3.5 Encourage consumers to become active partners in their healthcare and improve the quality of their lives.	3.5.1 Train and utilize peer counselors to provide outreach, education, advocacy and retention services. 3.5.2 Identify and implement consumer self management and adherence approaches (e.g., consumer/provider contracts). 3.5.3 Improve client involvement in planning and implementation of programs.	3.5.1 MAI funded peer counseling program was completed. Peer advocates continue to work in seven districts. 3.5.2 Statewide acuity scale developed and in the process of being implemented 3.5.3 Client representation is required on each districts' Consortia Planning Committee. Clients are also represented on many other committees.
3.6 Improve access and utilization of emergency financial assistance to clients.	3.6.1 Encourage Part B providers to budget funds for emergency financial assistance where needed. 3.6.2 Monitor use of Part B funds for emergency financial assistance. 3.6.3 Encourage collaboration with local community based agencies to assist with emergency financial services.	3.6.1 Fifteen of 16 Part B funded health districts have some funding allotted for EFA during 2011-12. 3.6.2 Funds for EFA are monitored quarterly via expenditure reports and reviewed during annual site visits.

Goal 4: Enhance collaboration and communication with partners statewide.

Objectives	Strategies	Progress, Successes and Challenges
4.1 Enhance relationship with state partners to identify common goals and coordinate utilization of resources.	4.1.1 Coordinate statewide HIV/AIDS meetings to share information and best practices and identify collaborative opportunities. 4.1.2 Work with the Department of Public Health to facilitate data sharing agreement. 4.1.3 Work collaboratively with the Southeast AIDS Education and Training Center (SEATEC) to improve the quality of provider and program staff education. 4.1.4 Maintain Part B Grantee participation in the Metro-Atlanta EMA Planning Council.	4.1.1 Statewide meetings occurred annually to share information and best practices. 4.1.2 The HIV Office continues to meet quarterly with the Surveillance team in order to obtain data and establish a process for data collection. 4.1.3 Collaborative efforts with SEATEC to provide training to health districts. 50 individualized clinical preceptorship trainings provided 156 training and/or technical assistance events provided 337 trainings conducted by SEATEC that addressed case management activities 4.1.4 Part B staff regularly attends and participate in EMA Planning Council meetings.
4.2 Improve communication, cooperation, and collaboration among HIV providers and key stakeholders.	4.2.1 Facilitate meetings and conference calls/and other communication technologies. 4.2.2 Develop and sustain state work groups to address system-level issues (e.g. oral health workgroup).	4.2.1 At least quarterly ADAP and QM Core Team meetings Annual Statewide HIV Coordinators meeting. 4.2.2 Case Management subcommittee, Perinatal Advisory Council, Oral Health Coalition, and ADAP workgroup

Section II. Where do we need to go?

A. Plan to meet challenges identified in the evaluation of the 2009 Comprehensive Plan

Part B Program was successful in addressing the strategies outlined in the 2009-2012 Comprehensive Plan, with many having been achieved and others currently in progress. Challenges were primarily encountered in implementing the following: 1.2 – Provide essential comprehensive oral health care. Despite successfully implementing our strategies oral health remains a priority area in Georgia due to overarching systemic barriers. Lack of oral health care was identified in multiple breakout groups as a barrier or gap. 1.7 – Identify and address client transportation barriers. One method of assessing these barriers would be to conduct a survey in order to identify district resources and barriers related to transportation.

B. 2012 proposed care goals

Since the earliest days of the HIV/AIDS epidemic, Georgia has had a substantial number of reported cases of AIDS. The epidemic continues to grow and more people are living longer with HIV/AIDS in the state. There are not enough HIV/AIDS prevention, care and treatment services in Georgia to meet the increasing demand for services, and there are not enough financial resources to meet all of the costs of medical and support service needs. The state recognizes the importance of addressing key HIV/AIDS care issues, enhancing coordination across Ryan White programs, and allocating and utilizing resources to address identified needs, especially those of traditionally underserved populations and subpopulations.

In developing a 2012-2015 Comprehensive HIV Services Plan that most effectively uses limited resources to meet the needs of Georgians living with HIV/AIDS, particularly its most vulnerable populations, Georgia utilized the following key HRSA directives and strategies:

Improve access to HIV-related core services by linking newly diagnosed individuals to care and identifying *individuals who know their HIV status but are not in care*, informing them about available treatment and services, and assisting them in the use of those services;

Improve the quality of HIV core services and health outcomes by ensuring the availability and adequacy of critical HIV-related local core services (primary medical care that is consistent with PHS Treatment Guidelines; HIV-related medications, mental health treatment, substance abuse treatment, oral health and case management; and

Increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment by addressing the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system through coordination of HIV prevention and treatment, including outreach and early intervention services;

Reduce health disparities in access to core and support services among disproportionately affected sub-populations and historically underserved communities.

Enhance collaboration and communication with partners statewide in an effort to maximize funding and resources for the mutual benefit of the HIV/AIDS community.

The values that guided the identification and selection of the state's strategic HIV system of care goals and objectives were derived from the Shared Vision, Mission Statement, and Shared Values listed below. The planning goals and objectives are consistent with the Healthy People 2020 goal for HIV services: *To prevent human immunodeficiency virus (HIV) infection and its related illness and death.*

Shared Vision

Excellence in Georgia's HIV/AIDS services through innovation and community partnership.

Mission Statement

To ensure collaboration and information sharing among programs in the state of Georgia funded under all parts of the Ryan White HIV/AIDS Treatment Act of 2009 and other partners to avoid duplication of services and to assure access to quality, cost-effective services that help individuals living with HIV have an improved quality of life.

Shared Values for System Changes

The development of Georgia's Statewide Coordinated Statement of Need and 2012-2015 Statewide Comprehensive HIV Services Plan were guided by the following shared values:

1. The quality and dignity of human life.
2. Cultural competency/appropriateness in service delivery.
3. Respect for diversity and cultural differences.
4. Effective and timely support for basic needs.
5. The involvement of HIV infected individuals in decision-making.
6. The involvement and support of each affected individual's personal support system, as well as the greater community, in caring for persons with HIV.
7. An individual's right to self-determination.
8. The health of the community.
9. Service delivery systems that promote independence and self-sufficiency.
10. The efficient use of resources.
11. Prevention, education, and early intervention.

The five 2012 Statewide Comprehensive HIV Services Plan goals and objectives will help assure availability and accessibility to core services in Georgia:

Goal 1: Improve access to HIV-related core services.

1.1. Ensure continuity and availability of HIV primary care consistent with Public Health Services guidelines.
1.2. Evaluate and respond to the changing healthcare environment to assure HIV health and support services are available and accessible.
1.3. Assure health districts are aware of changes in the health and support service access and availability to help clients navigate the system of care.
1.4. Assure consumers are consistently informed about changes in health and support service access and availability, as well as aware of available supports/resources to respond to their changing needs.
1.5. Assess barriers to accessing core and support services to identify potential solutions and best practices.
1.6. Assess and enhance access to HIV medications.

Goal 2: Improve the quality of HIV core services and health outcomes.

2.1. Assure standards of care, including Public Health Services (PHS) guidelines and best practices, are consistently applied in the provision of HIV services.
2.2. Improve HIV/AIDS case management services throughout Georgia.
2.3. Implement statewide Ryan White Part B quality management plan.
2.4. Improve recruitment and retention of health care staff.
2.5. Adapt the Georgia Department of Public Health, HIV Office, practices and guidelines as needed to align with the National HIV/AIDS Strategy, Healthy People 2020, the HIV/AIDS Bureau (HAB) Measures, and other state and federal initiatives focused on reducing health disparities.

Goal 3: Increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment.

3.1. Identify individuals unaware of their status.
3.2. Collaborate with counseling and testing and prevention programs to facilitate identification of individuals unaware of their status and link them to care.
3.3. In collaboration with the HIV Prevention program in the Georgia Department of Public Health and federal Department of Health and Human Services (DHHS) directly funded entities (e.g., health departments, community based organizations) develop and implement strategies to facilitate integration of care, treatment and prevention.

Goal 4: Reduce health disparities.

4.1. Identify health disparities and barriers to care.
4.2. Improve cultural competency of service providers and programs.
4.3. Improve the utilization of interpretation and translation services for clients.
4.4. Maximize opportunities for clients to access affordable, stable and safe housing.
4.5. Advocate for policy change.

Goal 5: Enhance collaboration and communication with partners statewide

5.1. Engage key stakeholders, including but not limited to Program Collaboration Service Integration (PCSI), HIV Office, Prevention Section grantees, Early Identification of Individuals with HIV/AIDS (EIIHA), Substance Abuse and Mental Health Services Administration (SAMHSA), Community Planning Group (CPG), the AIDS Drug Assistance Program (ADAP), ADAP Contract Pharmacy Network (ACP), Health Insurance Continuation Program (HICP), Preexisting Condition Insurance Plan (PCIP), Test-Link-Care Network, private providers, all Ryan White Parts, and Medicaid.

C. Goals regarding individuals *Aware* of their HIV status, but not in care (Unmet Need)

Georgia is approaching finding people not in care and getting them into primary care in several ways. Part B providers require that individuals must demonstrate enrollment in primary care prior to receiving other Part B funded services such as medical case management, oral health services, home delivered meals, etc. Second, the HIV Office is examining unmet need for HIV care among subpopulations and working with agencies and other Ryan White Parts (e.g., Part A) which target those subpopulations to enhance existing outreach efforts through client tracking and other methods. Finally, The HIV Office is working with Part A and the Counseling and Testing (CT) program and directly funded CDC programs to develop a coordinated plan to identify and link newly positive individuals into care.

Georgia's proposed 2012-2015 Goal 3 addresses individuals *Aware* of their HIV status, but not in care is to: *increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment.* Goal objectives and strategies are provided on page 82.

D. Goals regarding individuals *Unaware* of their HIV status (EIIHA)

To make individuals who are unaware of their HIV status aware of their status, all prevention and treatment partners will be identified, strong collaboration will be promoted among these partners, specific target populations will be identified, activities developed and implemented to address barriers in reaching the target populations, and proper documentation will be collected.

Goal 3 of the Georgia HIV Office's proposed 2012-2015 Comprehensive Plan goals addresses individuals *Unaware* of their HIV status, but not in care. (See page 82.) For additional information, see the Early Identification of Individuals with HIV/AIDS (EIIHA) strategies discussed on page 73.

E. Proposed solutions for closing gaps in care

In planning and implementing strategies to address issues of:

- Ensuring access and availability
- Reducing disparities
- Linking people aware of their status but not currently in care with appropriate care and treatment
- Integrating testing/counseling/prevention to facilitate linkage to care/treatment
- Evaluating and responding to upcoming changes as future aspects of the Affordable Care Act impact systems and services for persons living with HIV/AIDS

Comprehensive Plan Goals 1, 2, 3, and 4 investigate current gaps and search for solutions to close those gaps in order that Georgians living with HIV/AIDS access a client-centered, integrated and coordinated continuum of care.

F. Proposed solutions for addressing overlaps in care

Contractual requirements include client level data reporting in CAREWare by all Part B funded agencies for monitoring of services provided by site, payer of last resort determination, and coordination and collaboration with other Ryan White Part funded agencies. District liaisons conduct quarterly monitoring of sub-grantee contracts to ensure compliance with Federal and state Ryan White regulations and requirements.

G. Proposed coordinating efforts with the following programs to ensure optimal access to care

Ryan White Part B services in Georgia are coordinated with other programs and funding streams to ensure optimal access to care. Part B's coordinating efforts during 2012-2015 will build on existing coordination and collaboration of Federal, State and local services for individuals with HIV/AIDS. Part B clients receive services from other programs that enhance and augment the comprehensive range of services required by individuals and families. For example, Part B clients receive housing assistance through the HOPWA program; Women, Infants, Children, and Youth receive assistance through Part D funds; Primary Care and Counseling & Testing are provided through Part C funds; medications are provided through the State ADAP program; and insurance premium payments are provided through the HICP. In this environment of limited funding for HIV/AIDS and the increased prevalence among emerging populations, integration and coordination of services ensures timely, uninterrupted care.

Part B has well established relationships with other Ryan White Programs in Georgia as well as with other programs that provide prevention and care services for individuals with HIV/AIDS.

For example, Parts A, B, C, D, and F held Georgia's first Ryan White Statewide Conference in October 2007. For the first time, Parts A, B, C, D, and F Ryan White program administrators, staff, and clinicians were able to come together to learn, share, build skills, and network with their Ryan White colleagues throughout the State. The second Statewide All Parts meeting was held November 8-9, 2011. The three-day meeting included a clinical track on November 8, and a programmatic track on November 9 and 10. The clinical session was attended by over 60 physicians, nurse practitioners, physician assistants, nurses, dentists, dental hygienists, and pharmacists from across the state, and covered medical treatment topics. The programmatic session, attended by over 125 staff representing all Parts A, B, C, D, and/or F funded agencies in Georgia, included presentations on the federal Ryan White Program, the Affordable Care Act, medication assistance programs, testing and linkage to care, quality management, a variety of care topics, care for the caregiver, and the future of HIV medicine.

The following is a description of the type and scope of collaborative efforts currently in place in Ryan White Part B.

Part A Services: There is one Part A funded metropolitan area in Georgia. The Atlanta EMA consists of 20 counties and represents 53% of the state's population. Within the Atlanta EMA, 61% of the total population resides in the four most urbanized counties (Fulton, DeKalb, Cobb, and Gwinnett). Some of the counties also receive Part B funding, but Fulton and DeKalb Counties, where the largest percentage of PLWHA lives, do not. Fulton and DeKalb counties don't receive federal Part B funding due to the availability of Part A funding, although they do receive Ryan White state match funding. The EMA has a coordinated service delivery system, which encompasses a comprehensive range of primary care, other core services, and support services for individuals and families infected with, and affected by, HIV disease. These services are accessible to all eligible PLWH in the EMA. Included in this delivery system are mechanisms to address the service needs of newly infected, underserved, hard to reach individuals, disproportionately impacted communities of color and those who know their HIV status but are not presently in care to access and remain in care.

These services include those provided by ADAP and the Health Insurance Continuation Program (HICP). Some Part A funded agencies or health departments included within the EMA receive Part B funding to provide additional client services. Due to Part A funding, Fulton and DeKalb counties do not request, nor receive Part B funding. These areas coordinate Part A and B funds and other funding sources to provide a comprehensive continuum of care and ensure that a maximum number of clients receive services. Examples of such coordination are seen in Gwinnett County located in the northeastern part of the EMA. The Gwinnett County Board of Health receives Part B funds directly from DPH and contracts with AID Gwinnett, an AIDS Service Organization (ASO) that receives Parts A and C funds. Ryan White funds support the infrastructure for HIV services in this region. Without such coordination, services would be

significantly compromised, as none of the resources is sufficient to meet the growing demand for services in this region.

Further demonstration of collaboration is demonstrated in the Georgia ADAP. All primary care clients within the EMA are screened for ADAP eligibility. If eligible, applications are submitted to the Georgia DPH to complete the enrollment process. The Georgia DPH contracts with the Grady Health System, which participates in the State's ADAP Contract Pharmacy (ACP) Network. The pharmacy is co-located within the Grady Infectious Disease Program (IDP), one of the Part A funded primary care providers. IDP clients within the Atlanta EMA can pick up their ADAP medications. Of the 3,680 active clients in the State ADAP in FY11, 2,546 (68%) resided within the 20 county EMA. DPH implemented a waiting list on July 1, 2010. There are currently 490(6/7/12) persons on the waiting list with 304 (62%) residing in the 20 county EMA. DPH received in FY 11-12 an ADAP supplemental award of $3,000,000 which allowed 273 persons to be removed from the waiting list.

Prior to FY07, the Atlanta EMA supported the Georgia ADAP with funds in the amount of $1.5 to $1.9 million. In consideration of the overall increase in the Part B ADAP award, Part A funds were not allocated to support the ADAP for FY08-FY11 in the base funding range. However, unexpended Part A funds were redirected in FY08-$413,604; FY10-$789,530 and FY11-$848,731 to support increases in demand for ADAP. In FY12, Part A funds support the local AIDS Pharmaceutical Assistance (APA) program which provides clients an avenue to access ADAP formulary medications while waiting for final ADAP approval, and covers those clients who are not taking antiretrovirals and are, therefore, ineligible for ADAP

The HIV Office Ryan White Part B Program administers the Health Insurance Continuation Program (HICP). This program, funded with Ryan White State Match dollars, provides eligible clients assistance with third-party insurance premium payments. This program currently serves 405 active clients, with 352 (87%) residing within the EMA. By paying the insurance premiums for these eligible individuals, primary health care services are provided by the private sector, allowing Ryan White funds to be used for those with no other resources.

Part A and Part B program staff participate in meetings periodically to update each other on successes and barriers to provision of services, i.e. - the ADAP waiting list and wait times for new appointments in Part A funded primary care sites, Quality Management coordination.

Part C Services: There are 17 Ryan White Part C grantees operating in Georgia, providing early intervention and primary care services. Eleven of the 17 Part C grantees are public health districts. Ten of the Part C care sites are also Ryan White Part B funded recipients. As with all agencies receiving Ryan White funding from multiple sources applying for Part B funds, Part C recipients are required to describe and demonstrate how Part B funds will be coordinated with

Part C. Part B funds do not supplant services funded by Part C, or for any other funding source. Part B applications must include an itemization of other funding sources by line item for personnel, supplies, equipment, and services.

Part D Services: Georgia has two Part D funded programs. The Grady Health System, Infectious Disease Program (IDP), founded in 1986, serves as the grantee of record for the Atlanta Family Circle HIV/AIDS Network: Ryan White Part D Services for Women, Children, and Adolescents. The Part D Network includes four service providers: AID Atlanta, the Grady IDP's Ponce Family and Youth Clinic, Grady Health System's Department of Gynecology and Obstetrics (Grady OB), and Sister Love, Inc. The project serves women, children, youth and families infected or affected by HIV/AIDS who reside in the five core Metropolitan Atlanta counties (Fulton, DeKalb, Cobb, Clayton and Gwinnett) and the surrounding 15 Metro counties in the 20 county Atlanta EMA. The majority of the population targeted for Part D services are low-income minorities. The Atlanta Family Circle Part D supports a program to identify HIV positive Hispanics and provide linkage into care. Individuals identified through this program are referred to primary care throughout the EMA, some of which are supported directly by Medicaid, Part D, or by Parts A, B or C. Georgia's other Part D program is located in Waycross and serves a rural area of the state.

Georgia's other Part D Program is located in Waycross, Georgia and provides services to the Southeast area of the state. The Part D funding provides services to the following 16 rural counties: Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Wayne and Ware. Because of the limited number of specialty medical care providers, Southeast Health District (SEHD) has become recognized as the primary provider of services for patients with HIV/AIDS within the 16 county areas.

