Georgia Integrated HIV Prevention & Care Plan

2017-2021

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Introduction

On March 22, 2013 the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) released a letter indicating support for integrated HIV prevention and care planning groups and activities to further progress in reaching the goals of the National HIV/AIDS Strategy (NHAS) which include preventing new HIV infections, increasing access to care and improving health outcomes, and reducing HIV-related health disparities. This letter was followed-up with the June 2015 release of the: "Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017-2021" which established the framework for HIV prevention and care.

Georgia's 2017-2021 HIV Prevention and Care Plan (which includes the Statewide Coordinated Statement of Need (SCSN)) reflects the shared vision and values regarding how best to deliver HIV prevention and care services through three political jurisdictions and their respective planning bodies:

1. The State of Georgia provides HRSA-funded Ryan White Part B care and treatment services across the state and CDC-funded prevention efforts for 157 of Georgia's 159 counties through 16 of Georgia's 18 Public Health Districts. The Georgia Department of Public Health (DPH) integrated its prevention and care planning groups into the Georgia Prevention and Care Council (G-PACC).

2. The HRSA-funded Ryan White Part A Program provides care and treatment services for residents of the Atlanta Eligible Metropolitan Area (EMA): Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, and Walton. The Part A planning group is the Metropolitan Atlanta HIV Health Services Planning Council (Planning Council).

3. CDC-funded prevention programs in Fulton and DeKalb Counties are administered by the Fulton County Department of Health and Wellness. The City of Atlanta (Fulton/DeKalb Counties) Jurisdictional HIV Prevention Planning Group (JPPG) provides recommendations for Fulton County's High Impact HIV Prevention Program (HIPP).

The Georgia Integrated HIV Prevention and Care Plan identifies HIV prevention and care needs, existing resources, barriers, and gaps within our jurisdictions and outlines the strategies to address them through community developed and adopted Goals and Objectives. The Plan aligns with the goals of the NHAS and uses the principles and the intent of the HIV Care Continuum to inform the needs assessment process and service delivery implementation. The Plan is presented in three sections:

1. Statewide Coordinated Statement of Need/Needs Assessment;
2. Integrated HIV Prevention and Care Plan; and,
3. Monitoring and Improvement.

Section 1: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

According to the 2014 estimate for the federal census population, Georgia ranked eighth among states in population size, with a total population of 10,097,343. Females comprise 51.2% of the population while males are 48.8% of the population. Among Georgians reporting one race, 62.1% were White, 31.5% were African American and 9.3% were Hispanic. About one-half of the population, 52% of the state's African American population, 66% of the Hispanic population, and 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.

a. Description of the geographical region of the jurisdiction:

The Georgia Department of Public Health (DPH) is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. In 2011, the General Assembly restored DPH to its own state agency after more than 30 years of consolidation with other departments.

At the state level, DPH functions through numerous divisions, sections, programs and offices to fund and collaborate with Georgia's 159 county health departments and 18 public health districts. As it pertains to HIV, the Georgia Ryan White Part B Program and the HIV Prevention Programs are responsible for the coordination of HIV care and prevention services in 16 of the 18 health districts. The exceptions are Fulton and DeKalb health districts which are directly funded by CDC.

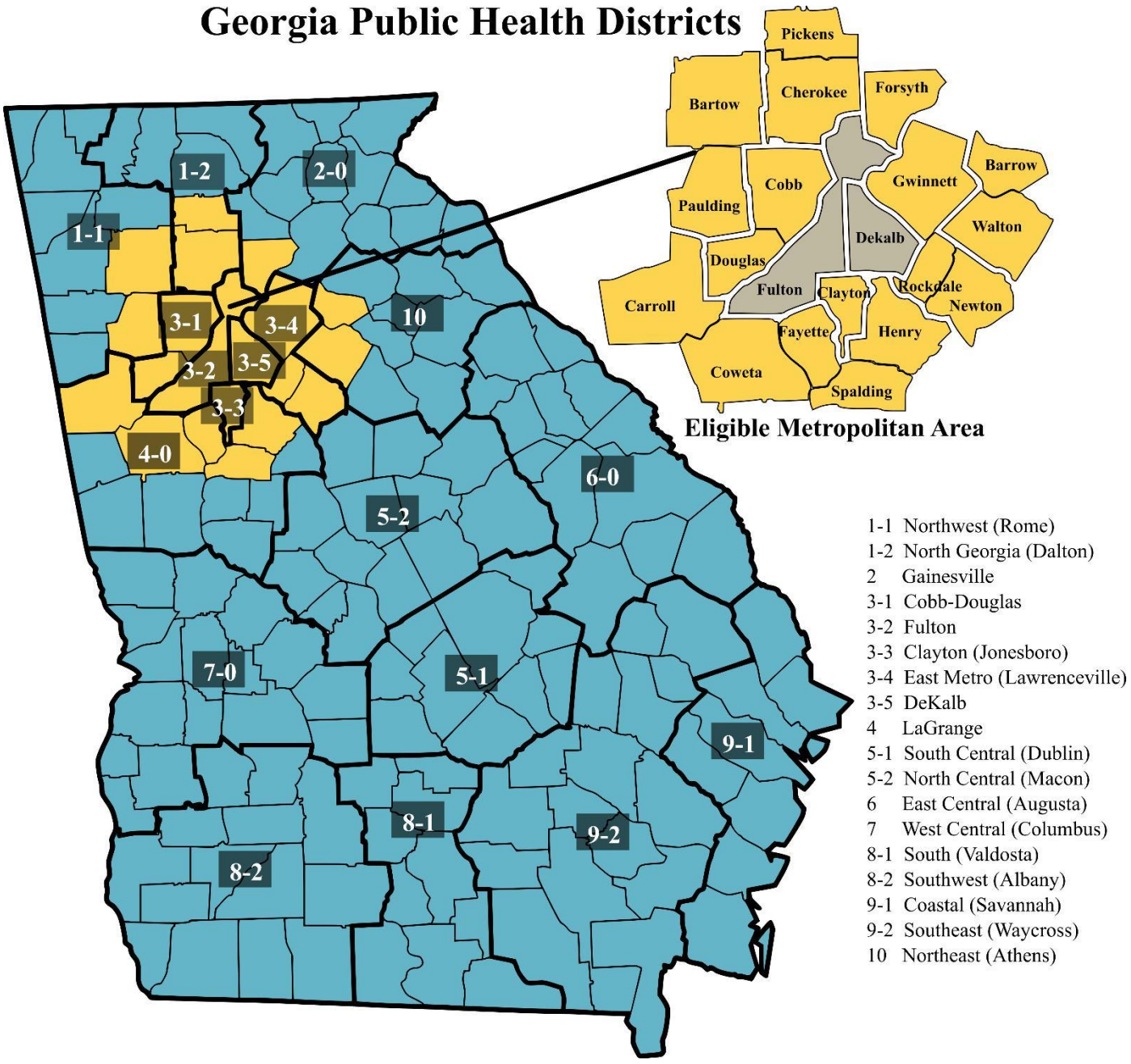
The Ryan White Part B Program funds essential medical and supportive services for persons with HIV disease or AIDS to 16 health districts and several agencies; manages the Georgia AIDS Drug Assistance Program (ADAP); Health Insurance Continuation Program (HICP); educates the public and health care professionals about HIV and AIDS; and, monitors the quality of medical care and case management services.

The Georgia HIV Prevention Program develops and coordinates the HIV testing program for the state, and provides capacity building and training for community partners and public health staff. The HIV Prevention Program also provides funding to community based organizations and public health districts throughout the same 16 health districts as the Ryan White Part B Program to implement comprehensive prevention activities for populations at greatest risk of HIV. Current data indicate that populations at greatest risk for infection include Black/African American and Hispanic gay and bisexual men, heterosexual women and injection drug users.

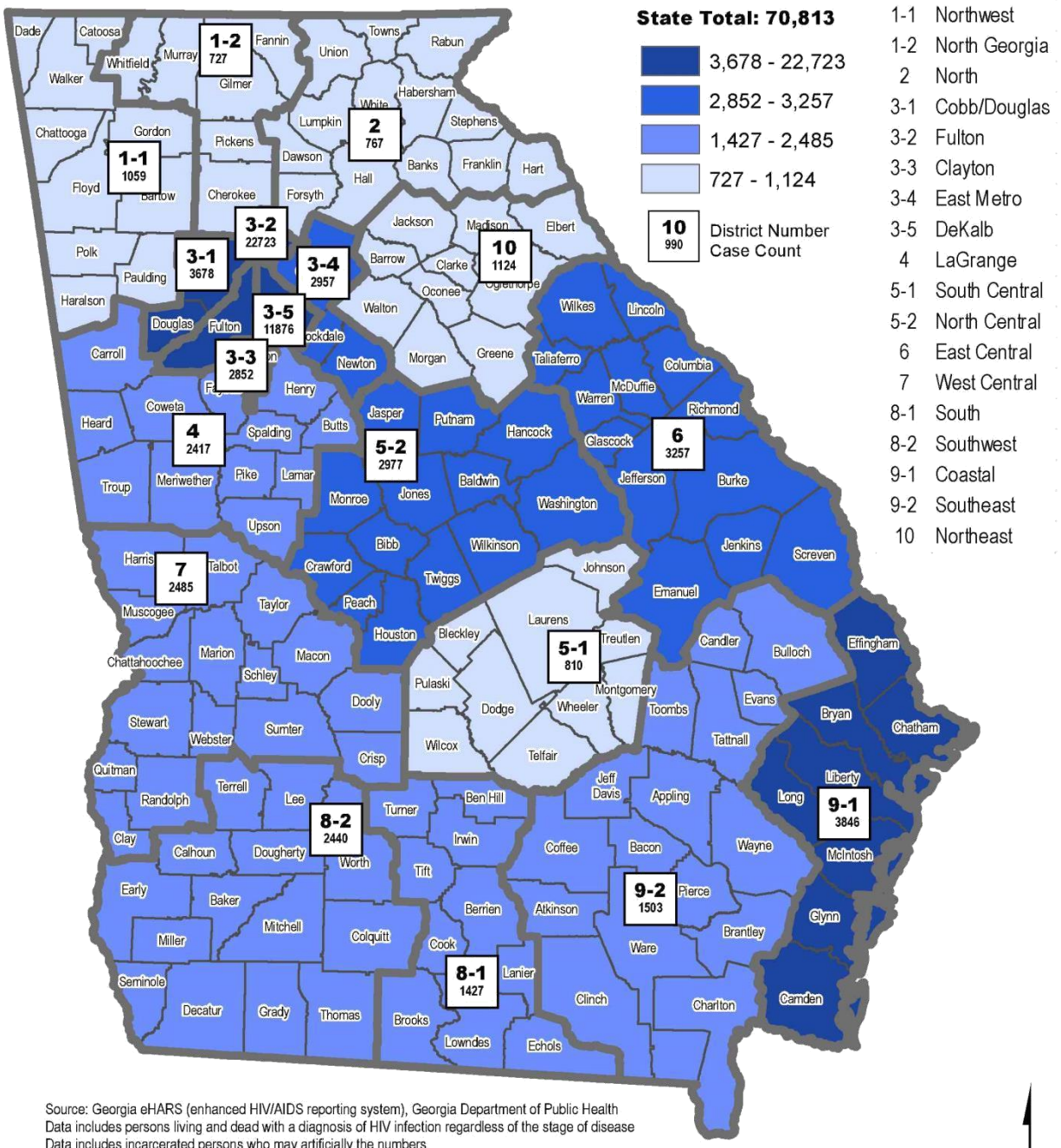
Georgia has one 20-county Eligible Metropolitan Area (EMA), and no transitional grant areas. The Fulton County Ryan White Part A Program is responsible for providing core medical and supportive services for persons with HIV/AIDS within the EMA. The 20 counties served are: Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta,

DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding and Walton (see yellow area in map below).

Fulton's High Impact Prevention Program (HIPP) focuses its prevention efforts on Fulton and DeKalb County residents at risk for HIV infection, including men who have sex with men, communities of color, women, injection drug users, transgender men and women, and youth (see light yellow areas below).



Cumulative cases of HIV infection by district of residence at diagnosis, Georgia, 1981 to December 31, 2014



Source: Georgia eHARS (enhanced HIV/AIDS reporting system), Georgia Department of Public Health
Data includes persons living and dead with a diagnosis of HIV infection regardless of the stage of disease
Data includes incarcerated persons who may artificially the numbers
Numbers are based on data entered as of December 31, 2014 and are not adjusted for reporting delays

Created: March, 2016
Source: Department of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

b. Socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area:

i. Demographic data including race, age, sex, transmission category, gender identity:

In 2014 there were 2,640 new HIV diagnoses, and 53,230 persons living with HIV (PLWH) in Georgia. The Atlanta EMA accounted for 66% of new diagnoses and 69% of PLWH. Fulton and DeKalb Counties accounted for 63% of new diagnoses and 68% of PLWH in the EMA, and 42% of new diagnoses and 45% of PLWH in Georgia.

Overall, approximately 80% of new diagnoses of PLWH were among males, and approximately two-thirds were among Blacks/African Americans (Tables 1 and 3). Among men, over 80% of new diagnoses were attributed to male-male sex; among women the great majority of new diagnoses and PLWH were attributed to heterosexual contact (Table 2 and 4). A higher percent of new diagnoses among White women was attributed to injection drug use than among Black/African American or Hispanic women. Almost two-thirds of new diagnoses in 2014 were among persons less than 40 years of age; almost two-thirds of PLWH were 40 years of age and older (Tables 1 and 3). In 2014, 9 transgender persons were diagnosed with HIV, and 148 transgender persons were living with HIV (these figures may be low as they rely on providers indicating transgender status on the HIV case report form).

Overall patterns were similar in the EMA and outside the EMA; however, women accounted for a higher proportion of new diagnoses and of PLWH outside of the EMA than in the EMA (Tables 1 and 3). Among males, heterosexual contact accounted for a higher percent of new diagnoses and of PLWH outside the EMA than in the EMA, particularly among Black/African American and Hispanic men (Tables 2 and 4).