In the SEHD, there were 207 (43.67%) Ryan White Part D clients actively enrolled in 2010. That number that has steadily increased since the beginning of the HIV service and care program was established in the late 1980s. Comparatively, Ryan White Part D accounts for only 23.33 % of enrolled patients statewide. Heterosexual contact is indicated as the primary risk behavior among women diagnosed with HIV infection in the SEHD (89%), much higher than the state incidence of 23.4%. (2010 Ryan White Data Report, Basic Epidemiologic Profile of HIV/AIDS, Georgia, 2011).

Part F Services: Part F - Special Projects of National Significance (SPNS): AID Atlanta, funded by Parts A and B, is also funded for a demonstration project to determine best practices/interventions for connecting HIV-infected inmates into medical care at release. The demonstration project targets HIV-infected substance abusing men in the EMA. Through this initiative, medical case management services are provided to inmates who agree to take part in the demonstration project. Inmates who decline to enroll in the demonstration project are

followed under Part A and B funded case managers for discharge planning. AID Atlanta receives Part A funding for its primary care clinic where inmates are linked for receipt of primary care services. The evaluation center for the project is Emory University Rollins School of Public Health in Atlanta.

Part F - AIDS Education and Training Centers: Georgia is served by SEATEC which conducts comprehensive training for healthcare providers who work throughout the state. Instruction focuses on medical management of HIV, ensuring that DHHS treatment guidelines constitute the core teaching message. SEATEC trainings frequently include Part B funded staff and health care providers associated with other Ryan White programs and other federal and non-federal programs.

SEATEC places special emphasis on training newly-hired medical staff that may have limited experience in HIV medicine in order to help them move quickly toward optimal functioning. In addition, SEATEC seeks guidance from Georgia's Ryan White Parts' (including Part B) administrative staff and clinical staff in identifying community clinicians who might benefit from HIV training and informs identified clinicians of training opportunities. SEATEC conducted a statewide training needs assessment. Topics identified were included in the agenda for the Georgia Ryan White Meeting being held November 8-10, 2011.

Part F - Dental Reimbursement Programs: Georgia Health Sciences University is funded to provide a full range of services for HIV infected clients. They provide a source of dental care for clients in regions of the state without dental resources. However, lack of transportation can be a barrier to accessing services.

Private providers (Non-Ryan White funded): Persons receiving primary care services from private providers who meet Ryan White eligibility criteria may access other Part B funded services in Georgia. Part B requires that all persons must have had a primary care appointment within the last six months. Part B works with private providers to obtain documentation regarding primary care. Individuals under the care of a private physician may also access ADAP and HICP.

Prevention programs including Partner Notification Initiatives and Prevention for Positive Initiatives: In Georgia, the Department of Public Health (DPH) is the recipient of the majority of funding through the CDC Prevention Program. As a condition of the new federal CDC funding opportunity, DPH will implement a comprehensive prevention program that will include: partnering with Community based Organizations (CBO), health districts, Ryan White (RW) Clinics, and other organizations that provide services to HIV positive individuals and those at highest risk for acquiring as well as transmitting HIV infection. To ensure that positive clients are being linked to care and receiving prevention services, both prevention and care is working

together to streamline data to be tracked.

Substance abuse and mental health treatment programs/facilities: The core of substance abuse and mental health treatment services in Georgia is funded through the Georgia Department of Behavioral Health and Developmental Disabilities (BHDD). Georgia has a set-aside for services to PLWHA in substance abuse treatment funding from the Substance Abuse Mental Health Services Administration (SAMHSA) for HIV/AIDS services through BHDD. The required 5% set-aside for HIV is $2,517,908.

STD programs: HIV/STD Programs are co-located in health departments in Georgia Department of Health. Persons who test positive in the STD clinics are counseled and linked to care. Part B providers utilize health department Communicable Disease Specialists for partner notification and assistance in directing clients to primary care sites.

Medicare: The Part B clinics remain diligent in their efforts to enroll clients in Medicare for coverage of medications to maximize Part B funds needed for HIV medications. However, enrollment in Medicare Part D presents challenges and compromises many clients' ability to receive and/or afford their ARVs. The standard drug benefit defined in the Medicare Modernization Act of 2006 has a $320 deductible and 25% beneficiary coinsurance in the initial benefit period. The initial benefit period ends after $2,930 in total drug costs. From this point until catastrophic coverage begins, the beneficiary pays 100% of drug costs. This gap in coverage is commonly referred to as the "doughnut hole".[35] The Affordable CARE Act changes which out-of-pocket expenses count towards the Medicare Part D annual out-of-pocket threshold. As of January 1, 2011, ADAPs became "TrOOP" (True-Out-Of-Pocket) eligible entities. Payment of Medicare Part D co-pays through the State ADAP will be effective with completion of testing and connectivity between the State's Pharmacy Benefit Manager (PBM) and the Center for Medicare and Medicaid Services (CMS). Full data exchange will begin after testing is completed. Part B-funded HIV clinics also bill Medicare for appropriate medical services and ensure that all clients are enrolled in medical care.

Medicaid: The Georgia Department of Community Health, Division of Medical Assistance, which administers Medicaid, is the largest payer for inpatient care for persons with HIV disease. Due to strict eligibility guidelines, males with HIV must become considerably ill, and be disabled before being eligible for coverage allowing access to necessary care. Part B clinics utilize Medicaid for services when a female client becomes pregnant.

State Children's Health Insurance Program (SCHIP): Enrollment in PeachCare (Georgia's SCHIP) is available by referral or on-site at all of the primary care sites although the majority of

[35] The Medicare Drug Benefit, "The Role of Part D for People with HIV/AIDS: Coverage and Cost of Antiretrovirals under Medicare Drug Plans", The Henry J. Kaiser Family Foundation, July 2006.

infants, children and youth (l8 and under) receive services at the Grady Infectious Disease Program's Ponce Family and Youth Clinic in metro Atlanta. Children also receive services in select areas of the state including Augusta (Georgia Health Science University Hospital), Macon and Waycross Health District.

Community Health Centers: Public health and community clinics serve as the foundation for the provision of primary care services in Georgia and enable disenfranchised populations to access care by providing services in clinics that are geographically located in communities where the majority of persons are minorities, indigent, and uninsured, and who represent the populations least likely to have access to care. There are 145 clinics which serve as "one-stop shops" that provide comprehensive services such as primary care, mental health treatment, substance abuse treatment, oral health care, medical case management, and support services in one location to facilitate client access and reduce barriers to system navigation. If the service is not readily available at one location, referrals are made

H. For jurisdictions that lost a TGA, describe the impact on services (Only Puerto Rico, New York, New Jersey and California grantees should respond)

N/A. Georgia did not lose a Transitional Grant Area.

I. Role of the Ryan White Program in collaborating with the Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas (MSAs) Most Affected by HIV/AIDS (ECHPP) initiative

The Ryan White Part B Program will continue participation in the EMA's Early Identification Workgroup (EIW) quarterly meetings. Other participants include leadership from Parts A, C, and D; Southeast AIDS Training and Education Center (SEATEC); State HIV Prevention Program including the Georgia Community Planning Group; HIV Surveillance Program; HIV Testing / Partner Services Program; Centers for Disease Control and Prevention (CDC); City of Atlanta Housing Opportunity for People with AIDS (HOPWA); ECHPP; and federal and state funded agencies for counseling and testing and prevention activities. The purpose of the EIW is to facilitate collaboration and coordination across all HIV/AIDS programs.

ECHPP, whose activities focus on five counties within the EMA – Clayton, Cobb, DeKalb, Fulton and Gwinnett, has representation on the EIW.

EIW is developing a standardized protocol to be used by all counseling and testing sites to promote linkage and retention to care. Work is also underway in the EMA to identify all service

partners, promote strong collaboration among partners, identify specific target populations, develop activities to address barriers for reaching the target populations, and ensuring proper documentation is collected. Parties responsible include the Fulton County Department of Health and Wellness and the State ECHPP.

Other Ryan White Part B Program's EIIHA strategies include the following:

Each strategy listed is consistent with the National HIV/AIDS Strategy (NHAS). The NHAS goals that are being supported by the collaborative efforts of the Part B program and the ECHPP initiative are (1) reduce new HIV infections, (2) increase access to care and improve health outcomes for people living with HIV, and (3) reduce HIV-related disparities and health inequities.

Goal 1: Reduce new HIV infection

To achieve this goal, the Georgia Department of Public Health (DPH), as part of its ECHPP activities, will increase HIV testing in clinical and non-clinical settings. These testing efforts will target high risk populations in the Atlanta metro area, including Clayton, Cobb-Douglas, DeKalb, Fulton, and Gwinnett public health districts, which are areas in Georgia that have been identified as having the highest concentrations of HIV cases. Health departments and organizations that receive resources from DPH to conduct HIV testing in clinical or nonclinical settings under the ECHPP initiative will also be required to establish a working and collaborative partnership with HIV care and treatment providers in order to link those testing HIV-positive into care. These collaborations will include establishing partnerships with service provides involved with Part B EIIHA.

Under ECHPP activities, DPH will also increase condom distribution in clinical and non-clinical settings (including Part B providers) to reach individuals at high-risk for HIV and those who are HIV-positive. Persons newly diagnosed with HIV will also have the option of requesting Partner Services (PS) under the ECHPP strategy, which will include three primary options: (1) elect to opt-out, (2) request PS by the service provider, or (3) postpone PS to another time. These services will be supported by ECHPP and, in some instances, be available at sites where Part B services are also rendered.

Goal 2: Increase access to care and improve health outcomes for people living with HIV

Georgia DPH provides technical assistance and support to increase linkage to care efforts and activities among its funded service providers and other community partners, including those participating in the EIIHA network. Under the ECHPP initiative, DPH will fund health departments in the Atlanta MSA to provide a comprehensive HIV prevention for positives program and services (i.e. a combination of services from HIV testing, prevention interventions for positives, condom distribution, linkage to care activities, perinatal transmission prevention, and partner services) that specifically target those persons newly diagnosed with HIV or those who are lost to care and re-enrolled into primary care services.

DPH recently received funding from SAMHSA to support mental health counseling, substance abuse prevention, and substance abuse treatment services for HIV-positive persons and those newly diagnosed with HIV. The purpose of this five-year program is to facilitate the development and expansion of a culturally competent and effective integrated behavioral health and primary care networks for 1,050 people living with HIV in the metro-Atlanta area.

Goal 3: Reduce HIV-related disparities and health inequities

Georgia DPH will reduce HIV-related disparities and health inequities by targeting and allocating resources to support programs and activities that are provided in areas and populations that have the highest concentrations of HIV infection based on current epidemiological data, HIV surveillance, and other sources of information (e.g. Community Planning priorities, unmet need estimates, etc.).

The strategies are also are consistent with making individuals who are unaware of their HIV status aware of their status by identifying all prevention and treatment partners, promoting strong collaboration among partners, identifying the specific target populations, developing activities to address barriers for reaching the target populations and ensuring that proper documentation is collected.

Section III. How will we get there?

The Georgia HIV Office's FY 2012-2015 Statewide Comprehensive HIV Health Services Plan on pages 75-87 provides the goals, objectives, and strategies that will be used to guide further development and monitoring of the state's HIV/AIDS health care delivery system over the next three years.

Georgia's Statewide FY 2012-2015 Comprehensive HIV Services Plan

Goal 1: Improve access to HIV-related core services.

Objectives	Strategies	Time Frame	Accountability	Measure
1.1. Ensure continuity and availability of HIV primary care consistent with Public Health Services guidelines.	1.1.1 Identify and assure points of entry for services exist in each health district.	Years 1-3	Part A Grantee, Part B Grantee Offices	1.1.1 HIV clinics in each health district and EMA.
	1.1.2 Establish system to regularly disseminate current contact information on all identified access points to providers throughout state.	Years 1-3	Part A Grantee, Part B Grantee Offices	1.1.2 HIV clinic and contact information posted on HIV Office and Ryan White Part A website.
	1.1.3 Assure transitional discharge planning for incarcerated individuals.	Years 1-3	Part B Grantee Office, Georgia Department of Corrections	1.1.3 The number of inmates who received an encounter with a case manager.
	1.1.4 Facilitate implementation of prescriptive authority for APRN's working in public health HIV clinics.	Years 1-3	Part B Grantee Office, HIV Nurse Consultants, HIV Coordinators	1.1.4 Number of trainings and/or meetings related to facilitating the prescriptive authority process.
1.2. Evaluate and respond to the changing healthcare environment to assure HIV health and support services are available and accessible.	1.2.1. Follow directives from the Affordable Care Act and/or Ryan White Reauthorization as applicable.	Years 1-3	Part B Grantee Office, health districts	1.2.1 Grantee Report • Review HRSA directives • Assessment reports • List and description of environmental changes • List and descriptions of adjustment

Objectives	Strategies	Time Frame	Accountability	Measure
				and modifications • Health districts consumer surveys • Review of budget revision requests
1.3. Assure health districts are aware of changes in the health and support service access and availability to help clients navigate the system of care.	1.3.1. Communicate effectively with health districts utilizing a variety of communication methods, including e-mail, website, conference call, and others.	Years 1-3	Part B Grantee Office	1.3.1 HIV Office website contains most updated information related to changes in health and support service access and availability. At least annually, sites will be provided the most updated information about changes in health and support services.
1.4 Assure consumers are consistently informed about changes in health and support service access and availability, as well as aware of available supports/resources to respond to their changing needs.	1.4.1. Encourage health districts to communicate with consumers utilizing a variety of communication methods, including posting changes and via case managers or other staff. 1.4.2. Include in district liaison site visit tool a question regarding methods of informing consumers of changes in health and support services provided.	Years 1-3 Years 1-3	Part B Grantee Office, HIV Coordinators	1.4.1-2. Number of health districts compliant with informing consumers of changes in health and support services provided (assessed annually).

Objectives	Strategies	Time Frame	Accountability	Measure
1.5 Assess barriers to accessing core and support services to identify potential solutions and best practices.	1.5.1 Explore ways to maximize available resources for dental services. 1.5.2. Explore ways to maximize available resources for case management services. 1.5.3. Explore ways to maximize available resources for transportation services. 1.5.4. Explore ways to maximize available resources for substance abuse/mental health services. 1.5.5. Explore ways to maximize available resources for primary care services.	Years 1-3	Part B Grantee Office, HIV Coordinators	1.5.1 Percentage of clients who received an oral exam by a dentist in the measurement year. List dental resources and barriers by health district. 1.5.2 Percentage of medically case managed clients who had an Individualized Service Plan (ISP) developed within 30 days of intake and updated 2 or more times in the measurement year. 1.5.3 List transportation resources and barriers by health districts. 1.5.4 List substance abuse/mental health resources and barriers by health districts. 1.5.5 List primary care resources and barriers by health districts.
1.6 Assess and enhance access to HIV medications.	1.6.1 Collaborate with Medical Advisory Committee to ensure newly FDA approved medications are added to the ADAP formulary. 1.6.2 Improve ADAP application process (e.g., web based application process).	Years 1-3 Years 1-3	Part B Grantee Office, Medical Advisory Committee	1.6.1 Number new FDA approved ADAP medications added to the ADAP formulary. 1.6.2 Implementation of a web-based ADAP application process.

Objectives	Strategies	Time Frame	Accountability	Measure
	1.6.3 Revise and disseminate HICP and ADAP policies and procedures.	Years 1-3		1.6.3 HICP and ADAP policies revised and posted on HIV Office website.
	1.6.4 Maintain a policy to allow Advanced Practice Registered Nurses (APRN) and Physician Assistant (PA) ADAP and HICP prescriptive authority	Years 1-3		1.6.4 ADAP APRN and PA Policies maintained and revised as needed.
	1.6.5. Continue to implement a process to assist clients with Medicare Part D co-payments for medications, as well as co-payments for PCIP.	Years 1-3		1.6.5 Number of clients receiving assistance with Medicare Part D and/or PCIP co-payments for medications.

Goal 2: Improve the quality of HIV core services and health outcomes.

Objectives	Strategies	Time Frame	Accountability	Measure
2.1. Assure standards of care, including Public Health Services (PHS) guidelines and best practices, are consistently applied in the provision of HIV services.	2.1.1 Monitor HIV/AIDS Bureau (HAB) Performance Measures.	Year 1-3	Part B Grantee Office, SEATEC	2.1.1 Performance measure reports monitored at least quarterly.
	2.1.2 Collaborate with SEATEC to provide education and training as needed to providers.	Year 1-3		2.1.2. Number of trainings conducted.
	2.1.3. Mentor HIV inexperienced providers.	Year 1-3		2.1.3 Number of providers mentored.
	2.1.4. Notify providers of revised PHS Guidelines.	Year 1-3		2.1.4 Providers updated of revised Guidelines at least biannually.
2.2. Improve HIV/AIDS case management services throughout Georgia.	2.2.1. Provide case management training.	Year 1-3	Part B Grantee, SEATEC, QM Core Team Case Management Subcommittee	2.2.1 Number of trainings conducted.
	2.2.2. Revise the Georgia HIV/AIDS Case Management Standards.	Year 1-3		2.2.2 CM Standards revised and finalized.
	2.2.3. Conduct case management chart reviews.	Year 1-3		2.2.3 Number of CM chart reviews completed.

Objectives	Strategies	Time Frame	Accountability	Measure
2.3. Implement statewide Ryan White Part B quality management plan.	2.3.1. Provide training in quality management.	Year 1-3	Part B Grantee Office, Quality Management Core Team	2.3.1 Number of quality management trainings conducted.
	2.3.2. Assure quality improvement projects occur at state and local levels.	Year 1-3		2.3.2 Number of district QM Plans reviewed containing quality improvement projects.
	2.3.3. Communicate findings to key stakeholders at least biannually.	Year 1-3		2.3.3. Findings disseminated to stakeholders at least biannually.
	2.3.4. Update the QM plan at least annually and the QM work plan at least quarterly.	Year 1-3		2.3.4 QM Plan and work plan updated.
	2.3.5. Require that all Ryan White Part B funded-sites revise written QM plans annually.	Year 1-3		2.3.5 Number of districts revising written QM Plans annually.
	2.3.6. Maintain QM Core Team.	Year 1-3		2.3.6 Number of QM Core Team meetings.

Objectives	Strategies	Time Frame	Accountability	Measure
2.4. Improve recruitment and retention of health care staff.	2.4.1 Assess barriers to recruitment and retention.	Year 1-3	Part B Grantee Office, SEATEC	2.4.1 List the barriers identified for the recruitment and retention of healthcare staff.
	2.4.2 Mentor HIV inexperienced providers.	Year 1-3		2.4.2 Number of HIV inexperienced providers mentored.
	2.4.3. Collaborate with SEATEC to provide training and onsite technical assistance.	Year 1-3		2.4.3 Number of trainings conducted.

Objectives	Strategies	Time Frame	Accountability	Measure
2.5. Adapt the Georgia Department of Public Health, HIV Office, practices and guidelines as needed to align with the National HIV/AIDS Strategy, Healthy People 2020, the HIV/AIDS Bureau (HAB) Measures, and other state and federal initiatives focused on reducing health disparities.	2.5.1 Review National HIV/AIDS Strategy. 2.5.2 Review Healthy People 2020. 2.5.3 Review HAB Measures and DHHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health care. 2.5.4 Review other federal and state initiatives to identify policies and best practices to reduce health disparities.	Year 1-3 Year 1-3 Year 1-3 Year 1-3	Part B Grantee Office	2.5.1-4 Documents were reviewed for policies and best practices.