Table 1. New HIV Diagnoses by Selected Characteristics, 2014

	Georgia (2,640)		Fulton/DeKalb (1,096)		Atlanta EMA (1,738)		Georgia excluding EMA (902)	
	N	%	N	%	N	%	N	%
Male	2,111	80	925	84	1,410	81	701	77
Female	521	20	169	15	322	19	199	22
Transgender	11	<1	7	<1	10	<1	1	<1
White	356	13	113	10	216	12	140	16
Black/AA	1,719	65	759	69	1,119	64	600	67
Hispanic	139	5	60	5	107	6	33	4
Asian	17	<1	9	<1	11	<1	6	<1
AI/AN	<5	--	<5	--	<5	--	<5	--

Table 1. New HIV Diagnoses by Selected Characteristics, 2014								
	Georgia (2,640)		Fulton/DeKalb (1,096)		Atlanta EMA (1,738)		Georgia excluding EMA (902)	
	N	%	N	%	N	%	N	%
API	45	2	19	2	29	2	16	2
Unknown	360	14	135	12	253	15	107	10
MSM	1,586	60	714	65	1,070	62	516	57
IDU	89	3	26	2	51	3	39	4
MSM/IDU	42	2	20	2	29	2	14	2
Heterosexual	554	21	198	18	329	19	226	27
13-19	101	4	36	3	64	4	37	4
20-29	968	37	407	37	637	37	331	37
30-39	636	24	281	26	439	25	197	22
40-49	469	19	213	19	310	18	159	18
50-59	335	13	128	12	215	12	120	13
60+	122	5	29	3	66	4	56	6

Table 2. New HIV Diagnoses, Transmission Category by Race/Ethnicity and Sex, 2014								
	Georgia (2,640)		Fulton/DeKalb (1,096)		Atlanta EMA (1,738)		Georgia excluding EMA (902)	
	N	%	N	%	N	%	N	%
White Male								
MSM	273	91	98	92	175	92	98	88
IDU	8	3	<5	--	<5	--	5	5
MSM/IDU	12	4	5	5	8	4	<5	--
Heterosexual	7	2	<5	--	<5	--	<5	--
Black/AA Male								
MSM	1,164	86	543	87	783	87	380	84
IDU	45	3	14	3	26	3	18	4
MSM/IDU	25	2	13	2	17	2	8	2
Heterosexual	121	9	53	8	75	8	47	10
Hispanic Male								
MSM	98	81	53	94	78	83	20	76
IDU	5	4	<5	--	<5	--	<5	--
MSM/IDU	<5	--	<5	--	<5	--	<5	--
Heterosexual	14	12	<5	--	10	11	<5	--
White Female								
IDU	9	18	<5	--	5	17	5	15
Heterosexual	45	82	6	80	21	82	23	83
Black/AA								

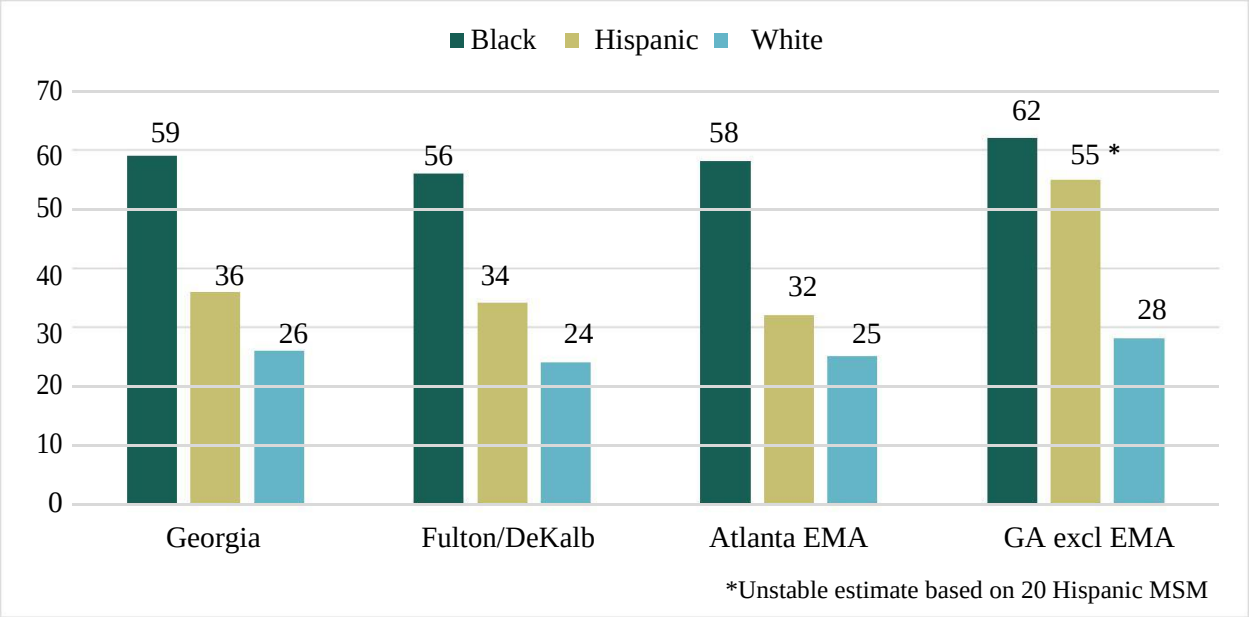
Table 2. New HIV Diagnoses, Transmission Category by Race/Ethnicity and Sex, 2014								
	Georgia (2,640)		Fulton/DeKalb (1,096)		Atlanta EMA (1,738)		Georgia excluding EMA (902)	
	N	%	N	%	N	%	N	%
Female								
IDU	18	5	6	5	11	5	7	5
Heterosexual	338	93	128	95	200	93	138	94
Hispanic Female								
IDU	<5	--	<5	--	<5	--	<5	--
Heterosexual	17	87	<5	--	11	85	5	90

Table 3. Persons living with HIV by Selected Characteristics, 2014								
	Georgia (53,218)		Fulton/DeKalb (24,997)		Atlanta EMA (36,923)		Georgia excluding EMA (16,295)	
	N	%	N	%	N	%	N	%
Male	40,412	75	20,606	82	29,266	79	10,886	67
Female	12,974	24	4,336	17	7,588	21	5,386	33
Transgender	157	<1	99	<1	132	<1	25	<1
White	10,377	19	4,495	18	7,036	19	3,341	21
Black/AA	35,346	66	17,265	69	24,470	66	10,876	67
Hispanic	3,043	6	1,223	5	2,238	6	805	5
Asian	201	<1	94	<1	171	<1	30	<1
AI/AN	29	<1	10	<1	17	<1	12	<1
API	17	<1	11	<1	16	<1	<5	--
Multiple races	1,804	3	873	3	1,301	4	503	3
Unknown	2,401	5	1,026	4	1,674	5	727	4
MSM	30,840	58	16,592	66	23,331	63	7,059	46
IDU	3,969	7	1,532	6	2,337	6	1,632	10
MSM/IDU	2,331	4	1,263	5	1,734	5	597	4
Heterosexual	13,007	24	4,361	17	7,439	20	5,568	34
13-19	329	<1	120	<1	229	<1	100	<1
20-29	6,862	13	3,148	13	4,768	13	2,094	13
30-39	10,969	21	5,414	22	7,998	22	2,971	18
40-49	15,260	29	7,244	29	10,831	29	4,429	27
50-59	14,180	27	6,641	27	9,556	26	4,624	28
60+	5,435	10	2,377	10	3,431	9	2,004	12

Table 4. Transmission Category by Race/Ethnicity and Sex for Persons living with HIV, 2014								
	Georgia (53,218)		Fulton/DeKalb (24,997)		Atlanta EMA (36,923)		Georgia excluding EMA (16,295)	
	N	%	N	%	N	%	N	%
White Male								
MSM	7,751	87	3,858	90	5,686	88	2,065	82
IDU	268	3	58	1	142	2	126	5
MSM/IDU	684	8	309	7	482	8	201	8
Heterosexual	190	2	38	<1	88	1	102	4
Black/AA Male								
MSM	19,863	78	11,101	82	15,111	82	4,725	69
IDU	1,766	7	825	6	1,121	6	645	9
MSM/IDU	1,373	5	820	6	1,036	6	337	5
Heterosexual	2,167	9	742	5	1,107	6	1,061	15
Hispanic Male								
MSM	1,913	79	904	86	1,503	83	410	68
IDU	119	5	34	3	70	4	49	8
MSM/IDU	137	6	61	6	110	6	27	4
Heterosexual	235	10	46	4	121	7	113	19
White Female								
IDU	340	24	65	30	152	25	187	23
Heterosexual	1,046	74	147	68	433	72	613	75
Black/AA female								
IDU	1,250	13	476	13	709	12	541	14
Heterosexual	8,375	85	3,101	85	5,045	85	3,330	84
Hispanic female								
IDU	77	12	25	15	53	13	25	12
Heterosexual	530	85	140	82	355	85	175	86

Marked differences in age at diagnosis were observed among MSM by race/ethnicity. Almost 60% of Black/African American MSM were less than 30 years of age at diagnosis, compared with 25-35% of Hispanic and White men. This pattern was observed both in the EMA and outside of it (Figure 1).

Figure 1. New Diagnoses among MSM: Percent <30 Years of Age by Race/Ethnicity, 2014



Overall, 23% of persons diagnosed in 2014 were diagnosed with Stage 3 disease (AIDS) within 3 months of their HIV diagnosis (Table 5). A higher proportion of Hispanics than Whites or Blacks/African Americans were diagnosed late. Late diagnoses were more common among persons 40 years of age and older, among injection drug users, among heterosexual contacts, and among Hispanics.

Table 5. Proportion diagnosed as stage 3 (AIDS) within 3 months of HIV diagnosis

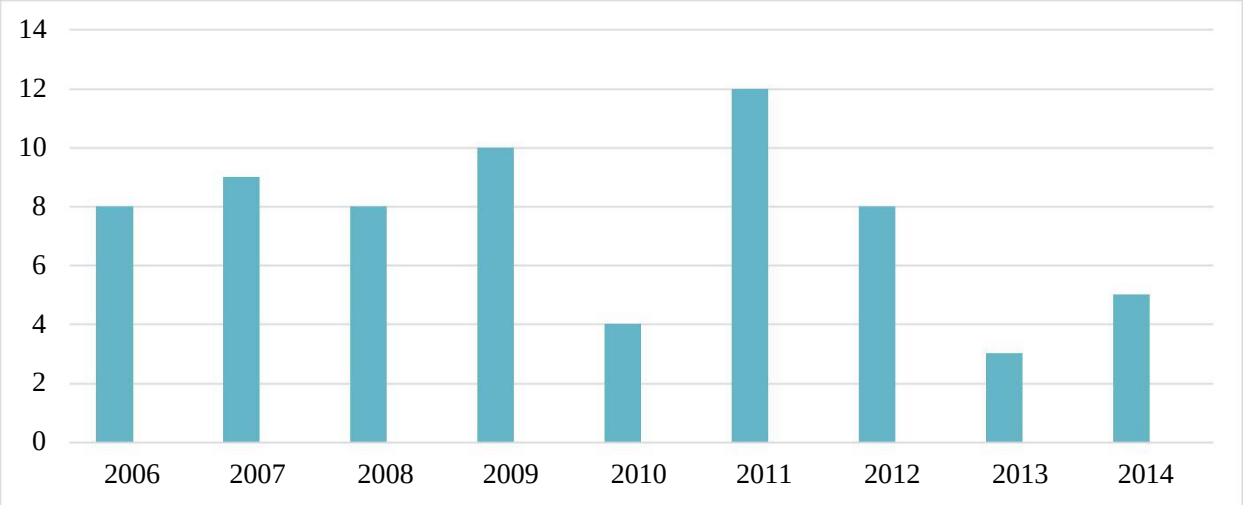
	Georgia (%)	Fulton/DeKalb (%)	Atlanta EMA (%)	Georgia excl. EMA (%)
Male	23	21	23	23
Female	22	18	21	25
White	20	18	20	20
Black/AA	23	21	22	25
Hispanic	31	32	34	25
Asian	--*	--	--	--
AI/AN	--	--	--	--
Multiracial	--	--	--	--
MSM	22	21	22	22
IDU	29	27	27	33
MSM/IDU	20	--	19	--
Heterosexual	26	21	25	28
13-19	11	--	11	--
20-29	14	14	14	14
30-39	27	27	27	28
40-49	30	23	29	31

Table 5. Proportion diagnosed as stage 3 (AIDS) within 3 months of HIV diagnosis				
	Georgia (%)	Fulton/DeKalb (%)	Atlanta EMA (%)	Georgia excl. EMA (%)
50-59	30	26	27	35
60+	32	24	33	30

HIV/AIDS is taking a substantial toll on the transgender community. Although there is no systematic surveillance data for the transgender population, it has been estimated in recent studies that between 41% to 63% of Black/African American transgender women, 14% to 50% of Latina transgender women, and 4% to 13% of Asian-Pacific Islander transgender women are HIV-positive. Initial studies of transgender male youth have also estimated the HIV prevalence to be between 19% and 22%. Other studies of the overall prevalence of HIV among transgender men estimate that 2% to 3% of transgender men are HIV-positive.[1] The Georgia DPH is undertaking efforts to revise HIV reporting processes and forms to collect surveillance data for transgender men and women. CAREWare data include client level data on transgender clients served.

The number of perinatally-infected infants born each year between 2006 and 2014 has ranged from 4 to 12 (Figure 2). Approximately two-thirds are born in the Atlanta metro area.

Figure 2. Perinatally-acquired HIV by year of birth, Georgia 2006-2014



ii. Socioeconomic data including percentage of federal poverty level income, education, health insurance status, etc.:

Federal Poverty Level (FPL): Approximately 37% (3,611,500) of all Georgia residents were living at or below 200% of the FPL in 2014 according to a U.S. Census Bureau poverty status report. Blacks/African Americans and Hispanics

[1] "Trans Lives Matter: All Lives Matter, but Not all Lives are Treated Equally", Fulton County Department of Health and Wellness, HIV High Impact Prevention Program, 2015.

continue to be disproportionately affected, with 26% and 32% of each population living below 100% FPL. Based on RDR data available for 2014, 70% (10,128) of clients who received services at Part B sites lived at or below 300% FPL. Of the 14,032 clients served in 2014 at Part A sites, income is known for 13,539. Of the 13,539, there were 8,170 (60%) with reported incomes below the Federal Poverty Level and 89.6% below 300% FPL.

Health Insurance Status: According to the Kaiser Family Foundation, 16% (1,546,500) of all Georgia residents in 2014 reported no health insurance coverage. Data from 2014 RDR indicated that 49% (7,441) of clients receiving medical services at Part B clinics had no medical insurance. As of March 2016, there were 537 Ryan White clients enrolled in the Georgia HICP, 416 of which have Affordable Care Act (ACA) health insurance marketplace plans.