Goal 3: Increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment.

Objectives	Strategies	Time Frame	Accountability	Measure
3.1. Identify individuals unaware of their status.	3.1.1 Request that local health districts evaluate HIV counseling and testing data to determine individuals who tested confidentially and did not receive their results, and follow up with those individuals.	Year 1-3	Part B Grantee Office, DPH HIV Prevention Program, HIV Coordinators	3.1.1 Number of individuals tested confidentially who did not receive their results.

Objectives	Strategies	Time Frame	Accountability	Measure
	3.1.2 Request that local health districts determine individuals with preliminary positive results who did not receive confirmatory testing, and follow up with those individuals. 3.1.3 Implement a statewide social marketing campaign for general HIV awareness to encourage testing and linkage to care.	Year 1-3 Year 1-3		3.1.2 Number of individuals with preliminary positive results who did not receive confirmatory testing. 3.1.3 Number of social marketing deliverables (ie, public service announcements, ads, billboards).
3.2. Collaborate with counseling and testing and prevention programs to facilitate identification of individuals unaware of their status and link them to care.	3.2.1 Standardize protocols for HIV care referral. 3.2.2 Standardize linkage Antiretroviral Treatment Access Study (ARTAS) protocol to ensure the client has one provider appointment within 90 days of first contact.	Year 1-3 Year 1-3	Part B Grantee, DPH Prevention Program	3.2.1-2 Standardized protocols developed and implemented.
3.3. In collaboration with the HIV Prevention program in the Georgia Department of Public Health and federal Department of Health and Human Services (DHHS) directly funded entities (e.g., health departments,	3.3.1 Develop an action plan to facilitate integration and coordination between prevention and care. 3.3.2 Implement action plan and monitor effectiveness of coordinating prevention, care and treatment.	Year 1-3 Year 1-3	Part B Grantee Office, DPH Prevention Program	3.3.1 Action plan developed. 3.3.2 Action plan implemented and monitored for effectiveness.

Objectives	Strategies	Time Frame	Accountability	Measure
community based organizations) develop and implement strategies to facilitate integration of care, treatment and prevention.				

Goal 4: Reduce health disparities.

Objectives	Strategies	Time Frame	Accountability	Measure
4.1. Identify health disparities and barriers to care.	4.1.1 Develop the statewide needs assessment.	Year 1-3	Part B Grantee Office, SEATEC	4.1.1-3 Statewide needs assessment developed, implemented and analyzed.
	4.1.2 Implement the statewide needs assessment.	Year 1-3		
	4.1.3 Analyze findings and prepare a written report.	Year 1-3		
4.2. Improve cultural competency of service providers and programs.	4.2.1 Coordinate training and education on cultural competence issues (i.e., language, race/ethnicity, literacy, religion, sexual orientation, gender identity, physical challenges).	Year 1-3	Part B Grantee Office, SEATEC	4.2.1 Number of trainings conducted and/or integration of cultural competence training into program-specific training requirements.
	4.2.2 Maintain client involvement in planning and implementation of programs.	Year 1-3		4.2.2 Continue to require client representation on district Consortia Planning Committees.
	4.2.3 Encourage the use of culturally and linguistically appropriate materials and resources.	Year 1-3		4.2.3 Number of districts funded to provide language services.
4.3. Improve the utilization of	4.3.1 Encourage Part B providers to budget funds for interpretation	Year 1-3	Part B Grantee Office, HIV	4.3.1 Number of clients receiving interpretation and/or translation

interpretation and translation services for clients.	services where needed.		Coordinators	services.
4.4 Maximize opportunities for clients to access affordable, stable and safe housing.	4.4.1 Maintain the case management intake process, including housing assessment. 4.4.2. Ensure clinic sites, community-based organizations, and other providers have current housing resource information for their area.	Year 1-3	Part B Grantee Office, HIV Coordinators	4.4.1 Case management housing assessment maintained. 4.4.2 Resource information disseminated as available (i.e., number of Key Contacts provided).
4.5 Advocate for policy change.	4.5.1 Continue to advocate for Georgia Ryan White clients during the implementation of the Affordable Care Act (ACA), the reauthorization of the Ryan White Care Act and other changes in the healthcare landscape.	Year 1-3	Part B Grantee Office	4.5.1 Number of advocacy activities and/or processes implemented.

Goal 5: Enhance collaboration and communication with partners statewide

Objectives	Strategies	Time Frame	Accountability	Measure
5.1. Engage key stakeholders, including but not limited to Program Collaboration Service Integration (PCSI), HIV Office, Prevention Section grantees, Early	5.1.1 Coordinate statewide HIV/AIDS meetings to share information and best practices, and identify collaborative opportunities. 5.1.2 Maintain Part B participation in all identified stakeholder activities and committees.	Year 1-3 Year 1-3	Part B Grantee Office, DPH Prevention Program	5.1.1 Number of meetings held. 5.1.2 Number and type of committee participation.

Identification of Individuals with HIV/AIDS (EIIHA), Substance Abuse and Mental Health Services Administration (SAMHSA), Community Planning Group (CPG), the AIDS Drug Assistance Program (ADAP), ADAP Contract Pharmacy Network (ACP), Health Insurance Continuation Program (HICP), Preexisting Condition Insurance Plan (PCIP), Test-Link-Care Network, private providers, all Ryan White Parts, Medicaid.				

A. Strategy, plan, activities (including responsible parties, and timeline) to close gaps in care

Strategies, plans, activities and timeline to close gaps in care are outlined in 2012-2015 Comprehensive Plan Goals 1, 2, 3, and 4 on pages 75, 79, 82 and 85. These goals support the provision of a coordinated, integrated and comprehensive system of care that is responsive to the needs of individuals with HIV/AIDS and helps closes the gaps in prevention and treatment services for these individuals.

Unmet Need results support the continuation of currently funded components of the care system including: activities to track individuals lost to care and bring them back into care (e.g., phone calls and letters after missed appointments, outreach to physically locate individuals, etc.), and linkages to care for individuals testing positive through Parts A and B primary care sites, Part C early intervention clinics, and at HIV counseling and testing sites. The state's HIV system of care is consistent with HRSA and NHAS goals of increasing access to services and decreasing HIV health disparities among affected subpopulations and historically underserved communities.

B. Strategy, plan, activities (including responsible parties), and timeline to address the needs of individuals *Aware* of their HIV, but that are not in care (with an emphasis on retention in care)

Strategies, plans, activities and timeline to address the needs of individuals aware of their HIV status but are not in care are outlined in 2012-2015 Comprehensive Plan Goals 1, 2, 3, and 4 on pages 75, 79, 82 and 85. The HIV Office and its other Ryan White partners (e.g., Parts A, C, D, F) will continue to work on identifying and addressing barriers that clients face in accessing primary care services. To address reported information barriers, Part B providers will use on-site medical case management to provide clients with information about available services. As additional persons are brought into primary care, the HIV Office and partners will evaluate the impact on the continuum to ensure the availability and accessibility of comprehensive services.

C. Strategy, plan, activities (including responsible parties), and timeline to address the needs of individuals *Unaware* of their HIV status (with an emphasis on identifying, informing, referring, and linkage to care needs)

Strategies, plans, activities and timeline to address the needs of individuals unaware of their HIV status are outlined in 2012-2015 Comprehensive Plan Goal 3 on pages 82 and 84**.**
As described previously, the Georgia Department of Public Health (DPH) is the recipient of the majority of prevention funding through the CDC Prevention Program. Counseling, testing and referral services target MSM, homeless, and African American heterosexual males and females.

Activities include linkage to care, evidence-based intervention in clinical and group settings, and case finding. These activities facilitate identifying individuals unaware of their status and promote linkage to primary care.

The Part B activities to address the needs of individuals unaware of their status and not in care will be coordinated with other programs/facilities and community efforts through information updates and progress reports provided by community partners at regularly scheduled EIW meetings. This will allow us to reduce duplication of effort, identify barriers to success or share best practices, support State policy and procedure updates (i.e., 'opt-out' or routine HIV testing) through distribution at jointly funded Ryan White sites, strengthen coordination between the correctional facilities and treatment sites, and evaluation of the EIW's social network.

EIIHA activities and strategies have been included in the Part B Request for Proposals (RFP) and will be included in future RFPs. Ryan White Part B applicants are required to describe current and proposed linkages with agencies that provide primary prevention and HIV counseling and testing. Descriptions of the target populations and activities in place to assure all clients are linked and maintained in care are also required.

D. Strategy, plan, activities (including responsible parties) for addressing the needs of special populations including but not limited to: adolescents, injection drug users, homeless, and transgender.

Goal 4 (To reduce disparities) on page 85 addresses the needs of special populations. Ryan White Part B addresses disparities in access and services among affected subpopulations and historically underserved communities through its identification of target populations and implementation of activities to eliminate barriers to counseling and testing, enrollment, and retention in treatment services. Ryan White Part B funds geographically located primary care sites, and access to other core medical and supportive services including medical transportation, peer counseling, and linguistic services.

Ryan White Part B funded health districts conduct individualized cultural competence activities to address the subpopulations represented in their clinics. Each local health district in collaboration with their consortium explores the special populations for their local geographic area, and develops strategies and activities to address their needs. Cultural competence activities are also supported statewide; for example all nursing staff must complete cultural competence training as part of the clinic orientation and training process. The HIV Office provides technical assistance to the local districts in developing their strategies and activities.

E. Description of activities to implement the proposed coordinating effort with the following programs to ensure optimal access to care:

Part A Services: Part B will coordinate with Part A in all aspects of EIIHA as well as data collection and sharing through the active participation on the EIW, collaboration on specific activities through quarterly updates, and ensuring that Part B primary care sites are participants in the ADAP network and aware of the HICP and PCIP.

Part B will also coordinate with Part A to ensure that funded providers are reporting cases to the state, that clients have received partner services, that routine opt-out HIV testing is integrated in other care settings for individuals seeking care for STIs (syphilis, gonorrhea, and Chlamydia), HBV and HCV and all individuals who present to their TB clinic for TB screening, medication or follow-up. Individuals who test positive are linked into HIV treatment and care while at the testing or clinic site.

With respect to referral to medical care and services, planned activities include ensuring access to a resource listing of care and treatment service providers, and prevention and counseling and testing programs across the state. These activities will assist in the referral process to facilitate access to care and treatment; as well as the development of inventive ways to educate providers on available resources to encourage referral. In addition, Part B will coordinate with prevention and disease control programs by providing the resource listing for distribution to all prevention and counseling and testing programs to be utilized in the referral for medical and support services.

Part B and Part A program staff will continue to participate in meetings periodically to update each other on successes, barriers to provision of services, and efforts to address barriers.

Part C Services: Part B will ensure that Part B funded HIV care sites that are also Part C funded recipients describe and demonstrate how Part B funds will be coordinated with Part C. Part B funds will not supplant services funded by Part C, or for any other funding source.

Part D Services: Part B will continue to work with the funded Part D providers in the Southeast Health District in Waycross, GA and the Atlanta Family Circle Part D Network to coordinate the referral to and provision of services for women, children, and youth living with HIV/AIDS. Part D agency representatives will continue to participate in statewide committees and meetings to facilitate communication and coordination of services.

Part F Services: SEATEC will provide training and mentoring for Part B providers to ensure the provision of quality services. The HIV Office will continue collaborations with SEATEC to develop and implement special projects statewide.

Private providers (Non-Ryan White funded): Persons receiving primary care services from private providers who meet Ryan White eligibility criteria will continue to be able to enroll in other Part B funded services, including core medical and support services along with access through State ADAP, HICP and PCIP.

Prevention programs including: Partner Notification Initiatives and Prevention for Positive Initiatives: To increase access to care and improve health outcomes for people living with HIV, Part B will continue to work with the Georgia Department of Public Health HIV Prevention Program to participate in Program Collaboration Service Integration (PCSI), which includes TB, STD, Hepatitis, Refugee Health, and HIV. This organizational structure and collaboration allows for coordinated efforts to conduct partner notification and identify individuals unaware of their HIV status.

Part B will also coordinate with prevention and disease control intervention programs through collaboration and participation on the Community Planning Group (CPG) by Ryan White Part B leadership to ensure the sharing of information pertaining to prevention, screening and treatment. Ryan White Part B staff will assist the HIV Prevention Program in developing Prevention Plans, including strategies for ensuring that individuals are provided their positive or negative test results. Part B funded providers will ensure appropriate case reporting.

Substance abuse and mental health treatment programs/facilities: To enhance substance abuse and mental health services, Part B will continue to fund substance abuse treatment programs to expand capacity and facilitate access to care and treatment. This will help address the increasing demand for substance abuse and mental health treatment services for individuals living with HIV/AIDS in the state.

STD programs: HIV/STD Programs are co-located in health departments in Georgia Department of Health. Persons who test positive in the STD clinics will continue to be counseled and linked to care. Part B providers will continue to utilize health department Communicable Disease Specialists for partner notification and assistance in directing clients to primary care sites.

Medicare: The Part B HIV care sites will continue efforts to enroll clients in Medicare for coverage of medications to maximize Part B funds needed for HIV medications.

Medicaid: The Part B HIV care sites will continue efforts to enroll eligible clients in Medicaid.

Children's Health Insurance Program: Part B will continue to provide enrollment in PeachCare (Georgia's SCHIP) by referral or on-site at all HIV care sites although the majority of infants, children and youth (l8 and under) receive services at the Grady IDP in Atlanta, the HOPE Center in Macon, and the Southeast Health District in Waycross. Families are assigned a

social worker who assists with the enrollment process.

Community Health Centers: Part B will continue to fund AID Gwinnett and Clayton County Board of Health, who are applying to become Federally Qualified Health Centers (FQHCs). These clinics provide comprehensive services such as primary care, mental health treatment, substance abuse treatment, oral health care, medical case management, and support services. Part B will continue to involve FQHCs in statewide planning processes.

F. How the plan addresses Healthy People 2020 objectives

The Georgia Part B Program 2012-2015 Comprehensive Plan is compatible not only with the Healthy People 2020 major goals of increasing the quality and years of a healthy life of all Americans and eliminating the country's health disparities, but also with specific Healthy People 2020 objectives. The Part B's 2012-2015 Goals 1 and 2 (*improve access to HIV related core services; Improve the quality of HIV core services and health outcomes*) will increase the quality and years of healthy life for people living with HIV/AIDS by providing an HIV/AIDS service delivery system that includes comprehensive health and support services and is flexible and responsive to a client's changing needs. Goal 3 (*increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment)* will assist in increasing the proportion of people living with HIV who know their status, and reduce HIV transmission by linking and retaining those individuals in care. Goal 4 (*reduce health disparities*) will facilitate identification of populations and communities with disparate health outcomes and develop and implement strategies to increase access to health services and related support services in order to reduce disparities. Goal strategies will also include adapting Part B practice and guidelines as needed to align the National HIV/AIDS Strategy, Healthy People 2020, the HIV/AIDS Bureau (HAB) Measures, and other state and federal initiatives focused on reducing health disparities.

The Healthy People 2020 (HP2020) HIV topic area objective most directly aligned with the purpose of the Ryan White Part B Program and the strategies outlined in the State of Georgia 2012-15 Comprehensive Plan is *HIV-10: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.* The Part B continuum of care efforts also demonstrates accordance with the following Healthy People 2020 *Oral Health* and *Sexually Transmitted Disease* topic areas:

HIV HP2020-1: Reduce the number of new HIV diagnoses among adolescents and adults. (*State of Georgia 2012-2015 Goal 3*)
HIV HP2020-2: Reduce new HIV infections among adolescents and adults. (*State of Georgia 2012-2015 Goal 3*)
HIV HP2020- 3: Reduce the rate of HIV transmission among adolescents and adults. (*State of Georgia 2012-2015 Goals 2 and 3)*

HIV HP2020- 4: Reduce the number of new AIDS cases among adolescents and adults. (*State of Georgia 2012-2015 Goals 1 and 4*)
HIV HP2020-5: Reduce the number of new AIDS cases among adolescent and adult heterosexuals. (*State of Georgia 2012-2015 Goals 1 and 4*)
HIV HP2020-6: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men. (*State of Georgia 2012-2015 Goals 1 and 4*)
HIV HP2020-7: Reduce the number of new AIDS cases among adolescents and adults who inject drugs. (*State of Georgia 2012-2015 Goals 1 and 4*)
HIV HP2020-8: Reduce the number of perinatal acquired HIV and AIDS cases. (*State of Georgia 2012-2015 Goals 1, 2, 3 and 4)*
HIV HP2020-9: Increase the proportion of new HIV infections diagnosed before progression to AIDS. (*State of Georgia 2012-2015 Goal 3*)
HIV HP2020-10: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards. (*State of Georgia 2012-2015 Goals 1 and 2)*
HIV HP2020-11: Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS. (*State of Georgia 2012-2015 Goals 1, 2, 3 and 4*)
HIV HP2020 -12: Reduce deaths from HIV infection. (*State of Georgia 2012-2015 Goals 1, 2, 3 and 4*)

G. How the plan reflects the Statewide Coordinated Statement of Need (SCSN)

The purpose of the Statewide Coordinated Statement of Need (SCSN) is to provide a collaborative mechanism to identify and address the most significant needs of people living with HIV/AIDS disease (PLWHA) and to maximize coordination across Ryan White Programs. Georgia developed its first SCSN in 1998 and updated it every three years thereafter. On May 2-3, 2012, the Georgia Department of Public Health, HIV Office convened a statewide meeting in Atlanta, Georgia to update the state's 2009-2012 SCSN.

The May 2012 SCSN meeting was the collective efforts of a planning committee consisting of eighteen (18) individuals representing Ryan White providers and HIV service providers. The planning committee was dedicated to developing a SCSN process that would result in useful data and to have wide range HIV service providers and consumers participants. Each planning committee participant was asked to forward the registration for the 2012 SCSN to their HIV Service Providers. All Part B recipients were invited and were asked to bring two (2) consumers. To maintain the focus of the SCSN on overarching goals, the planning committee decided to update the 2008 SCSN Input Summary, revise the questions asked in the 2008 SCSN, collect updated information, and maintain the types of focus groups from that meeting.

The 2012 Georgia SCSN meeting was well attended with a total of 162 participants including Ryan White providers, other HIV service providers (prevention and treatment), public agency representatives, and persons living with HIV/AIDS. (See Appendix 1-4 for meeting agenda and other meeting materials.)