Part A clients fall at or below 138% FPL (the catchment of people who would have been covered by Medicaid expansion, had Georgia decided to expand Medicaid). Data from 2014 indicated that 53.1% (7,450) of Part A clients had no medical insurance; 3.6% (509) were enrolled in ACA health insurance marketplace plans; 14.8% (2,078) were enrolled in Medicare 14.9% (2,078); and, 14.9% (2,090) receiving Medicaid. In FY13 prior to the roll-out of marketplace insurance, five clients (0.04%) had private-individual insurance. In FY14, that number increased to 509 people (3.6%), an increase of 102%.

Insurance and Medicaid Expansion: As in other states, most Georgians are covered by private health insurance**.** As of 2012, nearly six in ten (58%) were covered under an employer plan or in the individual private market.

One in five Georgians (20%) are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), also known in Georgia as PeachCare for Kids. Medicaid and CHIP help to fill gaps in the availability of private coverage, mostly for children, since Medicaid eligibility for adults has historically been limited to parents with very low incomes. As of 2012, four in ten Georgian children (40%) were enrolled in Medicaid or CHIP, compared to about one in ten nonelderly adults (11%). Prior to 2014, approximately 182,000 uninsured children in Georgia were eligible for Medicaid or CHIP but had not enrolled.

While a majority of Medicaid enrollees in Georgia are children, the elderly and disabled account for most of the expenditures in the program. As of Fiscal Year 2010, children made up 60% of Medicaid enrollees in Georgia, but accounted for about one-quarter (26%) of total Medicaid expenditures. Conversely, the elderly and people with disabilities accounted for less than one-quarter (24%) of enrollees, but 60% of total program costs. Average spending per beneficiary in Georgia was $3,916, the second lowest in the country after California, and much less than the national average of $5,563.

Although Medicaid and CHIP play an important role in coverage for some populations in Georgia, many individuals remain uninsured. As of 2012, Georgia had among the highest uninsured rates in the country, with more than one in five

nonelderly residents lacking coverage."[2] The U.S. Census Bureau's American Community Survey has a breakdown of uninsured residents by state. In 2012, Georgia ranked sixth, with about 19% of its residents uninsured, slightly above the national average of 16 %.[3] In 2013, Georgia ranked fourth, with 18.8%, which was greater than the national average of 14.5%.[4] More recent estimates of the uninsured in 2014 suggest that Georgia's uninsured rate is increasing relative to other states. In 2014, Georgia ranked fourth, with 15.8%, which was greater than the national average of 11.7%.[5] "Similar to the uninsured in other states, most uninsured Georgians are low-income individuals from working households. Nine in ten uninsured people in Georgia (90%) have income below 400% FPL, and three-quarters (75%) of the uninsured have at least one full-time worker in their household. Four in ten uninsured people in Georgia are White, but people of color make up a larger share (60%) of the uninsured. Specifically, Blacks/African Americans account for about one-third (35%) and Hispanics account for about one-fifth (18%) of the uninsured in the state. The nonelderly, uninsured in Georgia are not equally distributed across the state's counties, with the southern and central counties having higher uninsured rates than other areas of the state."[6]

A main goal of the ACA is to extend health coverage to many of the 47 million nonelderly uninsured individuals across the country, including many of the 1.8 million uninsured Georgians. The Supreme Court decision on the ACA effectively made the Medicaid expansion to adults a state option, and Georgia is not currently implementing the expansion. Georgia is one of 23 states not currently implementing the ACA Medicaid expansion, which could, if implemented, extend Medicaid coverage to nearly 600,000 low-income uninsured adults in the state. More than 409,000 uninsured poor adults who would have been eligible for Medicaid under the expansion fall into a coverage gap. In Georgia, the coverage gap has a disproportionate effect on people of color**.** Nearly half (48%) of uninsured, poor Georgian adults in the coverage gap are Black/African American, and 6% are Hispanic. Overall, people of color make up 60% of people in the coverage gap in Georgia. About four in ten Georgians in the gap (39%) are White.

Even without the Medicaid expansion, nearly half (45%) of uninsured Georgians are eligible for some financial assistance to obtain coverage under the ACA, largely through the Marketplace. Nearly one in five (17%) are eligible for coverage through existing eligibility pathways in Medicaid and CHIP, though most of these individuals are children. More than one-quarter (28%) are eligible for premium tax credits to help them purchase private coverage in the Marketplace, and 20% may benefit from employer-sponsored insurance or access to unsubsidized coverage in the Marketplace.[7]

2 http://kff.org/health-reform/fact-sheet/the-georgia-health-care-landscape/
3 http://www.politifact.com/georgia/statements/2014/feb/03/raphael-warnock/ranks-uninsured-high-georgia/
4 http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf
5 http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf page 26
6 http://kff.org/health-reform/fact-sheet/the-georgia-health-care-landscape/
7 http://kff.org/health-reform/fact-sheet/the-georgia-health-care-landscape/

c. Burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV:

In Georgia, Blacks/African Americans bear the highest burden of HIV; the rate of new diagnoses and of HIV prevalence in Blacks/African Americans is 8.5 and 6 times higher, respectively, than among Whites; rates among Hispanics are 2.2 and 1.7 times higher (Table 6).

Table 6. New HIV diagnoses and HIV prevalence by sex and race/ethnicity per 100,000 population, Georgia, 2014

	Population Size	New diagnoses	Prevalence
Black/AA	3,098,214	55.5	1140
Hispanic	935,279	15.0	325
White	5,487,103	6.5	189
Asian	378,945	4.5	53
American Indian	23,286	--*	124

*number too small to provide estimate

Rates of new diagnosis and prevalence rates also vary substantially by region of the state. For men, rates are highest in Metro Atlanta, followed by the southern part of the state and are lowest in the northern part of the state (Figures 3a. and 3b.); the difference in rates between Metro Atlanta and other areas is greatest for Whites, followed by Blacks/African Americans, and smallest for Hispanics. For women, rates are highest in the southern part of the state, followed by Metro Atlanta (Figures 4a. and 4b.). Metro Atlanta includes five health districts: Clayton, Cobb, DeKalb, Fulton and Gwinnett.

Figure 3a. HIV Prevalence Rate among Men by Race/Ethnicity and Health District per 100,000 Population

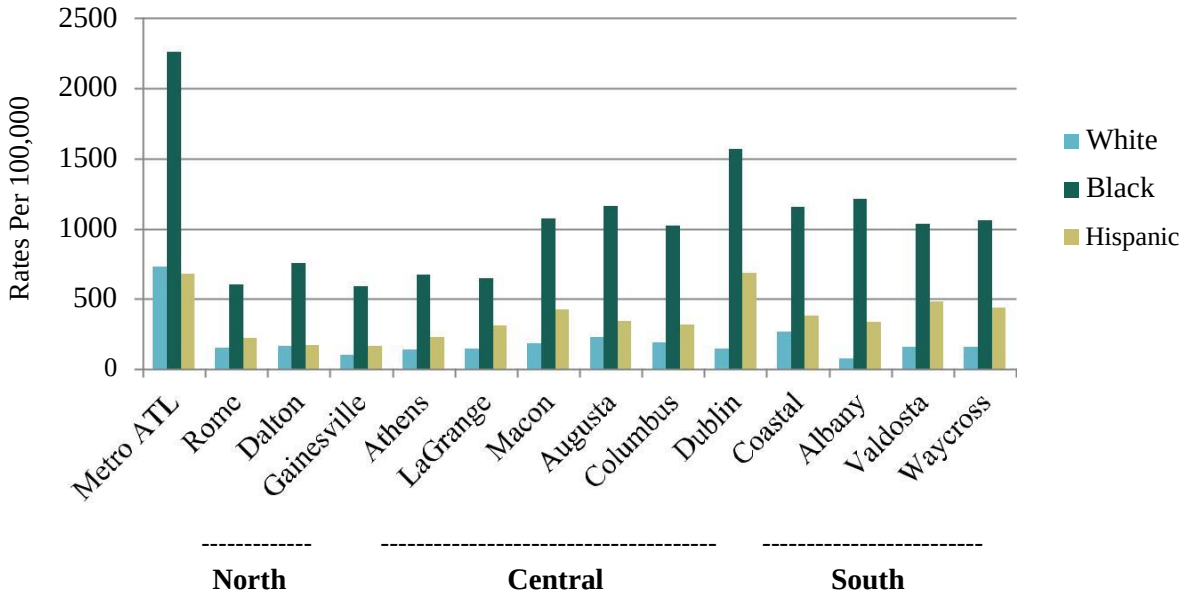


Figure 3b. New HIV diagnosis Rate among Men by Race/Ethnicity and the Health District per 100,000 Population

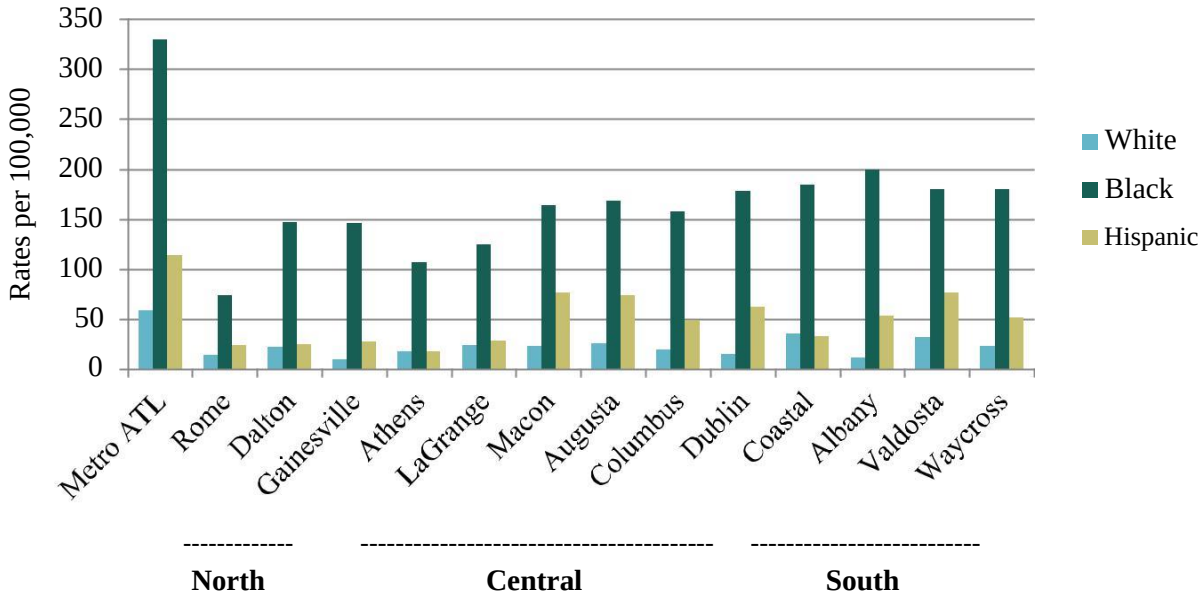


Figure 4a. HIV Prevalence Rate among Women by Race/Ethnicity and Health District per 100,000 Population

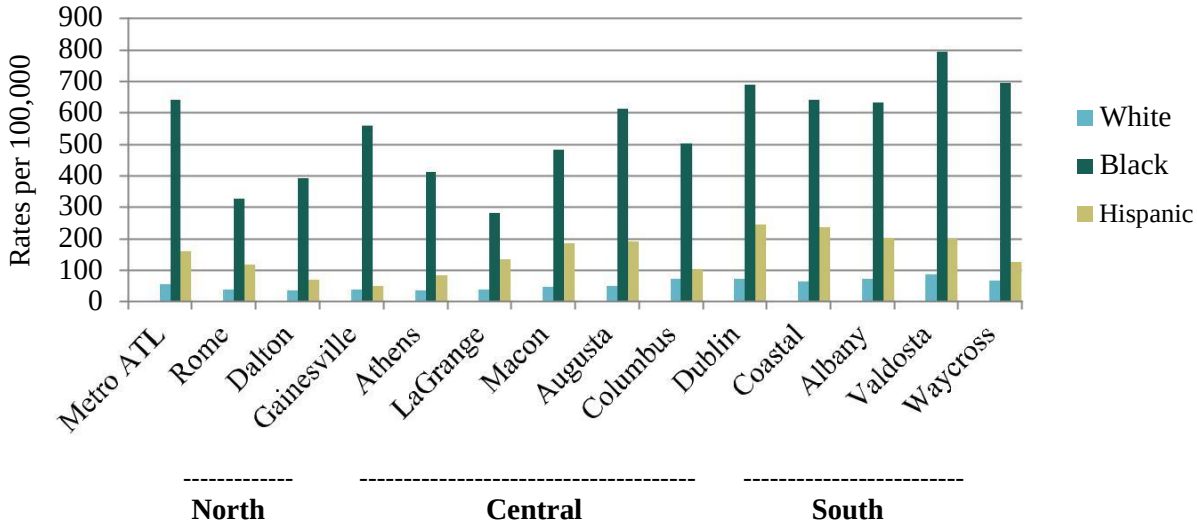
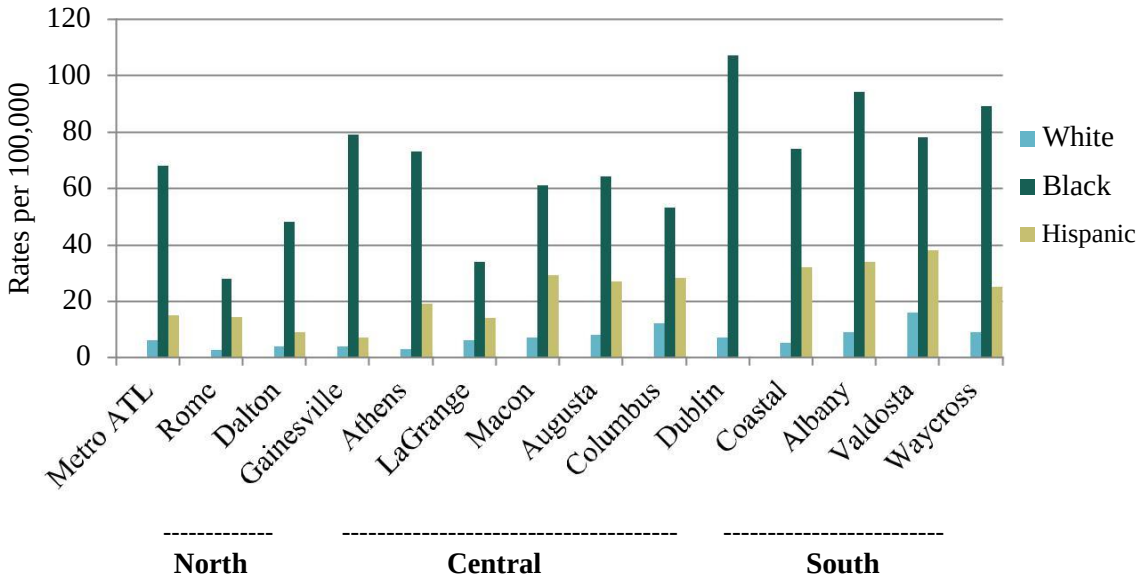


Figure 4b. New HIV Diagnosis Rate among Women by Race/Ethnicity and Health District per 100,000 Population



The especially high rates of HIV among men in metro Atlanta likely reflect relatively more MSM in metro Atlanta compared with other parts of the state. Women account for a higher proportion of cases outside of Atlanta than in Atlanta, potentially reflecting higher rates of bisexual behavior among men who have sex with men outside of Atlanta.