REPRESENTATIVES PARTICIPATING IN SCSN UPDATE MEETING

Part A Grantee, Planning Council representatives
Part A Funded Agencies
Part B Grantee, District Representatives, and Subcontractors
Part C Grantees
Part D Grantee, Atlanta Family Circle Part D Director and Project Coordinator, Subcontractors
Part F – Southeast AIDS Education and Training Center
Persons Living with HIV/AIDS
Community Based Organizations
Faith Based Organizations
Substance Abuse and Mental Health Organizations
HIV/AIDS Surveillance
Georgia Department of Behavioral Health and Developmental Disabilities – Divisions of Mental Health and Addictive Diseases
Georgia Department of Community Health, Division of Medicaid – Aging and Special Populations
Georgia Department of Corrections
Veterans Administration Medical Center, Infectious Diseases
State Refugee Health Program
HIV Prevention Providers
Georgia Health Sciences University
Kennesaw State University

Day one included presentations on HIV/AIDS in Georgia (epidemiological data and consumer survey data), an overview of the national HIV/AIDS strategy and its impact on Georgia, and an update on Georgia's 2009-2012 Comprehensive Plan. On the morning of day two, meeting participants were divided into six groups: administrators (2 groups), clinical care providers, social service providers, women consumers, and men consumers. The groups were asked to brainstorm responses to four questions:

1) What is working well?
2) What are the gaps in the provision of services for persons living with HIV/AIDS in Georgia?
3) Why are these gaps occurring?

4) What are the top issues on the horizon that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia?

In the afternoon, participants were assigned to one of five geographical focus groups: Metro Atlanta 1, Metro Atlanta 2, North Georgia, Middle Georgia, and South Georgia. Focus group participants were asked to help identify strategies to address key barriers or issues impacting access to HIV care. Each group developed strategies for at least three of the following barriers/issues:

1) How do we help persons who know their status and are not in care, access care?
2) How do we help them stay in care and fully participate in that care?
3) How do we reach persons who do not know their status?
4) How do we increase HIV testing?
5) How do we improve referral and linkage systems?
6) How do we develop and implement community-level approaches to reduce health disparities among young MSM of color?
7) How do we develop and implement community-level approaches to reduce health disparities among African-American women?
8) How do we develop and implement community-level approaches to reduce health disparities among adolescents?
9) How do we develop and implement community-level approaches to reduce health disparities among Hispanics/Latinos?

The tables beginning on page 97 provide a compilation of the comments that resulted from the focus groups discussions on day two. It is important to note that the need statements and gaps and barriers are not presented as, nor intended to be, a comprehensive listing of these issues nor do they necessarily represent a consensus. Instead, the SCSN seeks to highlight the most common perceived issues in providing HIV related services to consumers. Rather than an exhaustive list of specific needs, this document includes generalized descriptions that encompass many client needs. Additionally, the needs are not prioritized due to greatly varying geographic differences in intrinsic level of need. Finally, not all of the needs listed are, or can be, addressed by Ryan White programs.

Participants were surveyed at the completion of the meeting to determine there level of satisfaction with the process. A Lickert Scale was utilized in the evaluation process to determine responses. On a scale of 1 to 5, 1 = strongly agree and 5 = strongly disagree. A total of 106 participants completed the survey. Overall the meeting was well received by participants. Fifty-nine (59) percent of participants strongly agreed that the meeting was beneficial, additionally; thirty-nine (39) percent agreed the meeting was beneficial. Sixty-nine (69) percent strongly

agreed that they had opportunities to express their opinions during the meeting and twenty-eight percent agreed with this statement. (There were no 4's or 5's received for this question.)

SCSN Stakeholder Summary Tables
Georgia SCSN Meeting – May 2-3, 2012

What's working well	Administrators (divided into two groups because of size)	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Improvement in CAREWare documentation	Quality management (QM) - QM program progress with benchmarks from state and HRSA (with completion of RSR are able to get benchmark information – gives you a sense of where you are and where you want to focus on quality indicators - QM has improved and is more meaningful - Quality in public health – has been an improvement in quality structure in Ryan White. Really have performance measures that have had an upward movement. There is access to quality care	Supplemental transportation	OB/GYN services	Specialty care referrals for oral health (Douglas, GA – Waycross, GA)
	Coordination of services - Can be hard work, especially with changes at the State (see barriers)	Training - Training is better/good – between SEATEC and the State, between HIV basic and care. Trying to get more TB testing and similar topics - More webinars has helped	Consumer involvement on planning council – leadership	Peer advocacy program	Patient flow (less time waiting in lobby or waiting area)

What's working well	Administrators (divided into two groups because of size)	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Collaborative and better communication between Ryan White Parts	Nationally VA has been proactive related to HIV (last year VA lab tested 19,000 people –huge effort related to federal law for testing and counseling being repealed – are now able to test a huge number of people	Clinic appointments within 2 weeks upon release from prison	Primary care physicians and services	Primary care (Atlanta, GA) (Specially named Grady IDP – great clinic, provides seminars from pharmaceuticals) Increased self management
	Low turnover of providers, excellence in care, level of experienced providers	HIV screening in substance abuse clinics	Better communication - Inter- and Intra-clinic/agency relationships due to internal training - between office staff and CMS has improved with ADAP staff regarding the wait list (with some districts)	Case management services	Support groups for substance abuse and PLWHA (specifically named Fulton County Department of Health and Wellness)
	Fewer HICP complaints	Grady has removed barriers to HIV testing	Dental - Relationship with dental providers - Peer advocate, dental (Waycross) - Waycross dental services (also cited EMR and case management in Albany)	The clinics, labs, medications that are all accessible at one location, i.e., one stop shopping" (Grady IDP, Absolute Care, Decatur VA, Newnan's Haven Hope)	Food/Nutrition assistance (Specifically mentioned Meals on Wheels that serve in Atlanta, GA)

What's working well	Administrators (divided into two groups because of size)	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Drug assistance program (PAP)	Access to providers has somehow improved	Advisory groups - Grady IDP Youth Advisory Group - Client Advisory Board (Newnan, Grady IDP)	Peer advocates	Walk in clinic services - no appointment necessary, seen an increase number of people who access this service (Dalton, GA)
	Focus on quality of care (quality indicator targets)	ADAP working well by not going through Grady. Clients are happy with less medication waste and local pharmacist has gotten very involved in counseling clients	Linkage to care (IDP) - Adolescent clinic linkage to other facilities (Young Adult Network/YAN, newly diagnosed – IDP, teenagers transitioning in their last 3 months) African American Outreach Initiative linkage to care strategies to link people not in care to substance abuse services, case management, and medical care	Food services	Case management is good (Dougherty County), but not as good as in Atlanta.
	State office staff support; responsive (part B)	Better collaboration - with Grady IDP, state leadership (i.e. QM Process), Dr. Katner and Medical Advisory Committee, local dentists - with new clients (i.e. Consumer Advisory Boards), Part A consumer caucus, community leaders	Good collaboration between legal and case management. Also with private attorneys.	Client-provider relationship	'Wrap-around' services with all services being accessed through different Parts in one location.

What's working well	Administrators (divided into two groups because of size)	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Good use of consumer input	Patient Assistance Programs (PAP) working well	Advocacy efforts	Availability of educational materials	Contract pharmacies – money savings, drugs not being destroyed, home deliveries.
	Access and availability of services in each district	Case management services help maximize primary care	HOPWA	Some agencies clearly outline funding	Nursing case management (Dalton)
	Effective documentation of services	Expanded age range for pediatric care – continuing pediatric clinic to age 25 has helped with retention of adolescents	Electronic medical records and technology (being able to access information electronically)		Patient empowerment is good, but client capability to be empowered should be assessed
	Provision of surveillance data	Peer programs are working well although not to their full potential	Better reporting from private providers		Consumer advisory boards (Muscogee County, GA)
	Positive individuals finding our clinic	Having many services in one clinic works well	Utilization of peers		SCSN and similar meetings
	Testing programs and targeted HIV interventions by CDC	Outreach and collaboration with high risk OB	Case management training and peer advocate program (Albany)		African American Outreach Initiative (AAOI) in Atlanta.
	HIV Early Intervention services (substance abuse) linking well with HIV treatment services	Savannah – participating in clinical trials. Can get on meds and provide a better outcome. Provides funding for clinic to hire additional staff.	Reduction efforts for out-of-pocket expenses (Medicaid, insurance)		Transportation issues between services that may be referred by service providers
	Newly diagnosed individuals able to access care fairly quickly	Grady IDP – compassionate use - by using pharmaceutical companies for peds with a lot of resistance	Patient Assistance Programs are working well fill in the gap with ADAP		
	ARTAS program	Rotating staff among different clinics addresses access to care (satellite clinics) in rural areas			

What's working well	Administrators (divided into two groups because of size)	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	InCare campaign – retention strategies	Using Telehealth - physician does not have to go back and forth so much			
	Collaboration with other partners – like colleges, private CBOs – to get work done	Good participation with consumer advisory boards – good to have opportunity to hear clients' perspectives			
	Willingness of ADAP to take on pilots to transfer ADAP clients to PCIP				
	Partner services in districts (prevention and care)				
	Budget flexibility				

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Primary care	HOPWA working well in some places, but not in others	Need patient navigation services	Case management for the self-managed	Impact on budget cuts – consumers need to know
	Oral health, including insufficient funding	Referrals to clinic are delayed – referral process in private sector as well as knowledge of resources and appropriate management	Oral health services in many geographic locations in the state	Transportation	SSI eligibility should continue with HIV diagnoses not only AIDS diagnoses

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Subspecialty care (GYN, Orthopedics) – limited funds to pay for specialty care	Adolescents/Teenagers - behaviorally acquired and not referred for 6 months and then becoming complicated to manage - may not adhere to meds and waste medication	Loss of funding for CDS staff	Funds for emergencies (i.e., housing and utilities)	Need to strengthen the usage of electronic medical records and systems
	Job training – limited job supply, lower education level	Primary care gaps in HIV setting	HOPWA is non-existent (District 4)	Coordinated medical services	Access to after hour services – at least one wellness center open on weekends
	Integrated care (Women, Youth)	Access for transgenders - difficult to keep in care, housing, etc	Transportation	Adherence counseling	Less stringent housing criteria
	Housing	Lack of resources for Hep C - private sector, no funding for Medicaid/Medicare to pay, expense of labs	Access to food banks	Providers	Substance abuse and mental health services
	Needs of low-income population	ADAP - Need to maximize ADAP funding opportunities – Medicare Part D bureaucratic collaboration - Electronic filing for ADAP applications	Housing - Housing in general - Housing for felons (sex offenders)	Confidentiality	Vision care
	Aging population – Co-morbidities. Not clear what "geriatric" means.	Transportation to care	Prevention efforts	Takes too long to get medication after it is called in	Peer advocates and counselors

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Incarceration Issues - discharge planning, limited medication supply - Prison release services - Felons' ineligibility for services (i.e. Augusta) - Different providers serve different jails and lack of coordination	DPH bureaucracy	Funding	Lack of support for peer programs – why is peer position a volunteer position? Why are they not given anything or as much respect as other positions (Would be nice to have paid positions, structured plans in place, retreat, etc.)	Sub-specialty (mixed discussion)
	Mental Health Services - in rural areas, for undocumented workers, substance abuse	Pharmacy services - Do not include pharmacist in patient care team - ADAP pharmacists do not have access to patient ADAP data through dataRx	Providing services to consumers above the poverty level	Lack of information about services and providers (e.g., no primary care physician – does not know how to find one; had more funding in NYC)	Case management – overall too fragmented
	Training community health center staff about HIV/AIDS care – some are not willing to see HIV/AIDS patients without pay. Limited (acute) care provided, if any, in many rural areas.	Undocumented patients - Lack of services for pregnant, undocumented women	Uncertainty with case reporting when a client is referred from another agency	Supportive services, especially funding in rural areas (e.g., mental health, peer services)	Primary care doctors refusing Medicaid / Medicare clients

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Technology – telemedicine	Clients Lost to Care -unmet needs, retention, tracking	Access to Care -refugees, undocumented individuals, transgender persons	More collaboration with schools and community-based organizations	Facility space
	Legal services in rural areas – not available outside of Atlanta to protect the legal rights of HIV/AIDS patients, because of lack of funding	Access to education and lack of provider education	Data collection/access based on location for service integration	Marketing re: available programs - have to be pro-active to find what is out there	Staff training and shortages – not well trained and not enough of them
	Health information exchange – more funding needed	Limited providers for complex patients	Staffing - Lack of staff - Staffing expertise	Lack of faith-based support groups	Mental health services
	Stigma (primarily in rural areas)	Prescriptive authority for nurses in public health	Data collection for the non-identified risk group and no risk reported groups	Mental health services	Documentation of needs and what's not being provided as it relates to the client
	Substance abuse services in rural areas – no or limited programs available	Stigma	Life skills coaching (budgeting and employment, etc.)	Services to support "whole self" (e.g., healthy food, massage, nutrition education, etc.)	Nutrition / food pantry
	Access to healthy nutrition programs	Case management – screening people out of case management and they still need it	More outreach/prevention in colleges/universities	More participation from consumers in Ryan White consortium	Weak coordination of services across service providers

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Support systems /Education for peers – lack of funding in rural areas or motivation to train peers for other positions		Lost to care (target homeless population)		No merit for some service providers to provide quality services (an example shared was RateMyProfessor.com which allows students to provide feedback on their professors)
	Transportation Assistance –outside of Atlanta		Lack of education (schools, churches, colleges, general public, etc. that addresses discrimination)		Fragmented services and lack of communication between service providers
	Linguistic services and trained medical interpreters – bilingual does not equal interpreter		ADAP (waiting list, policy changes)		Weak leadership within service organizations
	Patients are losing insurance		Substance abuse and mental health		Clients are not always aware of what services are available
	OBs not testing women because of reimbursement issues (Medicaid will not reimburse for any test that the state lab will do). Have had six babies seroconvert recently.		Rise in STIs and Hep C		Rural areas do not have enough (if any at all) AIDS service organizations

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	New law requiring drug testing for individuals applying for TANF. Some HIV drugs "mimic" – individual on these drugs may test positive during drug testing. May have to disclose status. Also, patients with Substance Abuse (SA) problems who may lose benefits if they have to undergo a drug test.		Address issues for 45+ year old population		Not enough client satisfaction surveys / feedback regarding service providers and the availability of services available.
	Medical Case Management outside of Atlanta		Services for transgender population		Cultural barriers (e.g. lack of education, etc.)
	Services for transgenders (e.g., housing, job placement, lack of information on new rules & regs on housing and employment) – how to serve the transgender population as a whole		SSI/SSDI approval process – may take up to 2 years		People who fall out of services are not re-linked to services (follow up with lost to care clients)
	Physicians reporting "no identified risk" (NIR) – missing data, including risk factors. Need complete data sets.		Post release collaboration between jails/responses with case managers		Accessibility to assessments
	Out of pocket costs for patients		Poverty or unemployment		

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Staffing shortages and unrealistic demands within the districts				
	Services for undocumented individuals				
	Youth services – access issues for testing and treatment				
	Need to retrain staff on new ways of doing business (i.e. cultural diversity training for providers), especially staff who been there a long time.				
	Gaps in ADAP program – need better education for providers and consumers on how to access PAPs as well as mechanisms to help them access ADAP.				

Gaps/ Unmet Needs	Administrators (two groups)	Healthcare Providers (See barrier section below)	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Need to streamline ADAP process, e.g., electronic submission, web-based portals, telecase management programs like program in State of Washington. No need to reinvent the wheel. Look at Washington, Wisconsin and other states. Look at Medicaid system for Food Stamps.				
	Need to make use of all available resources while there is an ADAP waiting list, e.g., ADAP count as TROOP, using drug rebates, etc.				

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Limited funding	Longer turnaround to get patients in due to growth in number of patients coming into clinics	Funding – hard to retain staff, not enough pay leading to burn-out and high turnover	Dental care – lack of or delay in accessing care	Lack of service provider knowledge /familiarity with job description

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Funding policies – direct v. indirect expenses	Patients without ability to pay deductibles – impacts access to medications, labs	Politicians/supports don't care	Lack of insurance/eligibility (worry about loss if status is known)	Lack of familiarity with system navigation and when services are available
	Core v. Support Funding Model	Working with private providers for HIV testing for pregnant women – perinatal transmission	Impact of downturn of the economy (unemployment, etc.) on clients	Housing requirements to attain medication and services – need more adequate housing	Lack of cultural sensitivity from the provider
	Communication (i.e. No statewide listserv)	Paperwork involved with PAPs	Stigma (overall fear from dental offices), denial, shame	Lack of funding	Lack of planning and coordination of activities and services between agencies (i.e. providers) in rural areas
	Advocacy communication with consumers	Clients needing to inform case managers (?)	Refugees – language barriers, lack of translators	Stigma surrounding HIV/AIDS (e.g., perhaps work with college and high school professors and teachers to address stigma	Stigmas associated for heterosexual men accessing HIV-related services (i.e. heterosexual men being assumed to be homosexual)
	Lack of awareness/appreciation for nutrition	Private providers' lack of knowledge around state health benefits resources	Cultural sensitivity	Denial of HIV positive status (especially among young, newly diagnosed)	Lack of communication between state agencies
	Direct/indirect criminalization of HIV/AIDS clients	Difficulty finding peers to be peer advocates in pediatric/adolescent clinic due to stigma and reluctance to disclose	Need increased linkages for clients	Providers who do not accept Medicaid	There should be a portal for HIV services

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Housing - Affordability issues - Criminal history prohibits access to it	Difficulty for older peer advocates to relate to adolescents/children	Post-release collaboration between prison/jail and case management	Lack of services in particular areas of the state (e.g., Paulding County) – having to drive long distances to get services	Too much funding for top level position salaries instead of services
	Requirement for income before care (eligibility criteria for services)	Decreasing EFA funds	Proof of income requirements	Getting medication for other opportunistic infections/non-HIV meds	Better utilization of resources
	External/ internal stigma	Ability to access clinical trials in public health – loss of state staff related to research	10% administrative cap	Transportation	Requirements around fringe benefits
	Geographic (local) restrictions on providing services	Lack of staff for case management – high case loads	Lack of information about Ryan White services by private providers	Lack of funding for mental health services (time it takes to get a referral or names of people to talk to)	Confidentiality in rural clinics
	Poverty	Need more collaboration with faith-based organizations	Prioritization of resources	Uneducated/ inexperienced/ insensitive service providers	Lack of funding

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Resistance by private doctors to treat HIV	In some places CABs have not contributed anything positive – "going through the motions"	Collaboration among agencies/providers	New employment or beginning own business (entrepreneur example – providing peer counseling as a non-profit) – having to lose Medicaid, etc. if forced to disclose status	Burdensome paperwork and duplicate requirements across service providers
	Medicaid reimbursement rates resisted by private doctors	Need to access creative funding initiatives, need more funding opportunities	Navigating the system (clients)	Lack of knowledge of Ryan White Planning Council funding allocation process at consumer level	Limited peer advocacy and counselors
	Wait times (appointments and phone calls)	Clients who get better, make too much money to qualify for RW but still do not have health insurance	Inflexibility within the system	Questionable confidentiality	
	Gap between prevention and care providers	Community hospitals discharging patients at "poor" time		Lack of active role for consumers in Ryan White consortia that are already there - need more clients to show up (don't disclose what each person does at meeting, e.g., nurse, HIV positive client, etc. because it "outs" the client)	

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Paperwork	Lack of staff education or testing in the community/ private providers (i.e. to do testing).			
	Provider and staff turnover (state and agency levels) – burnout	Late testers with sicker patients			
	Sense of entitlement by consumers	Overall aging of population			
	Low levels of health literacy by consumers	Hospital do not want uninsured patients – dump them out very soon			
	Insurance co-pays/deductibles	Clients not admitted			
	Lag in lab time	Community health center testing issues related to funding and reimbursement			
	Scheduling appointments that are convenient for consumers	Fees related to accessing community health centers in rural areas to access care			
	Lack of priority for prevention	Application to different PAPs is a barrier to getting medications to patients			

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Perception of lack of confidentiality by patients	Community health center testing is an issue – patients do not want to pay for the test, would rather refer because RW clinics are less costly for patients			
	Still seen as a "gay" disease	Clinic entry process			
	Cost benefit analysis not understood	Private providers do not participate in state planning			
	HAB measures don't work in real world, regarding oral health – leaves clients hanging once met	Access to Grady for clients outside of Fulton and DeKalb			
	Lack of CBOs and ASOs to advocate in rural areas	Slow referrals for primary care			
	Policies/behaviors that promote waste/duplication	Limited formulary for primary care medications			
	Cultural competency and diversity among ID physicians and upper management	Primary care needs: training, personnel			
	Challenges as a result of changes in the Department – contracts, PCIP audit, etc.	Lack of funding to obtain primary care provider			

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	New drug screening/testing law	Can get patients seen by specialists but cannot pay for treatment			
	Archaic technology	Oral Health Care - lack of access to Grady IDP - VA does not provide it - Limited funding - No dental case managers - No collaboration with rural GA dental providers - Patients not educated on need for oral care, use peers - Funds by some agencies for oral care not being used			
	Lack of communication of policy and funding changes, including federal to state and state to local	Need to recruit providers for rural Georgia – need to do education			
	Lack of trust among Federal, state, and local	Hormone therapy for transgender patients			

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Lack of transparency up the management chain	Mental health/substance abuse			
	Need better written policies and procedures and dissemination of information	Lack of knowledge about HIV, lack of social marketing, public media			
	Regulations regarding sex offenders, including housing	Need to set up relationships in rural Georgia to prepare for needle sticks			
	Regulations regarding other felons (non sex offenders)	Lack of referral options for pap smears and women's health			
	Lack of staff and space available for one stop shop provision of services – integration of services	Lack of sex education in schools			
	Existing linguistic services are limited – difficulties with dialects, need for training on medical translation, lack of bilingual staff. Language Line can be intimidating for some clients. Services for hearing impaired.	With patients losing their insurance – patient had 3rd party insurance does not cover prescriptions and patient could not apply for patient assistance due to having insurance. Can see provider, but can't get labs or medications			
	Lack of political will to work with undocumented	VA is in a silo due to independent funding			

Barriers - why gaps occur	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Lack of funding for oral health services and availability of providers and services (preventive, maintenance, restorative)				
	Medicaid policies that do not pay for testing of pregnant women – vs. state lab				

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Health Care Reform impact	Medical nutritional therapy	Support services may disappear	Education about available resources	Money
	Ryan White Extension/ Reauthorization - Coverage for undocumented	Healthcare after 2014	Afford Care Act impact	Provider education – need sensitivity training	Public education and awareness
	Prevention technology	Needing more funding for less care	Medicare Part D rates increase and other health insurance (co-pays, deductibles, premiums)	Long term care for long term survivors – especially for aging women	ADAP/availability of medication

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Incomplete data	More HIV positive pregnant women and lack of carrying AZT on formulary (19% of 40 EMA hospitals)	PAP may disappear	HIV peer advocates—more attention on their value and role	Emerging senior population
	Technology	TEAP and HIV health reform	Drug test for entitlement programs	Mental and emotional health	Stigma
	Lack of diverse health care providers and providers in general	Prep: who will pay for it, who will see those clients	Social services disability re-evaluation of those on disability (are no longer eligible)	Funding	Medical side effects on long term survivors
	Quality HIV care at community health centers	Affordable Health Care Act does not impact oral health care	Need to acquire skills to obtain employment (funding for training/re-training)	Faith-based/church participation	Access to specialty referral care
	Long term effects of HAART	Getting other providers to do HIB counseling and testing	Partner notification with increased STIs (i.e., young adult population)	Programs that target the youth/young	Need for more advocacy (specifically for long term survivors)
	Health literacy and system navigation		Younger people becoming infected	Advocates for federal/state funding	Asking better questions by providers
	Immigration law		Criminalization of HIV positive inmates	Nutrition and exercise resources	Advanced training for the health care providers for long term survivors
	Adolescents		Ryan White funding going away	Info/resources to identify/foster "grass roots" advocacy within Georgia	Targeting certain populations
	Aging population		Poor quality of life	Community organizing; need to link groups and resources across the state	Comprehensive screenings (to include STD screenings)

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Medical home model		Political environment	Using technology and social media to connect HIV+ people/groups for mental health services (cyber psychology)	
	Need to demonstrate outcomes		Developing advocacy interventions	Including consumers when creating policy	
	Integration of prevention treatment and care		Returning military	Need for cultural competency/sensitivity training for providers	
	Young MSMs increasing HIV rates		Doomed!!	Annual/ongoing invitation for consumers to participate in planning/prioritizing process	
	Substance abuse treatment for crystal meth, prescription drugs		Hope is on the horizon		
	Sexual health education		City officials, clergy, and politicians taking a stand and being tested in public		
	Social media		Faith-based organizations stepping up		
	Treatment is prevention (reduced risk of transmission)		Lack of mass testing events		
	Availability of medications		Immigrants may go into hiding		
	Reductions in funding		Co-morbidities		

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Complicated Medicaid and Medicare reforms		Electronic health records & advanced technology – some clients cannot adapt with how to use tech.		
	Emerging populations – non Hispanic immigrants, transgenders, older adults, perinatal, youth		Revamp primary care for aging clients		
	Increased waiting lists for services, including ADAP, primary care, oral health, specialty care, housing				
	Putting caps on number that can be served				
	Lack of HIV knowledge within state legislature –. could increase with upcoming elections.				
	Individuals aware of and not aware of status and not in care. Need for surveillance.				
	Changing guidelines on when to initiative ARVs.				
	State laws requiring drug testing before can access services				
	Rising out of pocket costs				

Future Issues/ Emerging Needs	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	Need an economic impact study				

Top Five Priority Areas	Administrators	Healthcare Providers	Support Service Providers	Women's Consumer Group	Men's Consumer Group
	<u>Admin. Group 1</u> 1. ADAP gaps 2. Streamlining ADAP – electronic transmission, etc. 3. Transgendered population 4. Mental health services 5. Transportation <u>Admin. Group 2</u> 1. Primary care 2. Subspecialty care 3. Integrated care (co-morbidities, women, youth) 4. Mental Health/ Substance Abuse services 5. Aging population needs/technology	1. ADAP waiting list 2. Private sector involvement – miss or ignore HIV 3. Primary care gaps in HIV settings (i.e., training, personnel, funding) 4. Oral health services – including need for dental case management 5. Timely access to care – access to care begins late for some consumers	1. Funding 2. Housing 3. Transportation 4. Income 5. Lack of staff	1. Need more support services in rural areas 2. Advocates for federal/state funding (emerging needs) 3. Community organizing – need to link groups and resources (emerging need) 4. More collaboration between schools and community organizations 5. Programs that target youth/younger consumers (emerging need)	1. Lack of funding for services 2. Not enough peer advocates/counselor 3. Housing 4. Case management 5. Cultural barriers

Development of Strategy Area Action Steps

Using the met and unmet needs, barriers, and emerging issues identified by the five groups during the morning sessions, meeting participants were divided into five geographic groups (North Georgia, Metro Atlanta Group 1, Metro Atlanta Group 2, Middle Georgia and South Georgia). Each group was assigned barriers and/or issues and was tasked to identify to actions to address their assigned areas. These identified strategy area action steps beginning on page 122, guided the development of Georgia Comprehensive HIV Services Plan on page 75. The SCSN will also be used to guide the development of programs to provide services to persons living with HIV/AIDS in Georgia and to encourage effective collaboration and coordination among service providers across funding streams. As a living document, the SCSN will evolve to reflect the changing landscape of HIV in Georgia through subsequent revisions.

Strategy Area Action Steps

Strategy Area Question	Metro Atlanta Group 1	North Georgia (answered this question mainly for young MSMs)

How do we help people access care who know their status but are not in care?	• Outreach, intake, community involvement
	  • Community volunteers for outreach
	  • Open forum for community members/providers to share
	  • Public service announcements
	  • Case trackers who locate clients
	  • Appointment log – contact clients to confirm access to care
	  • Equip peers
	• Case management
	  - Increased linkage to care case management
	  - More community-based case management
	• Address other social issues (e.g., substance abuse, mental health housing)
	• Recovery support programs
	• Drop-in center
	• Transitional Center (Grady IDP)
	• Health literacy
		• Knowing what is available and give people the information they need
		• Knowing where HIV clinics are
		• Education with diagnosis so people do not think they can ignore diagnosis (it will go away if ignore diagnosis) and/or are scared because they do not want people to know
		• Younger people have a lot of denial – "I feel fine and my health is good, why do I want to start meds?"
		• Confidentiality and how to follow up
		• Calling agency to get the referral
		• Testing/screening: follow up care with linkage to stable relationship after diagnosis is given
		• Dalton – poor quality post-test counseling – "here's a brochure and off you go"
		• Culturally competent care – immigrants, non-native English speakers, transgender have a bad experience and do not return
		• Transportation and insurance
		• People there are not services – ADAP wait list, Medicaid, Medicare
		• Fear of rejection and stigma
		• Lack of peer advocate program a barrier due to increased rapport with peer advocate program
		• Location of clinic within health department is an issue due to confidentiality
		• Other issues for patients and different priorities: housing, substance abuse, other health conditions – also a challenge for retention

How do we help them stay in care	• Motivational incentives	• Peer advocates for tracking lost clients

and fully participate in their care?	• HIV/AIDS education opportunities (lunch/learn) - Health literacy - Staff educational opportunities/training • Elite services • Address mental health at intake • Track no-shows and identify how can help get them to next appointment • Stable housing • One stop shopping • Staffing cases • Consistency in care team • Address capacity/structural issues (i.e., wait time for appointments, ADAP recertification every 6 months, information needed for Medicare Part A • Non-traditional hours of operation • Peer advocates • Access case management services	• Clients need to "buy in" to their own care – may not mean medications adherence • Running reports to track and make contact (follow through) with lost clients • Home visits • Case conferences • Support groups if people will show up and stay interested, view of consequences ("scare tactics"), - people more likely to stay compliant • More satellite clinics available for areas with more newly diagnosed clients • Multiple services offered such as mental health, substance abuse • Less appointments and get more done (efficiency during visits, social stressors)
Realizing not everyone has equal access to services, how do we develop and implement community-level approaches to reduce health disparities and increase access to HIV services among Hispanics/Latinos?	• Address language barriers - Language Line (access to live person) - Interpreter on site/bilingual staff - Translate more documents/brochures into Spanish • Outreach/safe environments to avoid fear of immigration • Latin American Association – strategies for effective community outreach • Social media/marketing (e.g., television, Hispanic radio stations, Facebook, Linked In) • Advertise early testing • Hispanic health coalition • Reach out to Latino churches • Cultural competency (norms for particular group)	

	• Non-traditional hours of service	
What steps would you take to improve services?	• Latino lunch and learns • Involve prevention staff in outreach initiatives with the Latino community • Latino commission on AIDS • Less prevention efforts in the community – focus more on evidence-based interventions • Treatment is considered prevention • Address burn out of staff • Identify and collaborate with agencies that are currently providing services to the Latino community	
How do you deal with the fact that HIV isn't as big of an issue as in the past?	• Poor education around sex education (risk reduction skills) • Past efforts produced better results • Discrimination and stigma with the increase of infection rates among the African American community • Target youth before infection • Rapid test results may have given the illusion that it is ok to have unprotected sex • Partner notification is not working • Lack of communication among staff • Train on disclosing status • Mass test events – counseling portion is condensed or not offered • TB/HIV/STD clinics do not share data	
What do we need to do to help the Latino community be self-empowered?	• Healthcare is second; family comes first • Fear of deportation is biggest fear among Latinos • Gay HIV/AIDS is not acceptable in the Latino community • Resources are limited in country origin – Latinos are not used to asking for help	

Strategy Area Question	Metro Atlanta Group 2	South Georgia
How do we reach people who don't know their status?	• Go to non-traditional spaces (bars, parks, go at random hours)—but make sure that you have peer support and other supportive systems to ensure that someone can get immediate help and care if they have a positive result • Prioritize locations for testing—go to homeless shelters, not churches • Use social media to get the message out—Facebook/Twitter, etc.; so many people are meeting through the internet for sex—educate them • Target non-traditional lifestyles (for this work) (ex. Heterosexual couples) • Collaborate with colleges and high schools (and their teachers and professors) to encourage projects around HIV care • Educate students and others about HIV and risky lifestyles • Go to the people—find out where high-risk folks are and go to them • Do "one-stop" healthcare education—hand out condoms to get people's interest, then test. While waiting for the test to process—educate the people during that 20 minutes. Also, have peer educators and other resources on hand to help those with positive results • Outreach testing • Churches, communities where youth interact • Create a safe space for positive results • Educate about risks	• Make testing mandatory, e.g., medical clinics, entry into school, application for public services, etc. – test everyone because everyone is at risk. Make it part of standard care. • Education – increased educational efforts to the general population – on risks and need for care • Increasing awareness by advertising • Establish partnerships with the education community (colleges, high schools) that include assignment of projects to their students (e.g., nursing students) to not only educate the students, but also get the word out about the need to be tested • Include testing in faith-based venues • Educate primary care providers on CDC testing guidelines (if sexually active, get tested yearly) and provide op out annual testing • Include stigma reduction education as part of public awareness/testing campaign • Increase outreach to areas with high risk populations and/or prevalence and limited resources – cast a larger net for testing • Increase enforcement of protocols and guidelines, and regs • Eliminate the cost to individuals for test • Identify incentives to increase private provider testing

	• Conversations with PTA	• Allow increased testing ability outside prevention • Do better job of tracking down known positives and contacting their partners about getting testing – target newly identified positives. Strengthen partner notification and interviewing of known HIV+ individuals to identify if partners have been tested (both for newly diagnosed individuals as well as during care – need to regularly ask about new partners. • Increase communication among staff about clients, their partners, and risk behaviors • Allow RW funding to support testing in "low risk" populations
How do we increase testing?	• De-stigmatize and normalize testing—make it opt-out • Make testing a normal test for getting into a homeless shelter • "Bar cards"—help people recognize their risk levels—and then provide testing for them at that spot • OB-GYN—make tests more common there • Use better public service messages to talk more about HIV tests—make them more creative and frequent (ex. as frequent and on the same main-stream channels as Viagra commercials) • Use incentives to get tested • Work with mobile units that provide other care to de-stigmatize the test (ex. domestic violence care clinics) • See where HIV+ folks go—and use their social networks to figure out where to test • Test spouses of those at high risk (such as drug users) as soon as they begin care	• Use surveillance data to identify risk groups and develop plan to test identified groups • Create collaborative relationships with faith-based and other community organizations to test – such as Rotary Club. Make testing become the norm. • Requiring HIV testing as part of application for driver's license • Educate high school health education teachers about community testing resources for youth • Increase testing sites • Work with college health services to increase testing • Put STD/HIV and sex education back in high schools • Offer parental permission slips for testing as part of health education in schools and include testing at school sites • Develop relationships with schools and work collaboratively to access grant funds

	• Have folks from one county go into another to do testing (thus, people don't have to worry about someone from their community—such as an Aunt or neighbor—knowing their status) • Community testing—have someone visible from that community be seen—so it helps de-stigmatize the event (ex. think of how everyone flocks to people on American Idol who is from their community) • Change in the mechanism of testing • Testing of elderly	• Mobile testing • Use local and regional epi data to show local areas what HIV looks like in their community • Offer testing in gyms, etc. where young adolescents gather • Implement test initiative that encourages parent/adolescent testing • Link testing to everyone who gets a tax refund or that receives federal or state services of any kind, getting married – marriage license • Implement train the trainer in communities to increase educator resources, e.g., train barbers • Reduce stigma and fear thru education, decriminalization HIV, make sure people who are positive are protected and do not lose housing, jobs, insurance, etc. Protect people who are identified as positive • Increase education to business community on HIV discrimination in the workplace • Provide incentives to people who get tested (does not need to big). Decrease restrictions on providing incentives • Conduct testing where high risk populations go – such as sex workers • Add HIV testing to parental consent school health form for adolescents 13 and above (need permission for youth under 16) • Make HIV testing part of any routine hospital admission screening • Require mandatory HIV testing for state and local health care staff • Require mandatory testing for politicians • Add HIV testing as part of requirements with Drug Courts, drug probation, DFCS family

		reunification, etc. • Implement a "test everyone" media campaign • Offer op out testing with Viagra prescriptions • Include HIV testing education as part of reproductive health provision for not just females but males as well • Reframe mandatory HIV testing and sell it as normal part of medical testing – normalize HIV testing as a part of a normal healthcare screen • Increase in-home testing (include education resources) Offer confidential self testing at home that includes link to education resources (FDA is making a determination soon about whether home testing will be licensed) • Offer one stop shopping including walk in testing – make sure HIV clinics can also test
How do we improve referral and linkage systems?	• Have peer counselors/advocates to help folks new to care navigate the system • Meet people where they are—figure out what their barriers are to getting care • Have ability to make an appointment at the time of diagnosis—don't have 3-4 month wait to get into care • Establish a list/referral to those needing care • Work more with private providers • Make support groups readily available—they can tell someone the "ropes" and can help them get in the right mindset to get care • Use technology to connect to younger generations—respond to texts or emails • Use social media to link up to others (ex. Facebook, etc.) • Distribution of more condoms	• Increase advertisement of available HIV clinics and providers – better marketing • More provider education to increase referrals • Better tracking monitoring, and follow up to make sure identified individuals are in care (go with this one). • Establish clear guidelines and a process that gets a positive client into care at the community level (because systems and resources differ) • Require that testing sites make sure individuals identified as positive are referred and linked • Dissolve silos at the state and local level between prevention and treatment • Encourage American Red Cross to include a number to call when informing individuals that they tested positive

	RETENTION IN CARE • Elite society of undetectables at AID Atlanta—require labs in order to attend dinner celebrating the patients' accomplishments • Encourage patients with positive words and/or show them their labs for visual confirmation of their dropping viral loads • Incentives • Double up with other services (ex. food dispensing, etc.) • Use celebrations of life to keep everyone encouraged to keep up with their care • Help patient feel empowered—let them have an opportunity to help make decisions about their own care—helps them stay engaged • Give culturally compliant classes • Testing with elderly—meet them where they are • Transgender patients—be cognizant of their issues and help their care be compassionate and sensitive care • Let colleagues have contact information for each other so that someone can help meet a patient and take them over to the next clinic and help with paperwork to help them get from the hospital to the clinic without falling out of care • Continue to test repeatedly—use of Viagra is prevalent, etc.	• Increase collaboration at the local level between testing agencies and clinics, e.g., use consortiums • Work with private providers to make sure they know what to do if identify someone that has tested positive. Increase collaboration and communication between testing agencies, clinics, and private providers • Add to prevention to deliverables for Part B consortiums