New diagnoses, overall: The annual number of HIV diagnoses has been fairly stable between 2006 and 2014. This overall trend masks the dramatic increase in HIV diagnoses among Black/African American MSM age 20-29 between 2005 and 2011 (Figure 5a). While new diagnoses increased in this age group, the number declined in men 30-49 and was stable in men 50 and older. Among White MSM new diagnoses declined among men 30-49 and were stable among men 20-29 and among men 50 and older (Figure 5b). Among Black/African American women, new diagnoses declined among women 15-49 and were fairly stable among women 50 and older (Figure 6). For White and Hispanic women and for Hispanic men, trends by age group are difficult to interpret due to small numbers.

Figure 5a. New HIV diagnoses among Black/African American MSM, Georgia 2005-2013

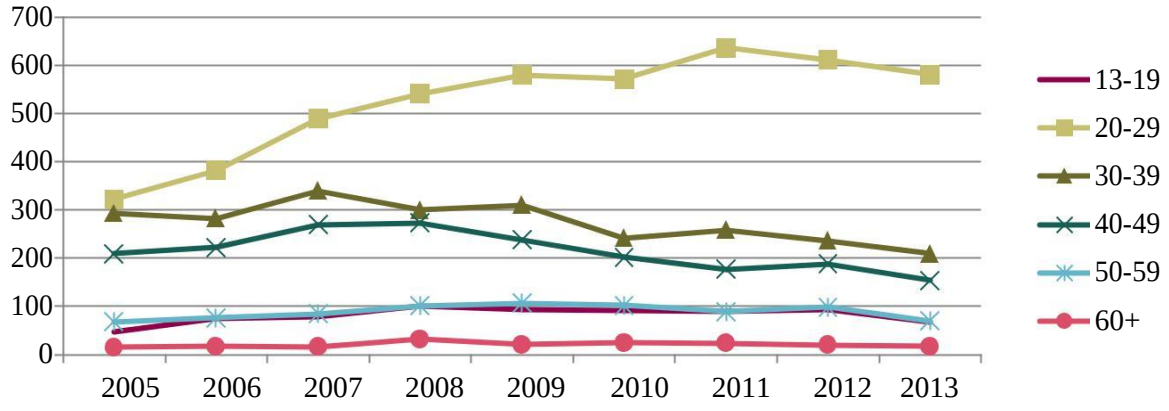


Figure 5b. New HIV diagnoses among White MSM, Georgia 2005-2013

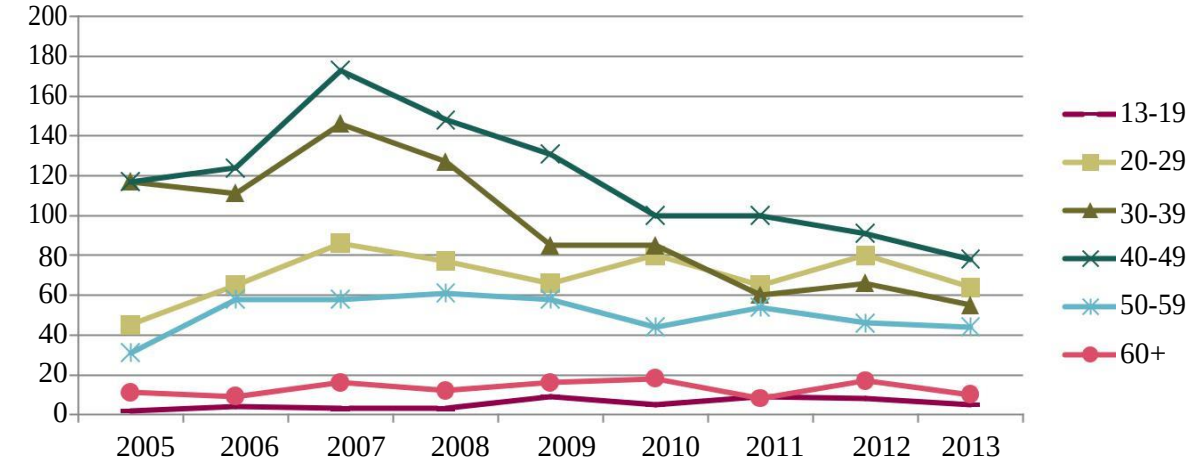
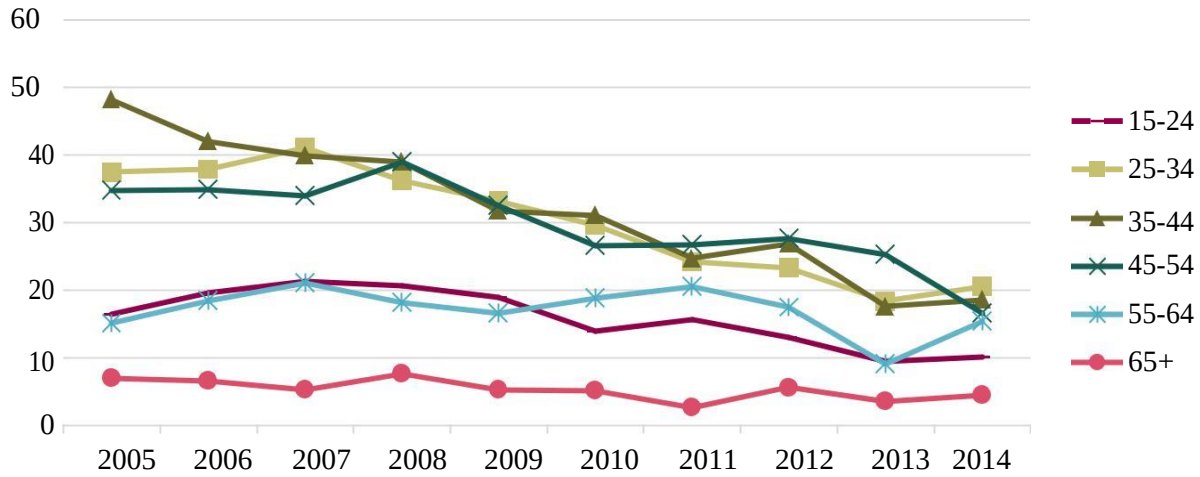


Figure 6. New HIV diagnoses among Women by Age at Diagnosis, Georgia 2005-2014



Overall there has been a shift with an increasing proportion of new diagnoses being Black/African American MSM, and a smaller proportion being women. This is illustrated by differences in breakdown of new diagnoses compared to the breakdown of PLWH, a group reflecting older transmission patterns. Black/African American MSM account for 44% of new diagnoses and 37% of PLWH; women account for 20% of new diagnoses and 24% of PLWH.

New diagnoses, in the EMA and outside the EMA: Among Black/African American men, new diagnoses among men less than 30 years of age outnumbered those among men 30 and older starting in 2010 within the Atlanta EMA and starting in 2011 outside of the EMA. Both in the EMA and outside, new diagnoses have declined in men 30 and older (Figures 7a and 7b). Among White men, the number of new diagnoses declined in men 30 and older and remained stable in men under 30 in the EMA; outside of the EMA new diagnoses were stable in both groups (Figures 8a and 8b). Among Hispanics new

diagnoses were fairly stable in men under and over 30, both in the EMA and outside of it (Figures 9a and 9b).

Figure 7a. New HIV Diagnoses among Black/African American Men by age at Diagnosis, Atlanta EMA, 2006-2014

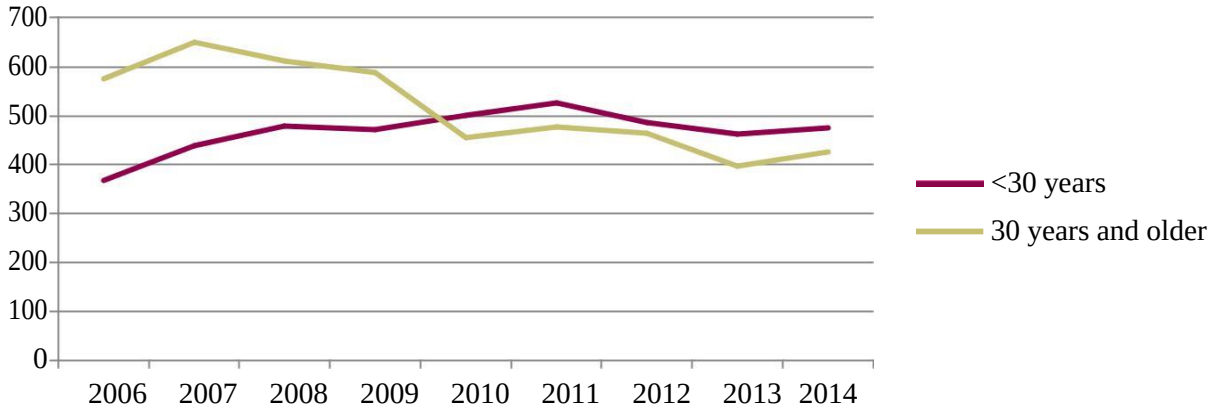


Figure 7b. New HIV diagnoses among Black/African American Men by Age at Diagnosis, Georgia outside the EMA, 2006-2014

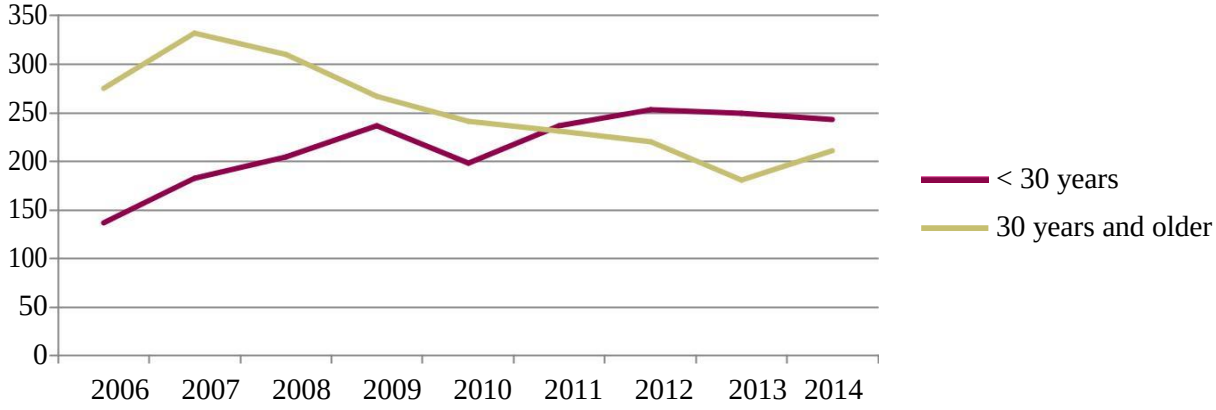
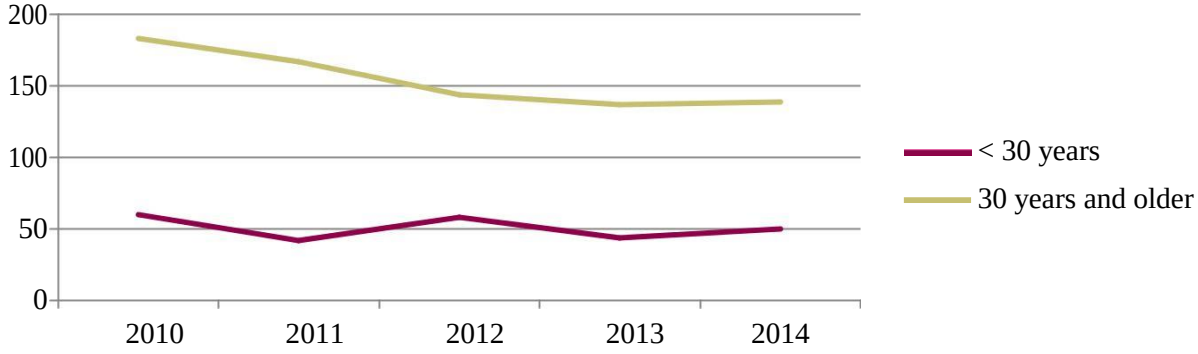


Figure 8a. New HIV Diagnoses among White Men by Age at Diagnosis, Atlanta EMA, 2010-2014



Figures 8b. New HIV diagnoses among White Men by Age at diagnosis, Georgia outside the EMA, 2010

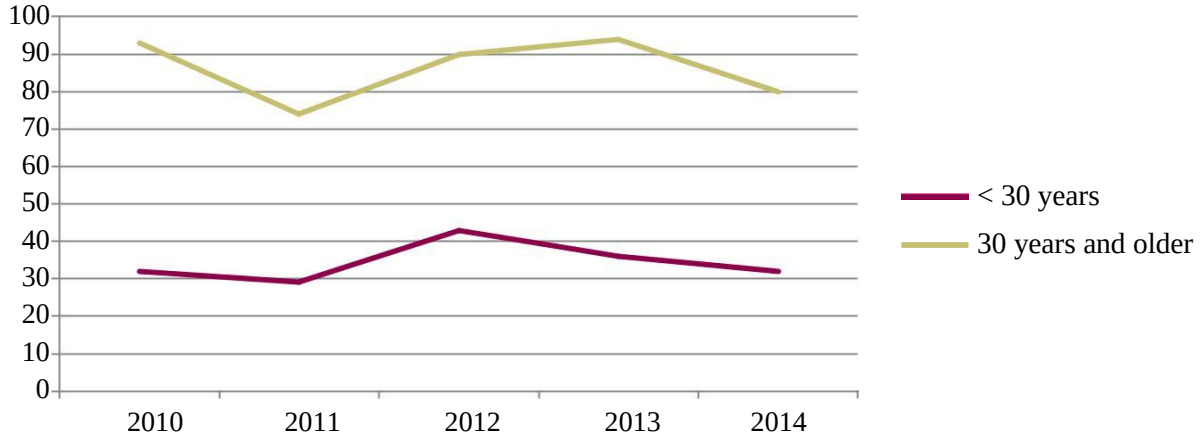


Figure 9a. New HIV Diagnoses among Hispanic Men by Age at Diagnosis, Atlanta EMA, 2010-2014

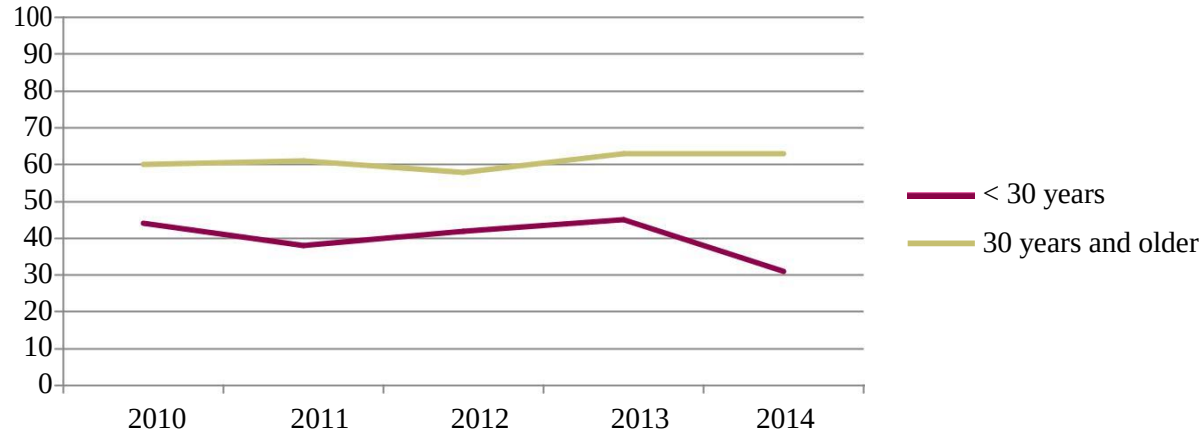
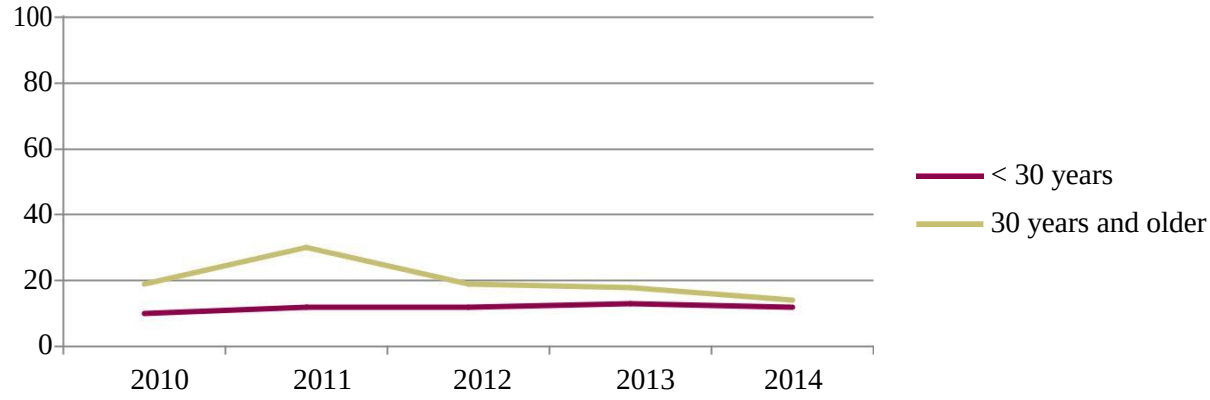


Figure 9b. New HIV Diagnoses among Hispanic Men by Age at Diagnosis, Georgia outside of the EMA, 2010-2014



Among Black/African American women, new diagnoses declined in the EMA and outside of it, both for women over and under 30 years of age (Figures 10a and 10b). For White and Hispanic women trends are difficult to interpret due to small numbers.

Figure 10a. New HIV Diagnoses among Black/African American Women by Age at Diagnosis, Atlanta EMA, 2010-2014

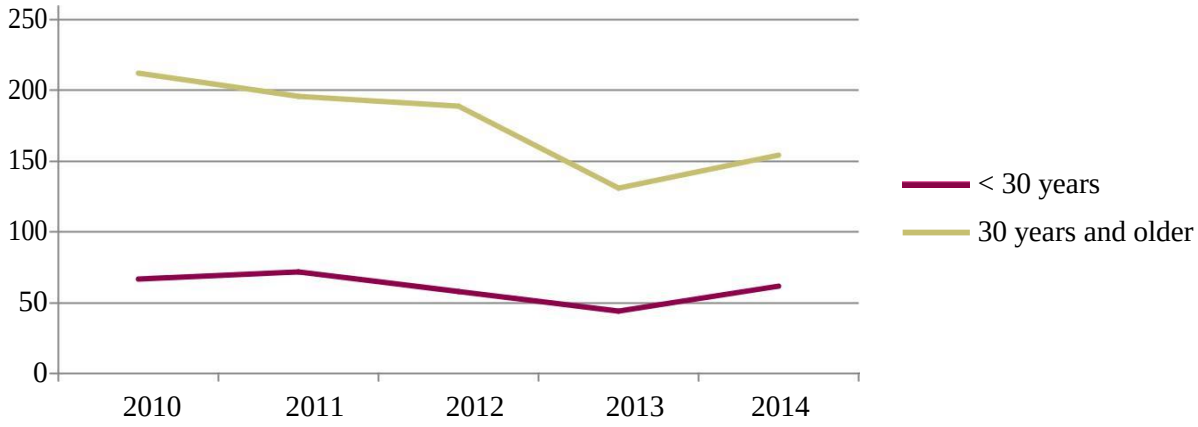
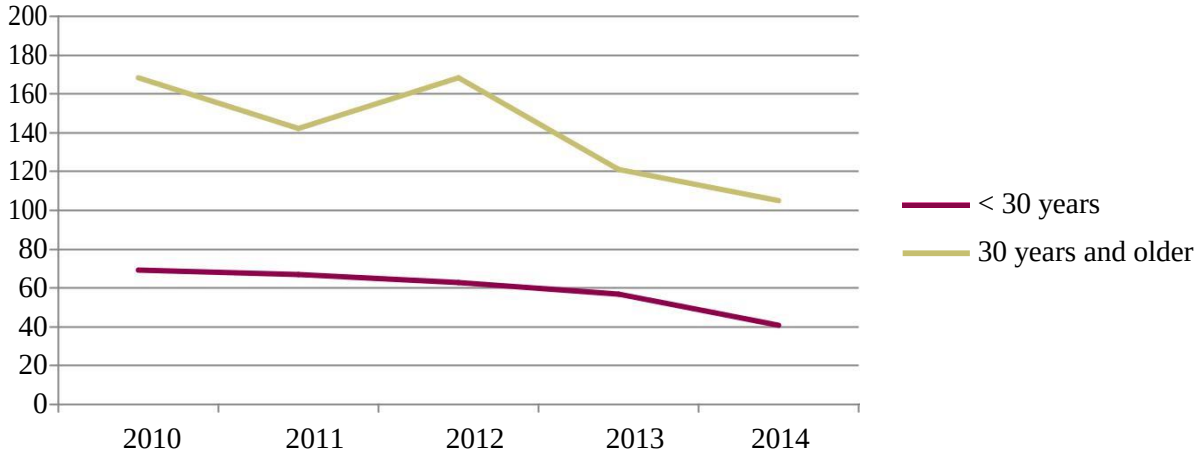


Figure 10b. New HIV Diagnoses among Black/African American Women by Age at Diagnosis, Georgia outside of the EMA, 2010-2014



The shift towards a higher proportion of new diagnoses being among Black/African American MSM has been particularly pronounced outside of the EMA, where Black/African American MSM account for 42% of new diagnoses and 29% of PLWH, and women account for 22% of new diagnoses and 33% of PLWH. In the EMA, Black/African American MSM account for 45% of new diagnoses and 41% of PLWH, and women account for 21% of PLWH and 19% of new diagnoses.

HIV prevalence: HIV prevalence has increased in all groups as a result of declines in mortality. Overall HIV prevalence for Georgia has steadily increased over time. In 2007 there were 38,080 PLWH, compared with 53,230 in 2014.

Unmet Need: The Unmet Need for HIV Primary Care for Georgia is included in Table 7. Table 8 provides Unmet Need for HIV Primary Care by demographics and transmission category.

Table 7. Quantified Estimate of Unmet Need for HIV Primary Care, Georgia (GA) 01/01/2014 - 12/31/2014

Quantified Estimate of Unmet Need for HIV Primary Care, Georgia, 2014				
Population		**Total**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA) as of 12/31/2014	28,350		eHARS and Laboratory Database
Row B.	Number of persons living with HIV (PLWH)/not AIDS as of 12/31/2014	25,705		C-A
Row C.	Total number of persons living with HIV Disease as of 12/31/2014	54,055		eHARS and Laboratory Database
Care Patterns		**Total**		**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014	18,136		eHARS and Laboratory Database
Row E.	Number of PLWH/not AIDS who received the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014	14,624		F-D
Row F.	Total number of persons living with HIV disease who received the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014	32,760		eHARS and Laboratory Database
Calculated Results		**Total**	**Percent**	**Calculations**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014	10,214	36%	A-D
Row H.	Number of PLWH/not AIDS who did not receive the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014	11,081	43%	B-E
Row I.	Total number of persons living with HIV Disease who did not receive the specified HIV primary medical care during the 12-month period, 01/01/2014 to 12/31/2014.	21,295	39%	C-F

Note:
1. Data sources were GA Laboratory Access Database and eHARS.
2. Reported cases in Electronic HIV/AIDS Reporting System (eHARS) were matched to reports in GA Lab Database.
3. Unmet need analyses performed on complete dataset as of December 31, 2014.
4. eHARS may contain fewer cases than the actual count due to delayed case reporting by providers.

Table 8: Unmet Need by HIV Status, Demographic Group and Transmission Category, GA 01/01/2014 -12/31/2014

	HIV (not AIDS)		AIDS		Total	
Gender	**Count**	**Percent[1]**	**Count**	**Percent**	**Count**	**Percent**
Male	8,141	42%	8,001	37%	16,142	40%
Female	2,866	45%	2,196	32%	5,062	38%
Subtotal[2]	**11,007**		**10,197**		**21,204**	
Age in years	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
<2	<5	-	<5	-	<5	-
2-12	69	46%	5	28%	74	44%
13-17	27	26%	<5	-	-	-
18-24	643	36%	116	22%	759	32%
25-29	1,458	44%	366	26%	1,824	38%
30-34	1,530	47%	595	29%	2,125	40%
35-39	1,380	46%	853	31%	2,233	39%
40-44	1,392	44%	1,302	35%	2,694	39%
45-49	1,464	42%	1,843	36%	3,307	38%
50-54	1,350	42%	2,089	39%	3,439	40%
55-59	890	41%	1,462	40%	2,352	40%
60-64	465	40%	832	41%	1,297	40%
65+	402	44%	743	47%	1,145	46%
Subtotal	**11,070**		**10,206**		**21,249**	
Race/Ethnicity	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Black/Non-Hispanic	7,282	45%	6,736	35%	14,018	40%
White/Non-Hispanic	1,768	37%	2,237	40%	4,005	39%
Hispanic/Latino, Any Race	563	44%	716	43%	1,279	43%
Other[3]	237	30%	297	25%	528	27%
Unknown	1,231	47%	234	32%	1,465	44%
Subtotal	**11,081**		**10,220**		**21,295**	
Transmission Category	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
MSM	3,698	39%	4,468	37%	8,166	37%
IDU	344	48%	906	49%	1,250	49%
MSM&IDU	237	42%	570	46%	807	45%
Heterosexual	1,037	37%	1,447	33%	2,484	35%
Other[4]	80	33%	85	33%	165	33%
NIR/NRR[5]	5,685	48%	2,738	33%	8,423	42%
Subtotal	**11,081**		**10,214**		**21,295**	

Note:

1. Percentages are indicative of row percentages with denominator of HIV prevalence as of 12/31/2014.
2. Subtotals may not be equal due to missing information.
3. Other includes non-Hispanic, Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, and Multiracial.
4. Includes hemophilia, blood transfusion, transplant and pediatric transmission.
5. NIR/NRR includes cases with 'no identified or no reported risk'.

Based on data from the Georgia Department of Public Health Electronic HIV/AIDS Reporting System (eHARS), Georgia reported 1,783 newly diagnosed AIDS cases during the period of January 1, 2013-December 31, 2014. This reflects a 26% decrease from the previous two-year period of 2012-2013. Approximately 77% (1,374) of diagnosed AIDS cases were males. In Georgia, there were 28,353 persons living with AIDS and 25,397 persons living with HIV (non-AIDS) as of December 31, 2014. Men who have sex with men (MSM) still represent the largest number of people living with AIDS in Georgia. Among males living with AIDS in Georgia, 74% of cases were attributed to the MSM transmission category as of December 31, 2014. MSM represent the largest number of people living with HIV in Georgia. Based on HIV (non-AIDS) prevalence among males, as of December 31, 2014, 76% of cases were attributed to the MSM transmission category.

Trends continue to indicate that HIV/AIDS is affecting the following groups at growing rates: Black/Non-Hispanics, women, heterosexuals, and individuals between the ages of 30-49, with new HIV diagnoses increasing among individuals aged 20-24 and 30-39. In the United States, Black/Non-Hispanic males and females are the most disproportionately affected population. Although, according to the US Census Bureau, individuals who were Black/Non-Hispanic comprised only 31.5% of Georgia's population in 2014, Black/Non-Hispanics accounted for 65% of the new cases of AIDS in 2013-2014. According to eHARS, as of December 31, 2014, 59% of Georgians living with HIV (non-AIDS) were Black/Non-Hispanic.

The HIV/AIDS epidemic in Georgia continues to affect a significant number of women. From 1984 to 2014, the cumulative proportion of AIDS cases among women increased from 4% to 24%. Heterosexual contact remains the primary mode of transmission among women in Georgia. As of December 2014, 78% of cases among women living with HIV (non-AIDS) and 79% of cases among women living with AIDS in Georgia were attributed to the heterosexual transmission category.