Strategy Area Question	**Middle Georgia**	**North Georgia**
Realizing that not everyone has equal access to services, how do we develop and implement community-level approaches to reduce health	• Look at other programs who have looked at targeted MSM of color • Consider social marketing strategies	<u>Barriers to access</u> • Younger people have a lot of denial "I feel fine and my health is good, why do I want to

disparities among young MSM of color?	• Partner with community partner (e.g. Walgreens, Bruster's Ice Cream) (Augusta, GA) • Garner or request statewide support and resources (e.g. posters, postcards, billboards, test kits) • Get more access to surveillance data • Partner with universities and colleges (as well as high schools) • Development of media materials (e.g. DVD) • Offer HIV testing in high schools, but this will encounter challenges with state boards of education • Continuation of the county-by-county disparities report • Include other health disparities (e.g. STD) • Train staff • Increase usage of the internet and social websites (e.g. Facebook) • Increase condom distribution and partner services • Use local media (e.g. radio, newspapers, television) • Use someone who young MSM of color can identify with to link clients to services • Change community perceptions • Figure out where young MSM of color hang out and use those areas to promote services • Conduct a community survey to ask young MSM of color what will it take to get them tested and into services • Use community champions to get the word out and get people tested via health fairs • Build positive rapport and trust with community leaders • Use unconventional HIV testing sites	start meds?" • Dalton: poor quality post-test counseling "here's a brochure and off you go" • People think there are not services, ADAP wait list, Medicaid, Medicare • Fear of rejection and stigma • Lack of peer advocate program is a barrier due to increased rapport with peer advocate program • Location of clinic within health department is an issue due to confidentiality • Other issues for patients and different priorities: housing, substance abuse, other health conditions – also a challenge for retention <u>Community approaches -Barriers to access</u> • Knowing what is available and give people the information they need • Knowing where HIV clinics are • Education with diagnosis so people do not think they can ignore diagnosis (it will go away if ignore diagnosis) and/or are scared because they do not want people to know • Confidentiality and how to follow up • Calling agency to get the referral • Testing/screening: follow up care with linkage to stable relationship after diagnosis is given • Culturally competent care – immigrants, non-native English speakers, transgender have a bad experience and do not return • Transportation and insurance • Peer advocates for tracking lost clients • Clients need to "buy in" to their own care: may not mean medication adherence

		• Running reports to track and making contact (follow through) with lost clients • Home visits • Case conferences • Support groups if people will show up and stay interested, view of consequences "scare tactics", people more likely to stay compliant • More satellite clinics available for areas with more newly diagnosed clients • Multiple services offered such as mental health, substance abuse
How do we develop and implement community-level approaches to reduce health disparities among African American women?	• Women who are married who think they are at low risk and don't believe they need to be tested because they are married • Host women's health summit and sex education themed party • Church collaboration • Partner with sororities • More effective advertising • Target married women • Encourage women to request an HIV test when they see their primary care doctor • Target spas and gyms where women go for general wellness and provide them with packets of information that includes HIV information • Target and address night integration • Empowerment messages, reduce dependency on partners • Target nail and hair salons	• Less appointments and get more done (efficiency during visits, social stressors) • Marketing: having other services available and clients will come to see therapist, dentist and be compliant with those appointments. • New programs (in-between appointment) Washington state: kiosks set up in community with case manager present, phone, fax to fill out paperwork • Lack of funding is a barrier • Clinics collaborating better together "playing nice with each other/clinics" • County structuring to reach more clients, be most convenient – restructuring districts for accessibility, customer services • Differences between Part B (serve your district) and Part C who you are able to serve • Serving people not directly in your district – lines were not so strictly enforced at that time and there were more resources, new people not so willing to take new people on who are not in district • Half the staff and more patients than someone

		else, would rather send to another district if that is more appropriate • Looking at obstacles faced beforehand for people coming back into care • Consistency with patients re-accessing due to going in and out of jail/prison • Issues with transition from prison to clinic • Lack of care in jail • Publicizing services offered to hospitals and referral centers, locations of clinics • Provider training and access to medications in hospitals for non-HIV providers • Providing holistic care (other health department clinics not doing pap smears, treating syphilis in HIV-infected client) • One reason may be would rather take care of non-HIV to be payor of last resort (protection of funding) • Marketing – having other services available – clients will come to see therapist, dentist and be compliant with those appointments • New programs (between appointments) Washington (state) has kiosks set up in community with case managers, phone, fax to fill out paperwork • Lack of funding is a barrier • Clinics collaborating better –"playing nice with each other/clinics" • County structuring to reach more clients, be most convenient – restructuring districts for accessibility, customer services • Differences between Part B (serve your district) and Part C who you are able to serve • Serving people not directly in your district –

		lines were not so strictly enforced at that time and there were more resources, new people not so willing to take new people on who are not in district • Half the staff and more patients than someone else, would rather send to another district if that is more appropriate • Looking at obstacles faced beforehand for people coming back into care • Consistency with patients re-accessing due to going in and out of jail/prison • Issues with transition from prison to clinic • Lack of care in jail • Publicizing services offered to hospitals and referral centers, locations of clinics • Provider training, access to medications in hospitals for non-HIV providers • Providing holistic care (other health department clinics not doing pap smears, treating syphilis in HIV-infected client) • One reason may be would rather take care of non-HIV to be payor of last resort (protection of funding)
How do we develop and implement community-level approaches to reduce health disparities among Hispanic and Latino consumers?		• Language barrier • Education of Hispanic serving workers (awareness of risk that HIV is a problem in this population) • Roman Catholic religion is a barrier • Cultural understanding of sexual orientation and fidelity “down low” • Anti-immigration laws are a barrier • Testimonies from previously-served members of community • Bilingual staff

		• Address issues with younger Hispanics/Latinos as may be more receptive • Use naturally occurring community centers • Hispanic religious leader buy-in (outreach at community centers, churches etc.) • Bundle with other services that affect the Hispanic community (HTN, DM, TB) • Education of non-Hispanic workers to be culturally competent • Hispanic peers, though may be difficult to recruit • Overly generalizing and identifying differences within the Latino community • Making assumptions about literacy in Spanish and education level
How do we develop and implement community-level approaches to reduce health disparities among adolescents?		• Work more closely with providers that offer HIV-related services • Develop a transition plan for adolescents to access services from adult-focused centers / clinics • Use social media • Street parties • Use colleges and university student organizations to come up with innovative ideas to reach young people • Tap into churches • Use attention grabbing media • Use scare tactics or more realistic consequences • Parental education • Use campaigns that reflect target audience

H. How the plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act (ACA)

The intent of the Affordable Care Act (ACA) is to "expand health insurance coverage while also reforming the health care delivery system to improve quality and value." Other provisions include eliminating health disparities, increasing access to health care, expanding and improving the health care workforce, and encouraging consumer wellness. ACA presents both challenges and opportunities for Ryan White funded programs, including Part B. Beginning in 2014, most Ryan White clients will have health insurance coverage. Although the exact impact is not known at this time, Part B recognizes that new reimbursement systems will be in place, health homes will play a new role in health care, new investments will be made in community-based care, and changes will be made in the mission of and services provided by Ryan White programs.

To coordinate with and adapt to the changes that will occur with ACA in 2014, the State of Georgia's 2012-2015 Comprehensive Plan includes Goal 1, objective 1.2, of evaluating and responding to the impact of the ACA on systems and services in Ryan White Part B. HRSA directives, assessment reports, environmental changes, adjustments and modifications will be reviewed. In accordance with Goal 1, objectives 1.3 and 1.4, any changes or needed alignments will be communicated with health districts and consumers. System modifications will be monitored and further modifications made as needed. Ryan White Part B will continue to explore opportunities to coordinate services and increase collaboration with state, federal and local partners.

I. How the comprehensive plan addresses the goals of the National HIV/AIDS Strategy (NHAS), as well as which specific NHAS goals are addressed

The Georgia Part B Program's Comprehensive Plan is compatible with and addresses all three of the National HIV/AIDS Strategy (NHAS) primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

Goal 1: Reducing the number of people who become infected with HIV.

To achieve this goal, the Georgia Department of Public Health (DPH) will increase HIV testing in clinical and nonclinical settings. This is in accordance with the State of Georgia 2012-2015 Goal 3 (*increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment).* These testing efforts will target high risk populations throughout the state with special emphasis on those health districts that have been identified as having the highest concentrations of HIV cases. Health departments and organizations that receive support from DPH to conduct HIV testing in clinical or nonclinical settings are required to establish functional partnerships with HIV care and treatment providers in order to link those testing HIV-positive into care.

DPH will also increase condom distribution in clinical and nonclinical settings to reach person at high-risk for HIV and those who are HIV-positive.

Goal 2: Increasing access to care and optimizing health outcomes for people living with HIV.

Starting in 2012, the Georgia Department of Public Health, HIV/AIDS Office will require that all newly diagnosed clients and those who have been "lost to care" be linked to HIV care, treatment, and prevention services using the Antiretroviral Treatment Access Study (ARTAS) intervention and/or other medical adherence interventions as deemed appropriate by the service provider. This is in accordance with the State of Georgia 2012-2015 Goals 1, 2 and 3 (*improve access to HIV-related core services; improve the quality of HIV core services and health outcomes; increase linkage to care for individuals newly diagnosed with HIV infection, through coordination of counseling and testing with treatment).* Linkage to care will be tracked and reported each month by HIV testing sites as part of contract requirements using the CDC-defined performance indicator CTR3: Linkage to Care. This indicator is calculated as the percent of newly identified, confirmed HIV-positive clients referred to medical care who attend their first appointment with a medical care provider with prescribing privileges. For those providers utilizing the ARTAS intervention, the Georgia Department of Public Health will use an Access Database, specifically tailored to ARTAS, to ensure that clients have successfully been linked to medical care and other social services with the first 90 days of diagnosis or enrollment. The Georgia Department of Public Health will also work with providers utilizing other interventions to develop similar tracking mechanisms.

Goal 3: Reducing HIV-related health disparities

This is in accordance with the State of Georgia 2012-2015 Goal 4 (*reduce health disparities)*. Ryan White Part B addresses disparities in access and services among affected subpopulations and historically underserved communities through its identification of target populations and implementation of activities to eliminate barriers to counseling and testing, enrollment, and retention in treatment services. Ryan White Part B funds geographically located primary care sites, and access to other core medical and supportive services including medical transportation, peer counseling, and linguistic services.

J. Strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts.

The Georgia Part B Program's strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts is first to prioritize the services provided with state funds. Prioritization will be based on the Statewide Coordinated Statement of Need, local priority needs, consumer and provider input. The majority of state funding is allocated for the purchase of ADAP medications and to support the HICP and PCIP programs. In the event of a decrease, patient assistance programs will be utilized to ensure the continuity of the services provided.

Ryan White Part B plans its allocations on a Ryan White funding award which would maintain the continuum of care. In times of uncertain funding, Part B recognizes the importance of planning for potential increases or decreases in the Part B award.

Section IV. How will we monitor our progress?

A. Plan to monitor and evaluate progress in achieving proposed goals and identified challenges.

Implementation, monitoring, and evaluation: Ongoing monitoring, input, and adjustment are critical in continuing to ensure that available HIV/AIDS resources in Georgia are maximized and the use of these resources are prioritized when changes to the system are needed. The State of Georgia FY 2012-2015 Comprehensive Plan Goals and Objectives will be monitored by the Part B Program staff, in collaboration with Prevention staff and colleagues across other Ryan White Programs. Progress will be evaluated based on the measures indicated in the document and periodic updates provided to colleagues throughout the state, particularly those participating in the recent meeting to establish the plan.

Each Objective of the State of Georgia 2012-2015 Comprehensive Plan contains strategies, time frame, measures, and identified parties responsible for implementation and evaluation. The State HIV Office will oversee coordination and collaboration of identified parties in achieving the stated goals and objectives of the Plan.

The HIV Office and Part B sub-recipients will continue generating reports from the CAREWare database to monitor consumer level utilization of core services. By complying with the Ryan White Services Report (RSR) reporting requirement, Part B funded health districts will continue entering client level data elements into CAREWare. Performance Measure (PM) reports generated in CAREWare continue to become more accurate and useful for quality improvement activities. RSR reports as well as PM reports are reviewed by the Part B Program staff and the QM Core Team to identify opportunities for quality improvement.

The Part B Program will continue utilizing CAREWare to report the RSR to HRSA. All Part B funded sub-recipients are required to use CAREWare for data collection. The Part B Program will participate in all HRSA training on client level data to assure understanding and compliance with reporting requirements. The Part B Program offers technical assistance to health districts providing outpatient/ambulatory medical care and medical case management services. The Part B Program will continue to collaborate with other Ryan White Parts to maximize opportunities for training and technical assistance

Part B health districts will continue reporting on progress toward goals and objectives via quarterly reports**.** The health districts are required to fulfill the quality management components of the Part B Program GIA contracts. Deliverables in the FY 2012 GIA Annex included QM Program requirements. These requirements include: Ensure that the medical management of HIV infection is in accordance with the U.S. Department of Health and Human Services (DHHS) HIV-related guidelines; develop and implement a quality management (QM) program that

include the following: a written QM plan; a leader and team to oversee the QM program; organizational goals, objectives, and priorities; performance measures and mechanisms to collect data; project-specific continuous quality improvement plan (CQI); and communication of results to all levels of the organization, including consumers when appropriate; participate in the statewide Part B QM Program; and monitor performance measures as determined by the QM Core Team. Part B funded health districts will be encouraged to utilize the State of Georgia 2012-2015 Comprehensive Plan to develop local strategic plans and activities.

The QM Core Team completes the National Quality Center's (NQC) *Part B Quality Management Program Assessment Tool* at least annually. The QM plan is assessed using the NQC's *Checklist for the Review of an HIV-Specific Quality Management Plan*. The Core Team completes an annual assessment and subsequent revision of the QM plan and evaluates the QM Program on an annual basis including rating the completeness of strategies.

QM staff members annually review local QM plans including QI activities and progress on case management standards and performance measures. Members provide feedback regarding each plan and provide technical assistance as needed. Health districts monitor selected performance measures and report to the HIV Office. The Core Team reviews these measures and compiles reports.

District Liaisons monitor health districts for general programmatic performance measures and compliance with the GIA deliverables. HIV Nurse Consultants and the HIV Medical Advisor review HIV clinical charts in Part B-funded agencies for specific clinical performance measures. The QM Coordinator monitors sub-recipients for compliance with case management (CM) standards and performance measures. Findings are summarized and reported back to each site with a request for improvement plan based on findings.

Clinical performance measures will be monitored through the following methods:
The QM program will continue to monitor the approved HAB performance measures in all 16 Part B funded public health districts at least annually. Starting in October 2009, the HAB performance measures were generated by site via the CAREWare performance measures module. Statewide averages are monitored and calculated through aggregating performance measures from all Part B districts. HAB performance measures are generated from the CAREWare preset performance measures module. Performance measures are also monitored via chart review.

During 2010-11, the Medical Advisor and Nurse Consultants initiated clinical chart reviews for the measurement period of calendar year (CY) 2009. A total of 697 charts were reviewed in 18 Part B clinics. Clinical measures selected for this chart review were the same as those from the CY2006 clinical chart reviews with a few additional measures from the new HAB clinical performance measures. The QM team utilized the Scantron® Class Climate system for data collection during the CY2009 clinical chart reviews. Individual summary reports were sent to each district after the review. Districts are required to submit an improvement plan within 60 days of receiving the review report, and encouraged to incorporate the plan into the local QM plan. Clinical chart reviews will continue to occur every three years.

ADAP and HICP will be evaluated through the following methods: ADAP will continue to monitor monthly indicators: 1) percentage of Georgia ADAP clients recertified for ADAP eligibility criteria at least annually, and 2) percentage of newly applying ADAP clients approved or denied within two weeks of ADAP receiving a complete application; and percentage of correctly completed new/recertification ADAP applications submitted to ADAP. Two new indicators were added in 2008 for HICP: percentage of active HICP clients recertifying before their six month due date to prevent delays in payment of health insurance premiums; and the percentage of correctly completed new/recertification HICP applications submitted to HICP. Administrative site visits will be conducted to monitor the validity of local ADAP programs. Data sources for the ADAP/HICP indicators are the customized Access database for ADAP applications, HICP Excel spreadsheets, CAREWare, and case management client records.

Fiscal Accountability will be evaluated through the following methods: The statewide accounting system, People soft, will be used to monitor all expenditures on a monthly basis to ensure accomplishment of program activities. A contract monitoring site visit tool was revised according to the new National Monitoring Standards to monitor HIV providers at the local level to ensure compliance. The tool enables state staff to review line items expenditures ensuring funds are expended appropriately.

Administrative and Case Management performance measures will be evaluated through the following methods: The HIV Care District Liaisons will continue to assess the programs' compliance with Ryan White guidelines and regulations by closely monitoring programmatic and fiscal requirements of all contracts and GIA awards including quality management requirements. They ensure QM/QI findings/reports are shared at public health districts meetings. The District Liaisons, at least annually, conduct administrative site visits at each Part B funded health district. During administrative site visits, District Liaisons assess the following: client's eligibility for Ryan White Part B-funded services and availability of other benefits; the clinic's sliding fee scale policy, grievance policy, client rights and responsibilities; clinic confidentiality and security procedures; submission of reports; and fiscal accountability. Upon completion of the performance review (administrative site visit), a summary of findings is sent to the HIV Coordinator and District Health Director. If corrective action is recommended by the state office, the district is expected to complete and submit an action plan that identifies key actions and time frames to improve program performance for those areas. Upon receipt of the final administrative report, the service provider has 45 days to submit their corrective action plan to the state office. If corrective action measures are not implemented within the specified timeframe, funding may be restricted.

Case management client chart review or performance measures reports in CAREWare will be utilized to monitor case management indicators. The QM Coordinator utilizes a chart review tool to monitor implementation of the approved Part B Program CM Standards and CM performance measures. The tool includes the following CM performance measures: ISP updated every 6 months, ISP signed and dated by the client and CM, completion of standardized Intake and Income/Expense Spreadsheet, follow-up of primary medical care and treatment adherence at least every 6 months, collaboration and coordination of services, face-to-face contact every 4 months, referrals and follow-up, goals established during assessment/reassessment. The QM

Coordinator will make recommendations on methods to improve CM services and documentation based on findings from this chart review process. Upon receipt of the final chart review report, the service provider has 60 days to submit their corrective action plan to the state office.

Data sources for the administrative and case management indicators include: case management client charts, review of district level client satisfaction survey results, health district quarterly reports, QM plan reviews, and CAREWare.

B. How the impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative will be assessed.

The HIV Office developed a plan to educate and inform the Part B health districts of the need to develop strategies focusing on EIIHA. Part B Health District Applications are evaluated for coordination of services and linkage to care strategies as part of an environmental scan of all HIV prevention interventions, counseling and testing, and care and treatment sites in each local district. HIV Office staff will continue participation in the EMA's Early Identification Workgroup (EIW) quarterly meetings. Participants include leadership of Parts A, B, C, and D; Southeast AIDS Training and Education Center (SEATEC); State HIV Prevention Program including the Georgia Community Planning Group; HIV Surveillance Program; HIV Testing/Partner Services Program; Centers for Disease Control (CDC); City of Atlanta Housing Opportunities for People with AIDS (HOPWA); Enhanced Comprehensive HIV Prevention and Implementation for MSA most affected by HIV/AIDS Group (ECHPP); and federal and state funded agencies for counseling and testing and prevention activities.

Georgia recognizes the need to widely promote routine HIV testing by creating more testing opportunities, both conventional and rapid, and to improve systems for linking newly identified clients to care that extends beyond the initial doctor visit. The Ryan White Program, along with the Georgia Department of Public Health HIV Prevention section collaborates to increase HIV testing opportunities for disproportionately affected populations, by providing HIV testing services in high prevalence areas of the state and actively linking individuals identified as HIV positive, to appropriate clinical care and supportive services.

The DPH HIV Prevention section will partner with Ryan White Clinics to promote routine HIV testing to high risk populations throughout the state and provide linkage to care to those newly diagnosed. Georgia DPH will comply with and follow the national-level objectives and performance standards for HIV testing and linkage to care activities: At least 85% of persons who test positive for HIV receive their test results; At least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment; At least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services (PS).

EIIHA HIV testing and awareness data is evaluated at both the state and local levels. The HIV Office requests that local health districts evaluate HIV counseling and testing data to determine individuals who tested confidentially and did not receive test results. Each site will be advised to

follow established protocols for contacting individuals. In addition, the HIV Office requests that local health districts determine individuals with preliminary positive test results, who did not receive a confirmatory test, in order to follow-up with individuals or referral sites to verify results of confirmatory test.

Appendix 1

Georgia Statewide Coordinated Statement of Need Meeting
Marriott Century Center Hotel – Atlanta, GA
May 2-3, 2012

AGENDA

Wednesday, May 2, 2012

General Session – *Centennial Ballroom*

12:00 – l:15 PM **Registration (Lunch on Your Own) –** ***Centennial A Foyer***

1:15 – 1:30 PM **Welcome**
J. Patrick O'Neal, MD
Director of Health Protection
Georgia Department of Public Health (DPH)

L. William Lyons, BS
State AIDS Director
Georgia Department of Public Health

1:30 – 1:45 PM **Purpose and Overview of the Day**
Jim Sacco, LCSW
Meeting Facilitator

1:45 – 2:30 PM **2009-2012 Comprehensive Plan Update**

Brief Summary on Plan Progress
Michael Coker, MSN, RN, ACRN

Quality Improvement for Cervical Cancer Screening
Christie Sims, RN, APRN, WHNP-BC

HIV/AIDS Prisons/Release Program
Chayne Rensi, MPH
Georgia Department of Corrections

2:30 – 3:00 PM **BREAK –** ***Back of Centennial Ballroom***

3:00 – 4:15 PM **HIV/AIDS in Georgia**
Y. Omar Whiteside, MSPH
Georgia Department of Public Health

Michael DeMayo, MPH
Southeast AIDS Education and Training Center

Jeffrey Moody
District Liaison

4:15 - 5:00 PM **Overview of the National HIV/AIDS Strategy and Its Impact on Georgia**

Donato Clarke, BA
Georgia Department of Public Health

5:00 – 5:15 PM **Overview of Day 2 Activities and Brief Update on New Goal Direction**
Jim Sacco, LCSW
Meeting Facilitator

5:15 – 5:30 PM **Wrap-up/Adjourn for Day**
Jim Sacco, LCSW
Meeting Facilitator

Georgia Statewide Coordinated Statement of Need Meeting
Marriott Century Center Hotel – Atlanta, GA
May 2-3, 2012

AGENDA

Thursday, May 3, 2012

8:00 – 9:00 AM **Registration and Breakfast - *Centennial Foyer***

9:00 – 9:15 AM **Overview of the Day/ Review of Day One – *Centennial Ballroom***
Jim Sacco, LCSW
Meeting Facilitator

9:15 – 12:00 Noon **Breakout Session 1 - *Centennial Ballroom and Breakout Rooms***
- Men's Consumer Focus Group
- Women's Consumer Focus Group
- Healthcare Providers' Focus Group
- Administrators' Focus Group
- Social Services Providers' Focus Group

12:00 – 1:00 PM **LUNCH – *Back of Centennial Ballroom***

1:00 – 1:15 PM **Report Out – *Centennial Ballroom***
Jim Sacco, LCSW
Meeting Facilitator

1:15 – 3:00 PM **Breakout Session 2- *Centennial Ballroom and Breakout Rooms***
- By Geographical Area

3:00 – 3:15 PM **BREAK – *Back of Centennial Ballroom***

3:15 – 3:30 PM **Wrap-up/Evaluation-*Centennial Ballroom***
Jim Sacco, LCSW
Meeting Facilitator

3:30PM **Adjourn**

Appendix 2

Georgia's 2012 Statewide Coordinated Statement of Need
Consumer Focus Group Facilitator's Guide

As participants arrive
Greet participants as they arrive. Ask them to take a seat and make themselves comfortable. (If there are refreshments, encourage them to help themselves)

Ask participants, if they have not already, to complete the profile questionnaire while they wait for the focus group to begin. Explain that the questionnaire will provide us information about their background and that this information will be used for descriptive purposes only. In other words, their name will not be in the survey, and we will never use any identifying information such as their name or the name of the agency where they get services in any of our reports.

For those participants who have not signed the informed consent, please have them do so at this time. Please read the consent forms to the participant since some people are reluctant to sign documents unless they have full understanding of what they are signing.

Be sure that participants who arrive later in the session also complete these forms.

Facilitator's Guidance

The focus group discussion will address the following four areas:

- What is working well? (Met needs)
- Gaps/Needs
- Why do gaps exist? (Barriers)
- Future Issues/Emergent Needs

Prior to the start of morning focus groups, printed summaries of stakeholder comments that were captured during the 2008 SCSN meeting will be given to each facilitator for distribution to focus group participants. The summary tables will serve as a point of reference for the group discussion.

At the end of each topic discussion, except the last one, ask the group to identify up to five main points from that discussion. If they identified less than five points that is fine. The facilitator should spend approximately 40 minutes on each section. Thirty minutes should be spent on the discussion and input and 10 minutes to summarize the main discussion points.

At the end of the session, the facilitators/recorders will summarize the main points for each topic on a flip chart sheet (one sheet per topic). Post these summary sheets on the walls of the main meeting room.

Recorders will deliver their laptops to Deb Bauer. Leave the remaining flip chart sheets from the first three topic discussions in the room.

Introduction

1. Introduction of facilitator and note taker

Welcome and thank you for coming today. My name is _____ and this is _____. We are from _____. I will be leading today's discussion. My role, for the most part, is to make sure that we get through our agenda, keep to the time frame, and make sure that everyone has a chance to participate. _____ will help me through the process, and s/he will also be taking notes. The discussion session today will take about two hours.

2. Participant Introductions

Now, let's go around the room and have each of you introduce yourselves; give your first name and any other information about yourself you want to share with the group.

3. Purpose of Focus Group Session

We have asked you here to talk about your experiences in seeking and receiving services – both about the things you like and the problems you may have encountered. We are also interested in hearing about other services or help you may need that you are not currently receiving. At the end of all except the last the topic discussion, we will ask each of you to rank your top 5 priorities.

4. Confidentiality

All of the information we collect here today is confidential. We will not identify any of the participants. Confidential means we will not use your name, address, or any other identifying information in reports or other materials related to this process.

Instructions

Let me begin our discussion by reviewing a few things about how we will conduct the session.

During this discussion, we would like you to focus on topics that are of particular interest to the SCSN process. We are interested in what everyone has to say about our discussion topics. Occasionally, I may have to interrupt the discussion in order to bring us back to a particular topic to make sure that we cover everything on the agenda.

There are several common-sense guidelines that we will follow during this session:

1. We want all of you to express your opinions about the discussion topics. We are interested in multiple points of view about them. There are no right or wrong answers, and we are not here to resolve any issues you may bring up.

2. Please do not hold side conversations. We want to be able to hear from everyone, and side conversations will disrupt the discussion. We want to make sure that we hear what everyone has to say. Because we are also recording the session, it would really help us if you could speak up so that everyone can hear you.
3. Please respect what each other has to say, because each comment is equally important.

Do you have any questions so far?

Let's begin.

Focus Group Topics

What is working well?

(Approx. 40 minutes total, 30 minute discussion, and 10 minute summary of main points)

Discussion Questions

- What services are working well for persons living with HIV/AIDS in Georgia?
- What services are meeting the needs of persons living with HIV/AIDS in GA?

Main Points

- Out of what we discussed, please rank up to your top five priorities. (Use colored dots to rank on flip chart paper)

Gaps/Needs

(Approx. 40 minutes total, 30 minute discussion, and 10 minute summary of main points)

Discussion Question

- During the 2008 meeting, the following were identified as gaps and/or needs (refer to summary table). Do these the gaps and/or needs in the provision of services for persons living with HIV/AIDS in Georgia still exist?
- Are there additional gaps/needs in the provision of services for persons living with HIV/AIDS in Georgia?

Main Points

- Out of what we discussed, please rank up to your top five priorities. (Use colored dots to rank on flip chart paper)

Why do you think these gaps are occurring? (Barriers)

(Approx. 40 minutes total, 30 minute discussion, and 10 minute summary of main points)

Discussion Questions

- Why do you think the gaps occur for each gap indentified above?
- Are there other obstacles/barriers that discourage or prohibit persons living with HIV/AIDS from receiving care?

Main Points

- Out of what we discussed, please rank up to your top five priorities. (Use colored dots to rank on flip chart paper)

Future Issues and Emergent Needs

(Approx. 30-40 minute discussion)

Discussion Question

- During the 2008 meeting, the following were identified as (refer to summary table list) the top issues on the horizon that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia? Are these still the top issues that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia?
- Are there additional issues on the horizon that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia?

NOTE: DO NOT RANK THIS LIST

Thank you very much for participating in this focus group. The information you have provided has been very helpful. This information will be used to help better make informed decisions about service priorities and the use of resources.

Appendix 3

Georgia's 2012 Statewide Coordinated Statement of Need
Facilitator's Guide

Healthcare Providers / Administrators / Social Services Providers
Breakout Session 1
9:15 a.m. to 12:00 p.m.

Non-consumers will be divided into three groups (Healthcare Providers, Administrators & Social Services Providers). Guide participants to their area/breakout room. Ask them to take a seat and make themselves comfortable. (If there are refreshments, encourage them to help themselves.) Let them know that there is no official break but they are free to step outside the room if needed. Introduce yourself. Have the recorder, note taker and participants briefly introduce themselves.

Facilitator's Guidance

The focus group discussion will address the following four topics:

- **What is working well? (Met needs)**
- **Gaps/Needs**
- **Why do gaps exist? (Barriers)**
- **Future Issues/Emergent Needs**

Prior to the start of morning focus groups, printed summaries of stakeholder comments that were captured during the 2008 SCSN meeting will be given to each facilitator for distribution to focus group participants. The summary tables will serve as a point of reference for the group discussion.

At the end of each topic discussion, except the last one, ask the group to identify (using colored dots) up to five main points (fewer is OK) for that topic that will be used for the afternoon report out.

The facilitator should spend approximately **40 minutes** on each of the four areas. About thirty (30) minutes should be spent on the discussion and input. Then spend about 10 minutes to summarize the main discussion points.

Remind the group to focus on realistic issues/needs in the current environment of flat or decreased funding. The goal is not to create a wish list, but to develop a realistic plan.

At the end of the session, the facilitators/recorders will summarize the main points for the topics on flip chart sheets. Post these summary sheets on the walls of the main meeting room.

Recorders will deliver their laptops to Deb Bauer. Leave the remaining flip chart sheets from the first three topic discussions in the room.

Introduction

5. Introduction of facilitator and note taker

Welcome and thank you for coming today. My name is _____ and this is _____. We are from _____. I will be leading today's discussion. My role, for the most part, is to make sure that we get through our agenda, keep to the time frame, and make sure that everyone has a chance to participate. _____ will help me through the process, and s/he will also be taking notes. The discussion session today will take about two hours.

6. Participant Introductions

Now, let's go around the room and have each of you introduce yourselves; give your first name and any other information about yourself you want to share with the group.

7. Purpose of Focus Group Session

We have asked you here to talk about your experiences in seeking and receiving services – both about the things you like and the problems you may have encountered. We are also interested in hearing about other services or help you may need that you are not currently receiving. At the end of all except the last the topic discussion, we will ask each of you to rank your top 5 priorities.

8. Confidentiality

All of the information we collect here today is confidential. We will not identify any of the participants. Confidential means we will not use your name, address, or any other identifying information in reports or other materials related to this process.

Instructions

Let me begin our discussion by reviewing a few things about how we will conduct the session.

During this discussion, we would like you to focus on topics that are of particular interest to the SCSN process. We are interested in what everyone has to say about our discussion topics. Occasionally, I may have to interrupt the discussion in order to bring us back to a particular topic to make sure that we cover everything on the agenda.

There are several common-sense guidelines that we will follow during this session:

4. We want all of you to express your opinions about the discussion topics. We are interested in multiple points of view about them. There are no right or wrong answers, and we are not here to resolve any issues you may bring up.
5. Please do not hold side conversations. We want to be able to hear from everyone, and side conversations will disrupt the discussion. We want to make sure that we hear what everyone has to say. Because we are also recording the session, it would really help us if you could speak up so that everyone can hear you.
6. Please respect what each other has to say, because each comment is equally important.

Do you have any questions so far?

Let's begin.

Focus Group Topics

What is working well?

(Approx. 40 minutes total, 30 minute discussion, and 10 minute summary of main points)

Discussion Questions

- During the 2008 meeting, the following were identified (refer to printed summary table) as services that were working well for persons living with HIV/AIDS in Georgia. Are these services still working well of persons living with HIV/AIDS in Georgia?
- Are there any additional services working well for persons living with HIV/AIDS in Georgia?

Main Points

- Out of what we discussed, please rank up to your top five priorities. (Use colored dots to rank on flip chart paper)

Gaps/Needs

(Approx. 40 minutes total, 30 minute discussion, and 10 minute summary of main points)

Discussion Question

- During the 2008 meeting, the following were identified (refer to printed summary table) as gaps in the provision of services for persons living with HIV/AIDS in Georgia. Do these gaps in the provision of services for persons living with HIV/AIDS in Georgia still exist?
- Are there additional gaps in the provision of services for persons living with HIV/AIDS in Georgia?

Main Points

- Out of what we discussed, please rank up to your top five priorities. (Use colored dots to rank on flip chart paper)

Why do you think these gaps are occurring? (Barriers)
(Approx. 40 minutes total, 30 minute discussion, and 10 minute summary of main points)

Discussion Questions

- Why do you think the gaps occur for each gap identified?
- Are there other obstacles/barriers that discourage or prohibit persons living with HIV/AIDS from receiving care?

Main Points

- Out of what we discussed, please rank up to your top five priorities. (Use colored dots to rank on flip chart paper)

Future Issues and Emergent Needs
(Approx. 30-40 minute discussion)

Discussion Question

- During the 2008 meeting, the following were identified (refer to summary table) as the top issues on the horizon that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia? Are these still the top issues that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia?
- Are there additional issues on the horizon that will significantly impact both the provision of services and the level of need for persons living with HIV/AIDS in Georgia?

NOTE: DO NOT RANK THIS LIST

Thank you very much for participating in this focus group. The information you have provided has been very helpful. This information will be used to help better make informed decisions about service priorities and the use of resources.

Appendix 4

Georgia's 2012 Statewide Coordinated Statement of Need
Facilitator's Guide

Consumers/Healthcare Providers / Administrators / Social Services Providers
Breakout Session 2
1:15 p.m. to 2:45 p.m.

Participants will be divided into five geographical groups and will develop broad action statements and strategies for their assigned barriers and/or issues. A facilitator will lead group discussion. A note taker will capture the action statements and strategies developed by the group. Guide participants to their area/breakout room. Ask them to take a seat and make themselves comfortable. (If there are refreshments, encourage them to help themselves.) Let them know that there is no official break but they are free to step outside the room if needed. Have the facilitator, note taker and participants briefly introduce themselves.

Facilitator's Guidance
The group's task is to help identify strategies to address how GA is going to meet expectations to maintain and improve the system of HIV care. The focus group discussion will develop broad action statements and/or strategies for each assigned barrier/issue:

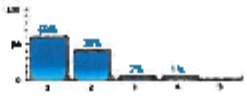
Barrier/Issues	Assigned Groups
Identifying individuals who know their status but are not in care, informing them about available treatment services and bringing them into care. How do we help persons, who know their status and are not in care, access care? How do we help them stay in care and fully participate in their care?	North Georgia, Metro Atlanta Group 1
Coordinate the provision of services programs for HIV prevention, including outreach and early intervention services. How can we better coordinate HIV care and prevention services?	South Georgia
Prevention and treatment of substance abuse. How can we better provide or link to substance abuse prevention services? How do we improve access to substance abuse treatment?	South Georgia
Eliminating disparities in access to core medical services and support services (In terms of sub-populations, hard to reach populations, and those historically underserved) Realizing that not everyone has equal access to services, how do we ensure that everyone has access to care and services?	Metro Atlanta Group 2, and Middle Georgia

Appendix 5

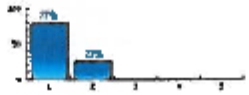
Georgia Statewide Coordinated Statement of Need (SCSN) Meeting 2012
No. of responses = 108

General questions about the meeting

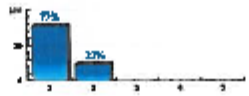
The meeting was beneficial.



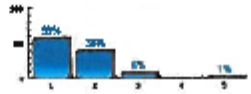
The meeting started on time.



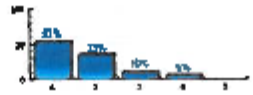
The meeting was facilitated well.



The meeting length was appropriate.



The meeting room was comfortable.



I had opportunities to express my opinions.