According to eHARS data, individuals between the ages of 40-49 and 50-59 years continue to comprise the age range with the largest burden of HIV/AIDS. As of December 2014, 26% of people living with HIV (non-AIDS) and 32% of people living with AIDS in Georgia were between the ages of 40-49 and 50-59 years. Among newly diagnosed individuals from January 1, 2013 through December 31, 2014, individuals between the ages of 30-39 accounted for 27% of new diagnoses of AIDS, followed by those aged 40-49 (25%). The highest percentage of new HIV (non-AIDS) diagnoses was among the age range of 20-24 and 30-39 (22%), followed by those aged 25-29 (20%) and 40-49 (17%).

d. Indicators of risk for HIV infection in the population covered by the service area:

i. Behavioral surveillance data:

Georgia National HIV Behavioral Surveillance (NHBS) data are used to describe socio-economic status and risk behaviors of populations at high risk of HIV: MSM, IDU, and high risk heterosexuals. The NHBS recruit MSM from venues frequented by MSM (venue-based sampling), and offers them an incentive to complete the interview and be tested for HIV. Respondent-driven sampling is used to recruit IDU and high risk heterosexuals, and they too are offered an incentive. The interviews are conducted every fall, with a different population targeted each time in rotation over a three-year cycle. Different participants are interviewed during each data collection period.

MSM: MSM were recruited and interviewed in the fall of 2014 from venues frequented by MSM. Demographic characteristics of the respondents are shown in Table 9a. Characteristics of Black/African American and White MSM are shown separately given the large age difference between the two (46% of Black/African American MSM vs 27% of White MSM were under 30). A lower proportion of Black/African American MSM had completed college, and a high proportion had an annual income of less than $20,000 (Table 9b).

Table 9a. Socio-demographic characteristics of persons at risk for HIV: People who inject drugs (PWID) and High Risk Heterosexuals, Georgia NHBS

	IDU (2012)[1] (n=561) %	High Risk Heterosexual [1,2] (2010 and 2013) (n=840) %
Age		
18-29	2	33
30-39	11	19
40-49	30	24
50+	57	23
Race/ethnicity		
White	11	1
Black/AA	87	97
Hispanic	1	2
Education		
BA or more	2	2
2 yr. college	25	18
HS/GED	40	45
<HS	34	35
Income		
<$20,000	85	84
$20,000-49,999	11	13

Table 9a. Socio-demographic characteristics of persons at risk for HIV: People who inject drugs (PWID) and High Risk Heterosexuals, Georgia NHBS		
	IDU (2012)[1] (n=561) %	High Risk Heterosexual [1,2] (2010 and 2013) (n=840) %
$50,000-74,000	3	2
Homeless	45	29

[1]Respondent driven sampling

[2]Recruited from low income census tracts

Table 9b. Socio-demographic characteristics of persons at risk for HIV: Men who have sex with men (MSM), Georgia NHBS[1]		
	MSM (2014)	
	Black/AA (n=198) %	White (n=132) %
Age group		
18-29	46*	27
30+	54	73
Education		
BA or more	42	64
2 yr. college	32	22
High school or less	27	14
Income		
<20,000	30	13
20,000-39,000	32	19
40,000-74,000	26	36
75,000+	13	33

[1]Venue-based sampling with effort to recruit young Black/African American MSM

*An effort was made to recruit young Black/African American MSM, accounting for the higher proportion of 18-29 in the Black/African American MSM sample

Overall, among those self-reporting negative HIV status, 21% reported condomless anal sex, 39% reported sex with a partner of unknown status, and 40% reported 5 or more sexual partners in the last 12 months. There were no major differences in risk behaviors between Black/African American and White MSM with the exception that a higher proportion of White men reported 5 or more partners (54% versus 32%).

Thirty-three percent of Black/African American MSM and 23% of White MSM responded very likely or somewhat likely to "what is your gut feeling about how likely you are to get infected with HIV?" Among men less than 30 years old, there was no difference between Blacks/African Americans and Whites (33% and 36% respectively), while there was a marked difference among Black/African American and White men 30 and older (33% and 17%, respectively). Awareness of PrEP was

substantially lower among Black/African American MSM than White MSM (43% and 66%, respectively). Overall 66% of MSM had an HIV test in the last 12 months; 9% of Black/African American MSM and 3% of White MSM reported never having had an HIV test.

Persons Who Inject Drugs (Injection Drug Use): A total of 561 persons who inject drugs (PWID) were interviewed in fall 2012. More than half of the respondents were 50 and older, and the great majority were Black/African American. Only 2% had completed college, 34% had not completed high school, and 85% reported annual income under $20,000.

Heroin was the most commonly reported often used drug (60%), followed by speedball (heroin and cocaine) (29%) and cocaine (9%). Twenty-nine percent reported using needles someone had already injected with, and 10% reported using needles someone else had already injected with half of the time or more. Forty-eight percent reported being tested for HIV in the last 12 months, and 8% reported having never been tested.

PWID were interviewed in fall 2015, with an emphasis on reaching young PWID. Compared with persons older than 35, a higher proportion of persons under 30 was White, and a higher proportion was previously addicted to prescription painkillers. Among PWID 18 to 35 years of age, 27% reported being HCV-positive and 23% had never been tested for HCV; 23% reported using a needle after someone else half of the time or more in the past 12 months, and 35% reported sharing other injection equipment (spoon, cotton, water).

High Risk Heterosexuals: High risk heterosexuals recruited from high poverty census tracts were interviewed in 2010 and 2013. A total of 840 persons were interviewed in both cycles combined. One-third of respondents were 18-29 years of age; the remainder was evenly divided between 30-39, 40-49 and 50+. The great majority were Black/African American. Only 2% had completed college, 35% had not completed high school, and 84% reported annual income under $20,000.

Seventy-one percent of males and 81% of females reported no condom at last sex encounter and over half reported not knowing last sex partner's HIV status. Eighty-five percent had ever been tested for HIV and 40% were tested in the last 12 months.

Demographic characteristics and risk behaviors among PLWH in care: One data source utilized to provide information on the demographic characteristics among PLWH in care is the Medical Monitoring Project (MMP). The MMP is a surveillance system through which behavioral and clinical information is collected via interviews and chart abstractions for a representative sample of PLWH receiving HIV care in Georgia.

MMP data for Georgia aggregated from 2009 to 2013 provide information on risk behaviors of PLWH in care. Overall, the sample was fairly representative in terms of distribution by gender, race, and transmission category (Table 10). Forty-four percent

of the sample had a high school education or less, and 57% reported annual income under $20,000. For 38% SSI or SSDI was the primary source of financial support and 42% were below the poverty line. Thirty-nine percent reported Ryan White support for ART, 30% reported support from private insurance, and 27% reported support from Medicare and Medicaid respectively.

Table 10. Socio-demographic characteristics of persons in HIV care -- Georgia MMP 2009-2013 (n=795)	
	%
Gender	
Male	71
Female	28
Transgender	1
Age	
18-29	9
30-39	19
40-49	35
50+	35
Race/ethnicity	
White	21
Black/AA	69
Hispanic	5
Education	
>HS	56
HS/GED	28
<HS	16
Income	
<$20,000	57
$20,000-49,999	20
$50,000-74,000	11
Homeless at some point in last 12 months	9
Incarcerated >24 hours last 12 months	6
Insurance for antiretroviral medicine	
Medicaid	27
Ryan White	39
Private	30
Medicare	27
Primary source of financial support past 12 months	

Table 10. Socio-demographic characteristics of persons in HIV care -- Georgia MMP 2009-2013 (n=795)	
	%
SSI or SSDI	38
Salary or wages	41
Family, partner or friends	12
Other	8
Poverty Guidelines	
Above	58
Below	42

Thirty-six percent reported no sexual activity in the last 12 months (22% of MSM, 56% of men who have sex with women [MSW], and 45% of women who have sex with men [WSM]). Among MSM, 12% reported unprotected anal sex with a partner of unknown or negative status in the last 12 months. Among MSW, 3% reported unprotected vaginal sex with women of unknown or negative status, and 15% of WSM reported unprotected vaginal sex with men of unknown of negative status.

Only 9 of 795 reported injection drug use in the last 12 months; 22% reported non injection drug use (the vast majority marijuana).

PLWH in care have lower rates of risky behaviors than PLWH who are not in care. Furthermore, a substantial proportion of PLWH in care are virally suppressed and therefore at very low risk of transmitting HIV. Data from the MMP do not provide information about transmission risk from HIV infected persons who are not in care.

ii. HIV testing data:

Table 11a: Assessment of Public Health Supported, Test-Level HIV Testing Data in Healthcare Settings, Georgia, excluding Fulton and DeKalb Counties: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	%	#	**Positivity Rate**	#	**Positivity Rate**
Total Test-Level Testing Events	71,920	100	292	0.41	220	0.31
Age						
Less than 13	93	0.1	<5	--	<5	--
13 – 19	8,359	12	15	0.18	12	0.14
20 – 29	32,854	46	160	0.49	130	0.40
30 – 39	17,498	24	60	0.34	41	0.23
40 – 49	7,834	11	26	0.33	17	0.22
50 - 59	3,905	5	25	0.64	18	0.46
60+	1,342	2	6	0.45	<5	--

Table 11a: Assessment of Public Health Supported, Test-Level HIV Testing Data in Healthcare Settings, Georgia, excluding Fulton and DeKalb Counties: 2014 – January 1 – December 31

Characteristics	Number of Test Events		Number of Confirmed Positives		Newly Confirmed Positives	
	#	%	#	Positivity Rate	#	Positivity Rate
Unknown	35	0.0	<5	--	<5	--
Race/Ethnicity						
American Indian/Alaska Native	83	0.1	<5	--	<5	--
Asian	570	1	<5	--	<5	--
Black/African American	41,071	57	234	0.57	184	0.44
Hispanic	6,141	9	11	0.18	9	0.15
More than one race	598	1	<5	--	<5	--
Native Hawaiian/Other Pacific Islander	53	0.1	<5	--	<5	--
White	23,144	32	40	0.17	25	0.11
Don't Know/Not Asked/Declined	260	0.4	<5	--	<5	--
Gender						
Female	50,605	70	56	0.11	39	0.08
Male	20,844	29	228	1.09	173	0.83
Transgender – Female to Male	242	0.3	<5	--	<5	--
Transgender – Male to Female	160	0.2	<5	--	<5	--
Transgender - Unspecified	<5	--	<5	--	<5	--
Other/Declined/Unknown	66	0.1	<5	--	<5	--
HIV Risk Factor						
Heterosexual Contact	57,477	80	98	0.17	68	0.12
Injection Drug User (IDU)	1,185	2	<5	--	<5	--
Men who have sex with men (MSM)	4,227	6	177	4.19	140	0.31
MSM/IDU	81	0.1	<5	--	<5	--
Male-to-Female sex with Male (MTFSM)	102	0.1	<5	--	<5	--
Other/Unknown	8,848	12	11	0.12	5	0.06

Table 11b: Assessment of Public Health Supported, Test-Level HIV Testing Data in Non-Healthcare Settings, Georgia, excluding Fulton and DeKalb Counties: 2014 – January 1 – December 31

Characteristics	Number of Test Events		Number of Confirmed Positives		Newly Confirmed Positives	
	#	%	#	Positivity Rate	#	Positivity Rate

Table 11b: Assessment of Public Health Supported, Test-Level HIV Testing Data in Non-Healthcare Settings, Georgia, excluding Fulton and DeKalb Counties: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	**%**	**#**	**Positivity Rate**	**#**	**Positivity Rate**
Total Test-Level Testing Events	7,968	100	109	1.37	99	1.24
Age						
Less than 13	8	0.1	<5	--	<5	--
13 – 19	842	11	<5	--	<5	--
20 – 29	3,638	46	59	1.62	53	1.46
30 – 39	1.707	21	24	1.41	21	1.23
40 – 49	926	12	14	1.51	13	1.40
50 - 59	622	8	11	1.77	11	1.77
60+	217	3	<5	--	<5	--
Unknown	8	0.1	<5	--	<5	--
Race/Ethnicity						
American Indian/Alaska Native	21	0.3	<5	--	<5	--
Asian	96	1	<5	--	<5	--
Black/African American	5,357	67	80	1.49	72	1.34
Hispanic	592	7	10	1.69	9	1.52
More than one race	85	1	<5	--	<5	--
Native Hawaiian/Other Pacific Islander	11	0.1	<5	--	<5	--
White	1.730	22	17	0.98	16	0.92
Don't Know/Not Asked/Declined	58	0.7	<5	--	<5	--
Gender						
Female	4,028	51	9	0.22	8	0.20
Male	3,717	47	86	2.31	77	2.07
Transgender – Female to Male	40	0.5	<5	--	<5	--
Transgender – Male to Female	158	2	13	8.23	13	8.23
Transgender - Unspecified	<5	--	<5	--	<5	--
Other/Declined/Unknown	23	0.3	<5	--	<5	--
HIV Risk Factor						
Heterosexual Contact	5,009	63	18	0.36	16	0.32
Injection Drug User (IDU)	76	1	<5	--	<5	--
Men who have sex with men (MSM)	1,983	25	75	3.78	68	3.43
MSM/IDU	17	0.2	<5	--	<5	--

Table 11b: Assessment of Public Health Supported, Test-Level HIV Testing Data in Non-Healthcare Settings, Georgia, excluding Fulton and DeKalb Counties: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	**%**	**#**	**Positivity Rate**	**#**	**Positivity Rate**
Male-to-Female sex with Male (MTFSM)	145	1.8	12	8.28	12	8.28
Other/Unknown	738	9	<5	--	<5	--

Table 11c: Assessment of Public Health Supported, Test-Level HIV Testing Data in Healthcare Settings, in Fulton and DeKalb Counties, Georgia: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	**%**	**#**	**Positivity Rate**	**#**	**Positivity Rate**
Total Test-Level Testing Events	24,265	100	637	2.6	208	.09
Age						
Less than 13	649	2.7	<5	--	<5	--
13 – 19	1,964	8.1	6	0.3	<5	--
20 – 29	10,199	42	257	2.5	100	1.0
30 – 39	5,677	23.4	159	2.8	53	0.9
40 – 49	3,143	13	107	3.4	28	0.9
50 - 59	1,895	7.8	83	4.4	21	1.1
60+	719	3	24	3.3	<5	--
Unknown	19	0.1	<5	--	<5	--
Race/Ethnicity						
American Indian/Alaska Native	12	0.0	<5	--	<5	--
Asian	1,739	7.2	<5	--	<5	--
Black/African American	19,543	80.5	568	2.9	191	1
Hispanic	1,143	4.7	24	2.1	8	0.7
More than one race	93	0.4	<5	--	<5	--
Native Hawaiian/Other Pacific Islander	32	0.1	<5	--	<5	--
White	1,619	6.7	38	2.3	5	0.3
Don’t Know/Not Asked/Declined	84	0.3	<5	--	<5	--
Gender						
Female	13,322	54.9	110	0.8	30	0.2
Male	10,820	44.6	512	4.7	171	1.6