2

Appendix 6

RESOURCE INVENTORY

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
A Friend's House	Macon				X															X				
Adult Health Clinic	Tifton Tifton City HD	X		X	X	X	X		X	X		X					X				X	X		
Adult Health Promotion Clinic	Valdosta (testing in 10 co.)	X		X	X	X	X		X	X							X				X	X		
AID Atlanta	Atlanta EMA	X	X	X	X	X	X		X	X	X	X							X	X		X		
AID Gwinnett	Atlanta EMA	X	X	X	X	X	X	X	X	X	X	X					X		X	X	X	X	X	
AIDS Alliance of Northwest Georgia	Northwest Georgia		X	X	X	X					X									X	X	X	X	
AIDS Coalition of Northeast GA	North Georgia				X	X																		
AIDS Law Project	Middle Georgia Macon																						X	
AIDS Legal Project	Atlanta																						X	
AIDS Research Consortium of Atlanta (ARCA)	Atlanta		X		X	X																		
Al-Anon Family Groups	Atlanta												X											
Alateen Groups	Atlanta Access website alanonatl.com												X											
Albany Area Primary are, Inc.	Albany						X																	
Alcoholics Anonymous	Atlanta												X											

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Alpha and Omega AIDS Foundation	Atlanta		X	X	X						X	X								X				
AM Ministries	Rome, Griffin, Carrollton, Dalton, Gainesville, LaGrange																		X	X				
ANIZ, Inc.	Atlanta		X	X	X	X				X	X	X	X							X	X			
Another Chance	Buford, GA Thrift Shop																							
Atlanta Area Service Group	Metro Atlanta and around Georgia											X												
Atlanta Harm Reduction Center	Atlanta		X	X	X	X							X											
Atlanta Legal Aid Society																							X	
Atlanta Outreach Projects																				X				
Atlanta Union Mission Men and Women Homeless Shelters	Atlanta			X							X									X	X			
Atlanta Urban Ministries	Atlanta																				X			
Beulah Grove Church	Richmond County		X		X	X														X	X			
Bridge, the	North Georgia				X							X	X							X				
Bulloch Wellness Center	Bulloch, Candler, Evans Co.				X	X	X			X														
Care and Counseling Center of Georgia	Atlanta				X							X												

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Center for Black Women's Wellness	Atlanta		X		X	X																		
Center for Family Resources	Atlanta (one time rent and utility assistance)				X		X												X	X	X	X		
Center for Family Resources – Cobb	Atlanta																		X	X	X			
Center for Pan-Asian Community Services	Atlanta EMA		X	X	X	X	X			X		X						X		X				
CEPTA (Center for Education, Treatment, and Prevention of Addiction	Atlanta EMA		X	X		X				X	X							X						
Central City AIDS Network	Macon	X	X	X	X	X				X	X		X				X	X	X	X	X	X	X	
Chatham County Board of Health	Chatham & Effingham Co.	X	X	X	X	X	X	X	X	X							X				X	X	X	
Childkind, Inc.	Atlanta				X		X					X										X		X
City of Refuge	Warner Robins		X		X						X													
Clarke County Board of Health	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe, Watson Co.	X	X	X	X	X	X	X	X	X	X	X	X				X	X	X	X	X	X		
Clayton College and State University Dental Hygiene Department	Clayton (cleaning and x-rays only)							X																

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Clayton County Board of Health	Clayton Co.	X	X	X	X	X	X		X	X		X									X			
Clayton Mental Health Substance Abuse Center	Clayton Co.		X	X	X		X					X	X											
Clifton Sanctuary Ministries Shelter	Atlanta																			X				
Cobb and Douglas Board of Health	Cobb & Douglas Co. Atlanta EMA (Part A)	X	X		X	X	X	X	X	X	X	X								X	X			
Coffee Wellness Center	Douglas				X	X	X			X														
Columbus Dept. of Public Health	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marian, Muscogee, Quitman, Randolph, Schley, Stewart & Sumter, Talbot. Taylor &Webster Co.	X				X	X	X	X	X														
Comprehensive AIDS Resource Encounter Inc. (CARE)	Jesup/ Southeast Georgia			X	X	X					X									X				
CSRA EOA	Richmond County				X				X	X									X	X				
CSRA AIDS Resources and Education, Inc. (CARE)	Central Georgia			X							X	X					X							

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
DeKalb Addiction Clinic	DeKalb											X	X											
DeKalb Board of Health	DeKalb Atlanta EMA (Part A)		X	X	X	X	X	X	X	X	X	X	X						X		X	X		
DeKalb Board of Health Early Care Clinic	DeKalb County	X				X	X	X	X		X	X	X											
DeKalb Community Service Board at Kirkwood			X	X	X	X						X	X											
DeKalb Prevention Alliance	DeKalb	X	X	X	X						X		X											
Diversity House Project	Macon					X				X										X				
Dougherty County Board of Health	Baker, Calhoun, Colquitt, Decatur, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas and Worth Counties	X				X	X	X	X	X							X			X	X	X		
Douglasville Community Health Center	Douglasville					X																		
Edgewood Medical Center, Inc.	Stone Mtn.						X																	
Edgewood SRO	Atlanta									X	X									X		X		
Ella Mae Thomas House	Atlanta																							

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Empowerment Resource Center, Inc.	Atlanta	X	X		X	X																		
Emory Psychological Counseling Center	Atlanta											X												
Emory University Hospital Midtown Infectious Disease Clinic	Atlanta						X																	
Extended Sisters	Columbus		X			X																		
Families First	Atlanta											X												
Feed the Hungry Foundation	Atlanta																				X			
Feminist Women's Health Center	Atlanta		X		X	X	X																	
First Call for Help	Atlanta				X							X							X	X	X			
First Metropolitan Community Church	Atlanta																				X			
Floyd County Board of Health	Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson, Paulding, Polk and Walker counties	X				X	X	X	X	X							X			X	X	X		
Fulton County Health Dept. IL	Fulton, Atlanta EMA (Part A)			X		X	X	X	X	X		X	X											
Furniture Bank																								
Gateway Center																	X			X				
Gay and Lesbian AA Club Galano	Atlanta												X											

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Genesis Shelter for women and newborns	Atlanta																	X		X				
Georgia Council for the Hearing Impaired	Atlanta, Statewide				X							X												
Georgia Crisis and Access Line (GCAL)												X	X											
Georgia Department of Corrections										X													X	
Georgia Law Center for the Homeless	Statewide																						X	
Georgia Legal Services – Atlanta	Statewide																						X	
Georgia Mutual Assistance Association Consortium	Statewide – services for refugees and immigrants		X															X						
Georgia Perimeter College Dental Hygiene Clinic	Atlanta							X																
Georgia Regional Hospital	Atlanta											X												
Georgia State University Psychology Clinic	Atlanta										X	X												
Georgia Therapy Associates, Inc.	North Central Georgia												X											
Gift of Grace Home	Atlanta																			X				

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Glynn Board of Health	Bryan, Camden, Liberty, Long, McIntosh, Glynn Co.	X			X	X	X	X		X														
God's House of Human Services, Inc.	Albany				X					X														
Grady Health System, Infectious Disease Program	Atlanta EMA		X	X	X		X	X	X	X	X	X	X					X	X	X	X	X	X	X
Grady Women's Health Services	Fulton and DeKalb Counties/Atlanta EMA				X	X	X	X	X	X	X	X				X		X	X	X	X	X		
Gwinnett County Board of Health	Gwinnett, Newton, Rockdale counties	X	X	X	X	X	X	X	X	X														
Gwinnett County Mental Health Center	Gwinnett											X												
Hall County Board of Health	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, and White Co.	X					X	X	X	X							X				X			

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Haven of Hope	Carroll, Heard, Troup, Meriwether, Pike, Upson, Lamar, Spalding, Butts, Henry, Fayette, Coweta Co.				X		X	X		X											X	X		
Hemophilia of Georgian	Statewide (for people with bleeding disorders and their partners)					X			X															
H.E.R.O for Children		X	X		X		X																	
H.O.P.E. Atlanta Programs of Travelers Aid of Metro Atlanta																			X			X		
HIV/AIDS Legal Project	Central and South Georgia Savannah																						X	
HIV Outpatient Services	Savannah Chatham CHD					X	X	X		X													X	
HIV Outpatient Services	Waycross				X	X	X																	
Home But Not Alone	Atlanta																			X				
Hope Center	Macon, Warner Robins, Fort Valley, Milledgeville, surrounding areas	X	X		X	X	X	X	X	X		X	X									X		
J&S Consultants	Macon			X	X					X														

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Jerusalem House	Atlanta		X		X					X		X								X				
Jewish Family and Career Services																								
Juxtaposed Center for Transformation		X	X	X	X																			
Kirkwood Mental Health Clinic	Atlanta											X	X											
La Gender	Atlanta		X		X						X													
Lanier Tech Dental Hygiene Clinic	North Georgia							X																
Lauren County Board of Health	Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, and Wilcox Co.	X				X	X	X		X							X				X			
Legacy House	Atlanta						X			X		X								X	X	X	X	
Legacy Village	Atlanta						X													X			X	
Link Counseling Center	Atlanta and Marietta			X							X	X	X											
Living Room	Atlanta EMA															X	X	X	X	X				
Lowndes County Board of Health	Ben Hill, Berrien, Brooks, Cook, Echols, Irwin, Lanier, Lowndes, Tift, and Turner Co.	X	X	X	X	X	X	X	X	X							X			X	X	X		

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Macon-Bibb Board of Health	Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Washington, and Wilkerson Co.	X	X	X		X	X		X	X							X	X	X		X	X	X	
Matthew's Place	Atlanta																			X				
Medical College of Georgia Adult ID Clinic	Central Georgia/ Richmond County	X			X	X	X	X	X							X				X	X	X		
Medical College of Georgia Dental Clinic	Central Georgia/ Richmond County							X																
Medical College of Georgia Pediatric ID Clinic	Central Georgia/ Richmond County				X		X		X		X										X	X		
Medical College of Georgia Title III-B	Richmond County	X	X			X																		
Michelle Antionette Jones Crisis Center, Inc.	Atlanta									X		X	X											
Midtown Assistance Center	Atlanta																		X		X			
Morehouse School of Medicine, PADP	Atlanta EMA				X	X	X		X	X									X	X	X	X		
IMANI Project Morehouse School of Medicine	Atlanta	X			X																			
Narcotics Anonymous	Metro Atlanta and GA												X											

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
National AIDS Education and Services for Minorities	Atlanta		X	X	X	X				X	X	X					X			X	X			
National Black Men's Health Network	Atlanta		X		X																			
New Start	Atlanta												X							X				
North DeKalb Mental Health Center **Part of Dekalb Community Services**	DeKalb				X					X		X												
North Fulton Regional Health Center	North Fulton					X																		
Northside Behavioral Health	Atlanta											X	X											
Northwest Georgia Specialty Care Clinic	Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson, Paulding, Polk, Walker Co.						X			X														
Oakhurst Recovery Program	Atlanta												X											
Outreach, Inc.	Atlanta		X	X	X	X					X											X		
Planned Parenthood	Central Georgia				X	X																		
Planned Parenthood	Savannah, Southeast Georgia				X	X																		

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Planned Parenthood of Georgia	Atlanta				X	X																		
Positive Impact	Atlanta EMA		X	X	X	X					X	X	X											
Positive Response	Carroll, Coweta, Fayette and Spalding counties		X		X	X	X			X	X										X	X		
PrimeCare of Augusta **Home Health Care Only**	Central Georgia				X	X					X			X										
Project Open Hand – Atlanta	Atlanta plus limited areas in Cobb, Clayton, Gwinnett Co.																				X			
Raksha, Inc.	Atlanta – assistance for immigrants from India, Pakistan, Bangladesh, Bhutan, Nepal, Sri Lanka			X														X			X			
Recovery Consultants of Atlanta			X	X	X	X							X											

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Richmond County Board of Health	Burke, Columbia, Emanuel, Glascock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliafero, Warren and Wilkes Co.	X				X	X	X										X		X		X	X	
Road to Recovery	Atlanta		X										X											
Rome AIDS Resource Council	Rome		X		X	X				X	X													
Ropheka Rock of the World, Inc.	Atlanta		X									X												
Salvation Army	Atlanta												X						X	X	X			
Secular Organizations for Sobriety (SOS)	Atlanta												X											
Sharing and Caring, Inc.	Toombs, Jeff Davis, Appling, Tattnall Co.				X		X				X											X		
Shepherd's Inn	Atlanta												X							X	X			
Shrine of the Immaculate Conception	Atlanta																				X			
SisterLove, Inc.	Atlanta EMA		X	X	X	X					X											X		
Someone Cares, Inc.	Atlanta	X	X	X	X	X					X	X							X		X			
Southeast AIDS Training and Education Center (SEATEC)	Atlanta and GA				X																			

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Southside Medical Care Substance Abuse Center	Atlanta			X								X	X											
St. Ann's AIDS Ministry	Cobb and North Fulton																				X	X		
St. Joseph's Mercy Care	Atlanta EMA		X		X	X	X	X		X	X	X	X					X		X				
St. Jude's Recovery Center	Atlanta	X										X	X											
St. Mark United Methodist Church	Atlanta										X								X	X				
St. Stephen's Ministry	Augusta			X	X					X	X						X			X	X	X		
St. Thomas the Apostle	South and West Cobb																				X			
St. Vincent de Paul Society	Atlanta				X														X	X				
Stand Inc.		X	X	X	X	X														X				
Sullivan Center	Clayton, DeKalb, and Fulton Co.																		X					
Task Force for the Homeless	Atlanta																			X				
Toombs Wellness Center	Toombs, Jeff Davis, Appling, Tattnall Co.				X	X	X																	
Travelers Aid of Metro Atlanta	Atlanta				X					X		X								X		X		

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Troup County Board of Health	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup and Upson Co.	X				X	X	X		X							X					X		
Union Mission Phoenix Project	Savannah				X															X				
Unique Community Women's Club	Soperton				X																			
United Hospice of Macon	Macon														X					X				
University of Georgia Student Health Center	Athens – students only					X						X												
University Hospital Retroviral Disease Outpatient Clinic	Augusta, Central Georgia				X		X		X													X		
Veterans Affairs Medical Center ID Clinic	Statewide – veterans only		X		X	X	X				X	X												
Visiting Nurse	Atlanta EMA					X						X		X										

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
Ware County Board of Health	Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware, and Wayne Co.	X				X	X																	
Ware Wellness Center	Ware, Pierce, Charlton, Brantley Co.				X	X	X																	
Wayne Wellness Center nm	Wayne Co. In Jessup				X	X	X																	
Welcome House	Atlanta																			X				
Wellness Clinic	Bryan, Camden, Liberty, Long, McIntosh, Glynn Co.				X	X	X	X						X										
Whitfield County Board of Health	Cherokee, Fannin, Gilmer, Murray, Pickens, and Whitfield Co.	X				X	X	X	X								X				X	X		
Wholistic Stress Control	Atlanta		X		X	X																		
Winn Way Mental Health Center	DeKalb											X								X				
Women's Resources Center to End Domestic Violence	Atlanta																			**X**		**X**	**X**	

Provider	Service Area	Early intervention services.	Outreach/case finding	Peer education/co.	Health ed/risk reduction.	Counseling & testing	HIV medical care	Dental Care	Medications	Case management	Support groups	Mental health co.	Substance abuse tx.	Home Health	Hospice	OB care for + women*	Emergency assistance	Translation assistance	Financial assistance	Housing assistance	Food/Nutrition assist.	Transportation assist.	Legal services	Child care
World Youth Alliance, Inc.	Atlanta				X																			

* Many providers that offer HIV medical care work with local Obstetrician and Gynecologists (OB/GYNs) to provide care for HIV positive pregnant women.

Additional Resources for People Living With HIV/AIDS

HIV/AIDS Information Lines/Hotlines and General Information

- AID Atlanta – Educational Outreach
- Aniz
- Centers for Disease Control and Prevention Information Network (NPIN)
- Centers for Disease Control and Prevention National STD/AIDS Hotline
- Cocaine Anonymous Hotline
- Feminist Women's Health Center
- Georgia AIDS/STD Information Line
- Georgia Crisis and Access Line (GCAL) central access point to connect youth and adults to local services for mental health, addictive diseases and developmental services
- Georgia Interpreting Services Network
- Healthy Mothers/Healthy Babies PowerLine
- Helpline Georgia
- H.O.P.E. Atlanta Programs of Travelers Aid of Metro Atlanta
- Project Inform HIV Treatment Hotline
- Public Health Information Line
- United Way 2-1-1 Call Center

Advocacy

- AID Gwinnett (client services, including Hispanic services) – Gwinnett, Rockdale, Newton
- AIDS Alliance for Faith and Health
- AIDS Survival Project – statewide advocacy training through Positive Action Network
- Al-Anon Family Groups
- ANIZ, Inc. – Atlanta
- Atlanta Legal AID Society – AIDS Legal Project
- Caminar Latino, Inc. – Hispanic services
- Committee of Ten Thousand (grassroots nonprofit advocacy and policy group for people who contract HIV and/or HCV through blood products)
- Feminist Women's Health Center
- Georgia Equality
- Juxtaposed Center for Transformation
- Mothers' Voices/Atlanta Chapter
- Positive Outlook Foundation
- Project Inform HIV Treatment Hotline
- St. Vincent de Paul Society
- SisterLove, Inc.
- Stand Inc.
- Vocational Rehabilitation Services

Clinical Research

- AIDS Research Consortium of Atlanta (ARCA)
- Emory Center for AIDS Research (CFAR)
  Hope Clinic of the Emory Vaccine Center
- Emory University Hospital Midtown Infectious Disease Clinic
- Georgia AIDS/STD Information Line
- Grady Health System – Ponce de Leon Center/Infectious Disease Program – Emory AIDS Clinical Trials Unit and Ponce Center Family and Youth Clinic Pediatric HIV Clinical Trials
- SHARE Project
- Veterans Affairs Medical Center ID Clinic (available only to veterans)

Spiritual Support

- AIDS Alliance for Faith and Health
- Al-Anon Family Groups
- Care and Counseling Center of Georgia
- Concerned Black Clergy of Metropolitan Atlanta
- Congregation Bet Haverim
- First Metropolitan Community Church
- Greater Piney Grove Baptist Church
- Hillside Chapel and Truth Center – Life Ministry
- Jewish Family and Career Services – Your Tools for Living
- Lutheran Church of the Redeemer
- Lutheran Services of Georgia
- North Decatur Presbyterian Church AIDS Ministry
- Oakhurst Baptist Church
- Salvation Army – Red Shield services
- Shrine of the Immaculate Conception
- St. Mark United Methodist Church
- St. Phillip Benizi Catholic Church AIDS Ministry
- Tabernacle Baptist Church – TBC Health and Wellness
- Visiting Nurses Health System – Hospice Atlanta

Clothing/Food/Furniture

- Absolute Care Medical Center and Pharmacy
- AID Gwinnett
- ANIZ
- Atlanta Union Mission – Women
- Atlanta Union Mission – Shepherd's Inn soup kitchen
- Center for Family Resources food pantry
- First Metropolitan Community Church food bank/pantry
- Furniture Bank of Metropolitan Atlanta

- Legacy House
- Midtown Assistance Center Assistance Line
- National AIDS Education and Services for Minorities
- Open Hand
- Raksha
- Salvation Army Family Emergency Services
- Shrine of the Immaculate Conception food pantry
- St. Philip Benizi Catholic Church AIDS Ministry
- Stand Inc.
- United Way 2-1-1 Call Center
- Women's Resource Center

Other
ChildKind
Partnership for Prescription Assistance
Pets Are Loving Support

Appendix 7

Contact Information

Georgia Department of Public Health
Division of Health Protection
Infectious Disease and Immunization Section
HIV Office

2 Peachtree Street, N.W.
12th Floor
Atlanta, GA 30303

Website: http://health.state.ga.us/
Telephone: 404-657-3100
Fax: 404-657-3119