Table 11c: Assessment of Public Health Supported, Test-Level HIV Testing Data in Healthcare Settings, in Fulton and DeKalb Counties, Georgia: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	**%**	**#**	**Positivity Rate**	**#**	**Positivity Rate**
Transgender – Female to Male	39	0.2	<5	--	<5	--
Transgender – Male to Female	50	0.2	15	30	7	14
Transgender - Unspecified	<5	--	<5	--	<5	--
Other/Declined/Unknown	34	0.1	<5	--	<5	--
HIV Risk Factor						
Heterosexual Contact	18,970	78.2	223	1.2	73	0.4
Injection Drug User (IDU)	125	0.5	5	4	<5	--
Men who have sex with men (MSM)	1,673	6.9	348	20.8	116	6.9
MSM/IDU	27	0.1	9	33.3	<5	--
Male-to-Female sex with Male (MTFSM)	37	0.2	13	35.1	7	18.9
Other/Unknown	3,433	14.1	39	1.1	7	0.2

Table 11d: Assessment of Public Health Supported, Test-Level HIV Testing Data in Non-Healthcare Settings, in Fulton and DeKalb Counties, Georgia: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	**%**	**#**	**Positivity Rate**	**#**	**Positivity Rate**
Total Test-Level Testing Events	11,260	100	72	0.6	82	0.6
Age						
Less than 13	10	0.1	<5	--	<5	--
13 – 19	826	7.3	<5	--	<5	--
20 – 29	3,930	34.9	38	1	34	0.9
30 – 39	2,369	21.2	15	0.8	12	0.5
40 – 49	1,811	16.1	13	0.7	12	0.7
50 - 59	1,552	13.8	<5	--	<5	--
60+	665	5.9	<5	--	<5	--
Unknown	77	0.7	<5	--	<5	--
Race/Ethnicity						
American Indian/Alaska Native	18	0.2	<5	--	<5	--
Asian	196	1.7	<5	--	<5	--
Black/African American	9,000	79.9	57	0.6	49	0.5
Hispanic	628	5.6	5	0.8	5	0.8

Table 11d: Assessment of Public Health Supported, Test-Level HIV Testing Data in Non-Healthcare Settings, in Fulton and DeKalb Counties, Georgia: 2014 – January 1 – December 31						
Characteristics	**Number of Test Events**		**Number of Confirmed Positives**		**Newly Confirmed Positives**	
	#	**%**	**#**	**Positivity Rate**	**#**	**Positivity Rate**
More than one race	105	0.9	5	4.8	<5	--
Native Hawaiian/Other Pacific Islander	18	0.2	<5	--	<5	--
White	1,202	10.7	<5	--	<5	--
Don't Know/Not Asked/Declined	93	0.8	<5	--	<5	--
Gender						
Female	5,160	45.8	9	0.2	9	0.2
Male	6,015	53.4	63	1	53	0.9
Transgender – Female to Male	31	0.3	<5	--	<5	--
Transgender – Male to Female	43	0.4	<5	--	<5	--
Transgender - Unspecified	<5	--	<5	--	<5	--
Other/Declined/Unknown	11	0.1	<5	--	<5	--
HIV Risk Factor						
Heterosexual Contact	8,133	72.2	23	0.3	18	0.2
Injection Drug User (IDU)	202	1.8	<5	--	<5	--
Men who have sex with men (MSM)	1,569	13.9	45	2.9	40	2.5
MSM/IDU	28	0.2	<5	--	<5	--
Male-to-Female sex with Male (MTFSM)	38	0.3	<5	--	<5	--
Other/Unknown	1,290	11.5	<5	--	<5	--

HIV testing efforts are aligned with the need to target those populations that are at greatest risk of HIV infection consistent with prevalence and new diagnoses trends noted from HIV Surveillance data. Positivity rates are highest among Blacks/African Americans, Hispanics, males, MSM and transgender. Provisions of HIV testing in non-healthcare settings see high impact in the identification and diagnoses of young persons and MSM unaware of their positive status with positivity rates of 3.78% and 2.9% for Georgia and Fulton/DeKalb respectively. HIV testing in healthcare settings for Fulton/DeKalb saw positivity rates greater than 20% for MSM and MSM/IDU. Planning efforts around testing will continue to use existing prevalence data to better coordinate activities and target those undiagnosed persons unaware of their HIV positive status within prioritized populations. This includes focusing HIV testing resources to geographic areas that are most impacted.

Ryan White HIV/AIDS Program data:

Table 12: Demographics of Populations Served by the Ryan White Parts A, B, and ADAP Programs in FY 2014			
	Number Served		
	Part A	***Part B***	***ADAP***
Gender			
Male	10,205	6,105	7,610
Female	3,205	3,331	2,425
Transgender	113	55	65
Unknown/Unreported	2	0	3
Race			
American Indian or Alaskan Native	12	10	300
Asian	119	40	116
Black/African American	10,629	6,793	7,248
Native Hawaiian/Pacific Islander	10	2	77
White	2,528	2,492	2,516
More than one race	169	137	0
Unknown/Unreported	58	17	0
Ethnicity			
Hispanic	752	523	829
Non-Hispanic	12,773	8,968	9,274
Poverty Level			
<100%	7,920	6,345	4,995
101-200%	3,270	--	--
100-138%	--	1,580	1,266
139-200%	--	537	1,500
201-250%	--	404	586
201-300%	924	--	--
251-400%	--	168	260
>300%	891	--	--
401-500%	--	--	--
>500%	--	--	--
Unknown/Unreported	520	457	7
HIV Risk Factor			
MSM	6,574	3489	1828
IDU	288	351	112
MSM/IDU	185	115	41
Hemo/Coag Disorder	20	25	10
Heterosexual	4,358	5,487	2103
Blood Transfusion	29	132	33
Perinatal Transmission	366	116	29
Unknown	71	127	5947

iii. Other relevant demographic data including Hepatitis, STD, TB and Substance use data:

STDs: Incidence of STDs is a proxy measure for risky sexual behaviors and bacterial STDs can facilitate transmission of HIV. Syphilis, Gonorrhea, and Chlamydia rates in Georgia are among the highest in the U.S. The great majority of primary and secondary (P&S) syphilis occur among males (MSM), among Blacks/African Americans, and among persons 20-29 years of age. Women account for approximately half of gonorrhea diagnoses, and for approximately three quarters of chlamydia diagnoses. Blacks/African Americans and persons 15-25 years of age account for the majority of both. While P&S syphilis occurs throughout the state it is concentrated in metro Atlanta. Gonorrhea and Chlamydia are more spread throughout the state. In 2013, rates of Syphilis ranged by health district from 0.9-39.6 per 100,000 with an overall rate of 10.5 per 100,000; Gonorrhea rates ranged by health district from 38-268 per 100,000 with an overall rate of 105 per 100,000, and Chlamydia ranged from 171-732 per 100,000 with an overall rate of 474 per 100,000. P&S syphilis increased between 2009 and 2013, while both Chlamydia and Gonorrhea increased between 2009 and 2011 then decreased.

Based on a match between STD data and HIV Surveillance: Among 1,311 P&S syphilis diagnoses in 2014, 893 (68%) had also been diagnosed with HIV.

Tuberculosis: TB patients need to be tested for HIV because TB treatment may change when antiretroviral therapy for HIV infection is given, and because active TB often accelerates the natural progression of HIV infection. In Georgia in 2014, HIV status was reported for 93% of TB cases overall, and 98% of persons 25-44. Among 311 TB cases with known HIV status in 2014, 37 (12%) were HIV positive.

In 2014, a TB outbreak occurred in Fulton County, with 43 TB cases reported among homeless persons; of these 16 (37%) were HIV infected. In 2013, only 3 homeless TB cases were reported in Fulton County, none were HIV infected. The background rate of HIV infection among TB cases in Fulton County in 2014 was 28%, indicating that persons with HIV infection were particularly vulnerable to the outbreak in 2014.

Hepatitis C: Diagnoses of hepatitis C have been steadily increasing in Georgia over the last five years, most likely as a result of improved surveillance and increased testing efforts. Because of the chronic nature of hepatitis C infection, diagnoses provide limited information about incidence. Diagnoses in persons 30 and under are a better indicator of recent infection and have also been increasing over the last five years. Georgia has observed a 230% increase in reported hepatitis C infections since 2010. Less than half of the reported HCV infections in this young adult population were confirmed with HCV PCR testing.

The maps show the geographic distribution for all ages as well as young adults aged 30 years and younger. Areas outside of the major urban centers are experiencing higher rates, specifically North and Southeast Georgia. A high proportion of hepatitis

C cases for which risk information is obtained in the young adult population are found to have a current or past history of injection drug use. Among the PWID interviewed as part of the NHBS almost half of those 35 and older reported testing positive for hepatitis C and one-third of those 35 and younger.

Figure 11. Total Reported and Confirmed Hepatitis C Infections, All Ages, Georgia, 2010-2015

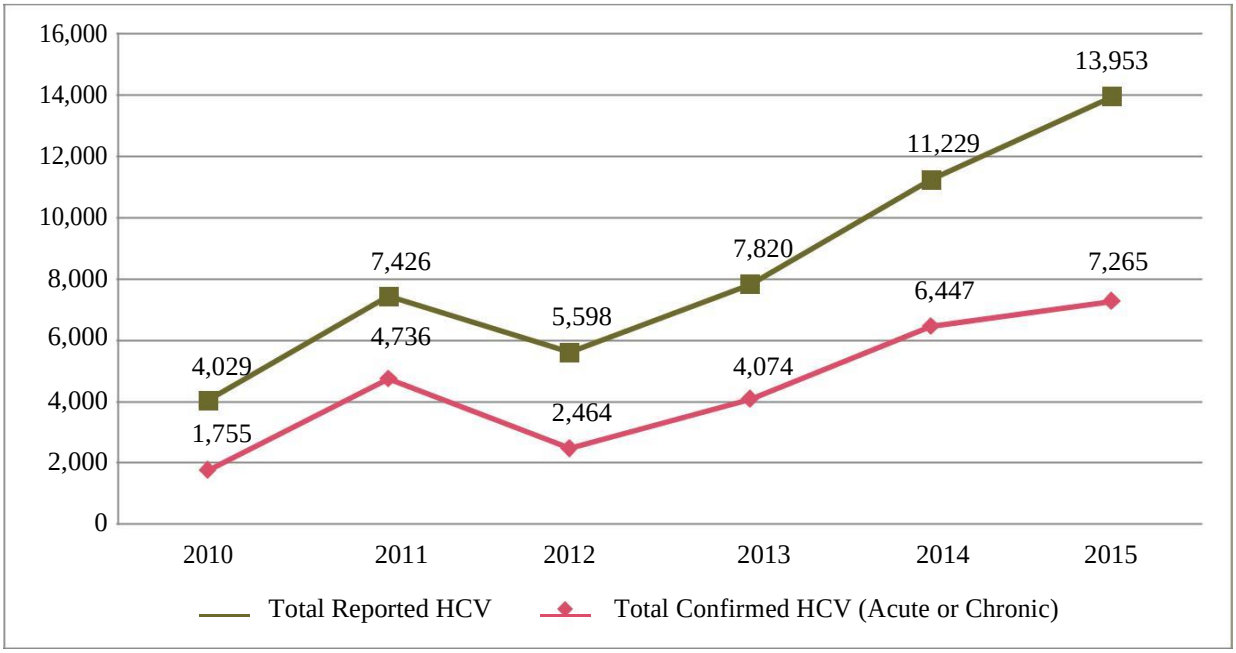


Figure 12. Total Reported and Confirmed Hepatitis C Infections, Ages 30 Years and Younger, Georgia, 2010-2015

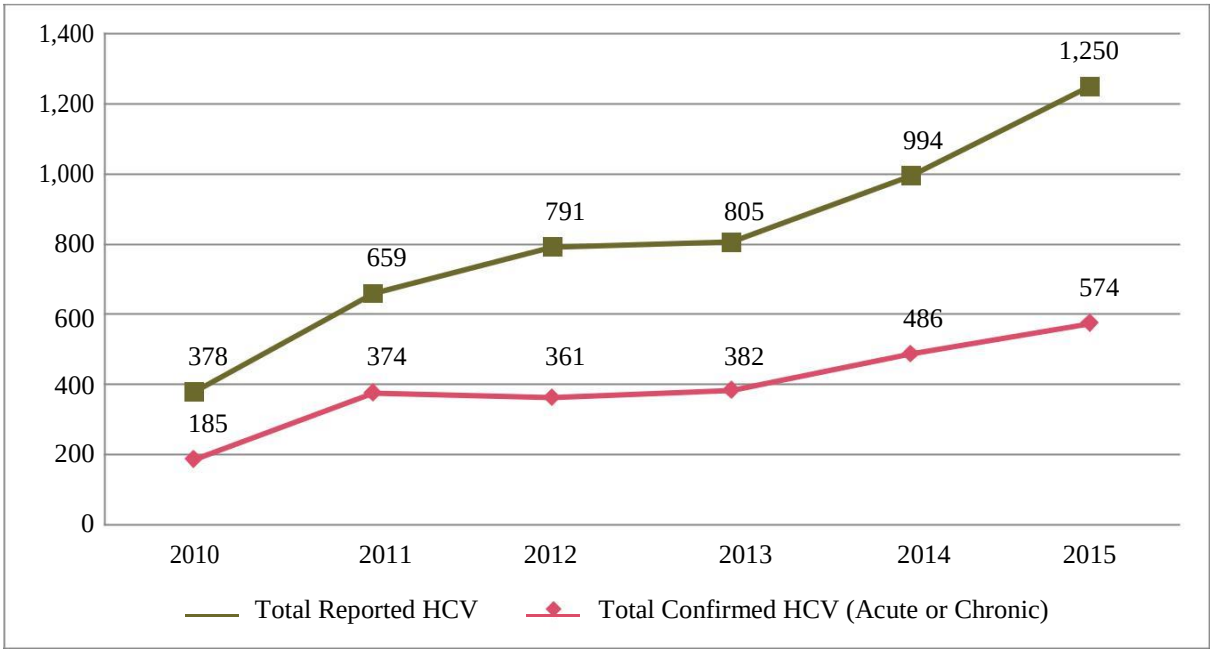


Figure 13. Rate of Reported* HCV, All Ages, Cumulative 2010-2015

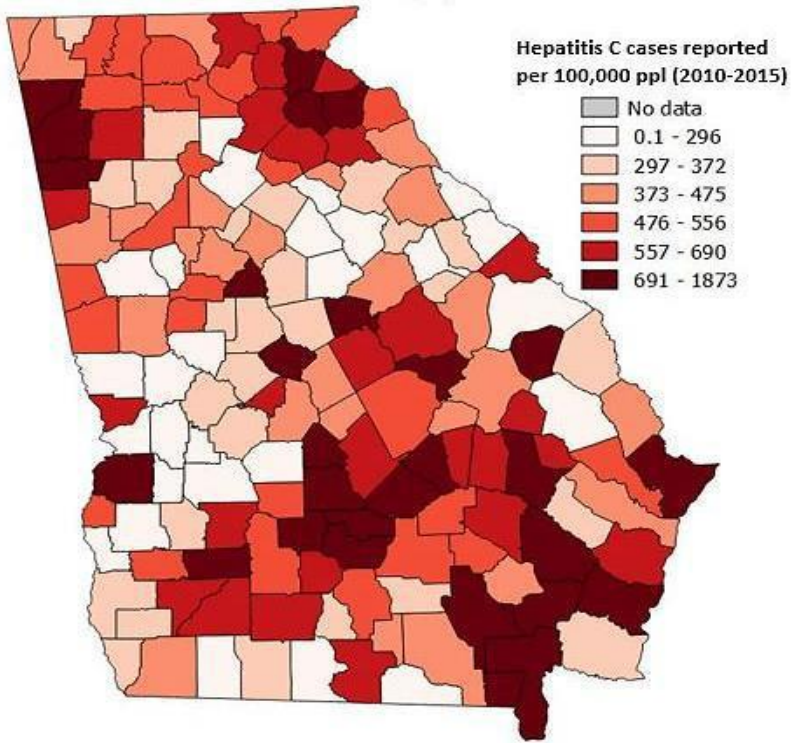


Figure 14. Rate of Total Reported* HCV, Ages 30 Years and Younger, Cumulative 2010-2015

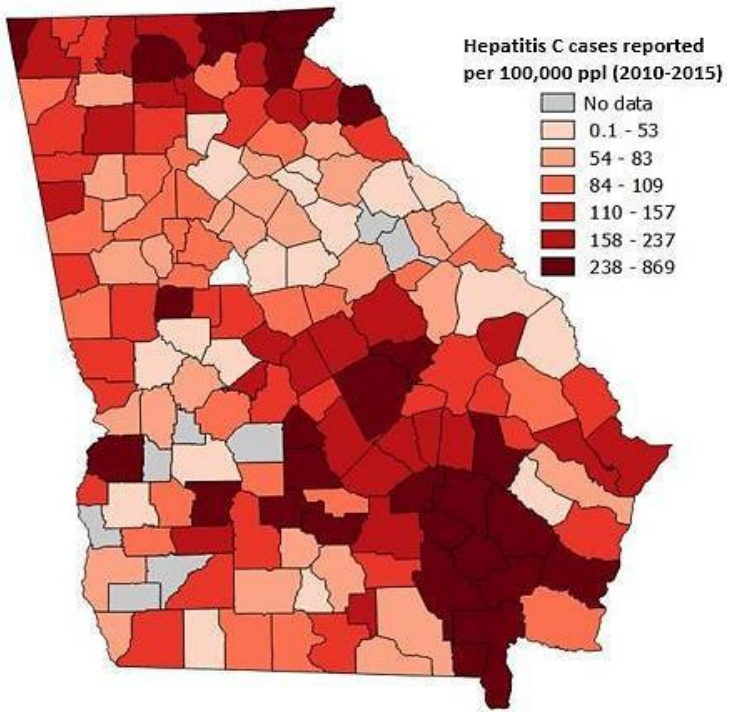
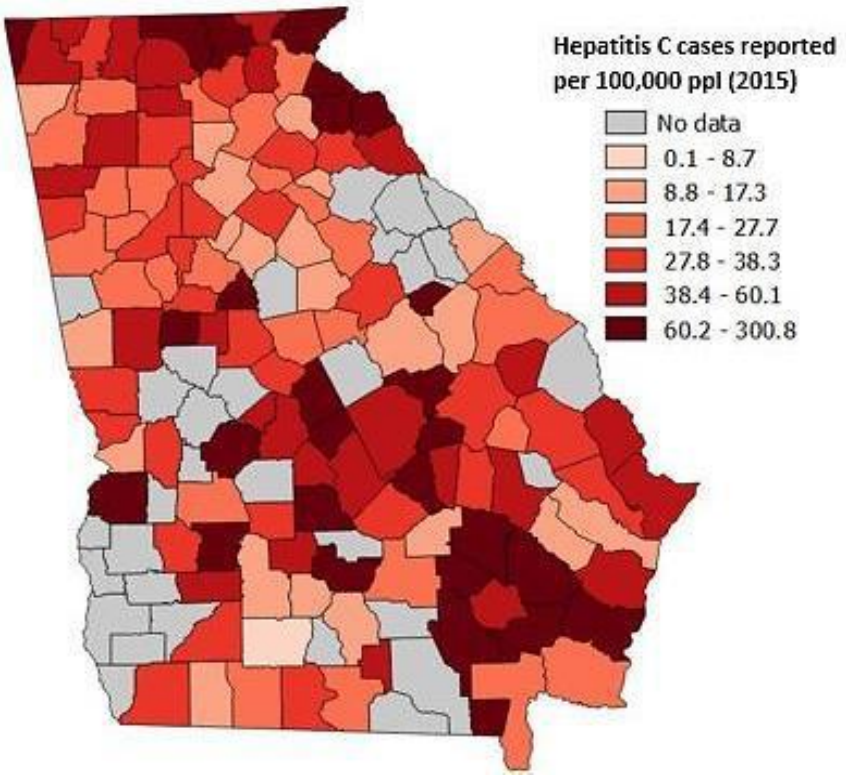


Figure 15. Rate of Total Reported* HCV, Ages 30 Years and Younger, 2015



Poverty: In Georgia, areas of high poverty tend to correspond to areas of high HIV prevalence though there is not a complete correspondence. This pattern can be observed at the zip code level for the Atlanta MSA, and also statewide, with the highest rates of poverty in the southern part of the state, corresponding to areas of high HIV prevalence. A high proportion of MMP participants (42%) live below the poverty line, though information is collected at the time of their interview, not as of when they were infected.

iv. Qualitative data:

The National HIV/AIDS Strategy reminds us that structural and social determinants are serious indicators that reveal an individual's perception of personal health as well as the health of a community. In order to implement interventions and activities to combat the rise in HIV/AIDS infection the G-PACC continues to provide guidance on effective ways to target populations who present indicators for HIV infection through community engagement sessions and stakeholder activities. Collaboration and participation of community representatives and other stakeholders in the research process helps to build faith, trust and gives to the acceptance in the use of intervention. Collaboration from community partners and agencies increase the opportunities to build communities and secure invested stakeholders to support engagements, activities, and strategies for alleviating the burden from populations who present high risk for HIV/AIDS.

It has been determined that collaborative efforts work best when planning activities for populations at risk. The Georgia DPH, the Fulton JPPG, and HealthHIV collaborated to share concerns on the HIV Epidemic, provide strategies to the epidemic, strategies to structural barriers, and to bridge the gap on working together. This engagement session placed a special emphasis on engaging special populations in HIV planning, including transgender, homeless, recently released individuals, and young, Black/African American MSM. An Additional collaborative engagement session with Fulton County JPPG resulted in the presentation of *Public Attitudes and Knowledge about HIV/AIDS in Georgia* by Kaiser Family Foundation (KFF) as part of a public information partnership with the Georgia DPH.

Next steps and ongoing engagement sessions resulted in an increase in stakeholder engagement within the statewide planning group, G-PACC, and more community sessions such as a youth engagement on the campus of Savannah State University, a transgender lock-in that included the participation of 13 transgendered woman whom have disclosed their HIV status and were later reengaged into HIV care and treatment; rural community engagement sessions, and a community engagement session which focused on the homeless population and the distribution of resource manuals that were updated by the statewide planning body.

The G-PACC has also hosted a faith-based community engagement session with faith leaders and university officials to address the need for their involvement in HIV community planning.

Community Advisory Groups (CAGs) are comprised of community stakeholders of varied disciplines and backgrounds that have an interest in local HIV/AIDS related issues and serve as consultants to the City of Atlanta (Fulton/DeKalb Counties) Jurisdictional HIV Prevention Planning Group (JPPG) to ensure that jurisdictional planning and resources are responsive to Atlanta's unique prevention and service needs, and are reflective of the diverse community served.

The purpose of a CAG is to provide a forum to ensure key stakeholder involvement in the jurisdiction's ongoing prevention planning to reduce HIV disease in Fulton and DeKalb Counties and that priority populations, including persons who represent these populations, are actively engaged in the process. CAGs are the link between the JPPG and the communities most affected by HIV and AIDS. The objective is that each CAG:

- Communicate to JPPG community issues related to the specific population
- Identify the gaps in HIV-related services
- Advise HIV-related service needs in the area
- Recommend new programs and changes to existing programs
- Bring specific and unique expertise to the prevention planning process

Membership includes community members living with HIV/AIDS and other consumers, healthcare providers, health educators, youth, representatives from

diverse racial and ethnic communities, advocacy groups, faith- and community-based organization representatives, and other people affected.

Based on JPPG recommendations, the following populations have a CAG to represent them:

- African Americans
- Men who have sex with Men (MSM)
- Transgender
- Young Adults (17-25)

Each group advocates for its specific population/community within the City of Atlanta (Fulton/DeKalb Counties) Jurisdiction, advises JPPG regarding the unique needs of its specific population/community, including behavioral trends, access to healthcare and HIV/AIDS prevention, treatment and related services. The group makes recommendations to JPPG relative to HIV/AIDS programs that serve its specific population/community and policies which impact this population.

Each CAG has at least one JPPG member and one Fulton County Department of Health and Wellness or DeKalb County Board of Health representative at each meeting. Each CAG is used to discuss pertinent topics, concerns, and trends within their respective communities, events and gatherings, and brainstorm prevention ideas, and each CAG is responsible for at least one HIV/AIDS prevention event/program per year.

The African American CAG's recommendations included collaborations and partnerships with faith-based organizations, recruitment from a more non-traditional, diverse age group, and an event that required a collaboration and involvement of all CAG groups. This year the event will be a Flash Mob HIV awareness Experience that will occur in local malls. A flash mob is a large public gathering at which people perform an unusual or seemingly random act and then disperse, typically organized by means of social media channels. During the Flash Mob HIV awareness experience, participants will be wearing T-shirts displaying HIV prevention messages.

The MSM CAG's recommendations consisted of forming a subcommittee for event planning, participating in Black Pride and Atlanta Pride activities annually, and supporting the Undedectables Conference by forming abstract and community award nomination committees. Additionally, the MSM CAG had a special listening session with the Fulton County HIV Task Force, which was also part of the PBS News Hour show "Why the South is the Epicenter of the AIDS Crisis in America" which aired on July 12, 2016. The MSM CAG has three events planned for the year. During Black Pride, the "PrEP for Pride" event will be organized, which is an educational social geared towards African American MSM that focuses on HIV prevention, community support, and providing information on PrEP. During Atlanta Pride, the CAG will participate in the parade on a float and pass out condoms and HIV prevention educational material. The third event, "Take Back the Night", is a call to higher

awareness of homelessness in the Lesbian, Gay, Bisexual, Transgender (LGBT) community. It will be a coordinated approach, inclusive of other cities, during the week of Gay Men's Health Day. The purpose is to coordinate media in addition to other cities across the south where homelessness in LGBT communities is high.

The Transgender CAG's recommendations are comprised of changing the composition of the CAG by reaching out to other groups in the Atlanta Area that serve the transgender community, creating more incentives for CAG participants, being more inclusive to the overall transgender community, and changing the meeting location in order to be more convenient to public transportation. The annual project for the Transgender CAG is establishing a Trans Health Wellness Center that not just focuses on HIV, but the overall health care of the Transgender community.

The Young Adult CAG's recommendations included changing the time of the meeting that is more convenient to college students, providing outreach at large campus events, and provide HIV testing in dormitories. The year event will be a Young Adult HIV Prevention & Sexual Health Conference: "Be the Change" for the purpose of increasing the knowledge and skills among young adults in order to promote healthy behavior. The Young Adult CAG also disseminated a survey to obtain information on sexual behaviors, attitudes and beliefs about sex and sexual health pertaining to young adults and desired Young Adult CAG future activities and topics.

v. Vital statistics data:

In 2012-2014 there were 1.1 to 1.5 HIV-related deaths per 100,000 population among Whites, 9.6-10.1 among Blacks/African Americans, and 0.7-1.0 among Hispanics.

vi. Other relevant program data including Community Health Center data:

Georgia's health care delivery system, including its safety net providers, will continue to play an important role in delivering health care to the state's vulnerable populations. Georgia's community health centers and hospitals provide access to needed primary, preventive, and acute care services for low-income and underserved residents. Georgia is home to 29 federally qualified health centers (FQHCs), together operating 161 clinic sites throughout the state. In 2012, the state's FQHCs saw over 320,000 patients and had nearly 1 million patient visits. Over half (53%) of patients were uninsured, while 26% had Medicaid or CHIP. Nearly all (96%) were low-income, including about three-quarters (73%) who had income below poverty.

In 2014, Georgia's FQHCs saw 3,530 patients with HIV. Demographic data were not available for inclusion in this document.

B. HIV Care Continuum

a. Graphic and narrative describing the HIV Care Continuum including definitions of numerator and denominator:

The 2014 HIV Care Continuum is calculated for persons diagnosed as of the end of 2013 and living (i.e. not known to be dead) as of the end of 2014. Persons are considered to be **engaged** in care if they have at least one CD4 or VL during 2014; they are considered **retained** if they had 2 or more CD4/VL at least 3 months apart in 2014; and **virally suppressed** if the last viral load test in 2014 was <200 copies/ml. Timely linkage to care is assessed among persons diagnosed in 2014, with a CD4 or VL within one month of diagnosis. **Linkage to care** can be calculated by including or excluding CD4 counts and viral load tests done on the same day as confirmatory diagnostic tests. It is unclear whether labs done on blood drawn on the same day as diagnosis represent true linkage to care. This probably varies by setting. A substantial proportion of persons have CD4 and VL tests done on the day of diagnosis, and so the percent linked to care varies by about 20 percentage points between the 2 estimates.

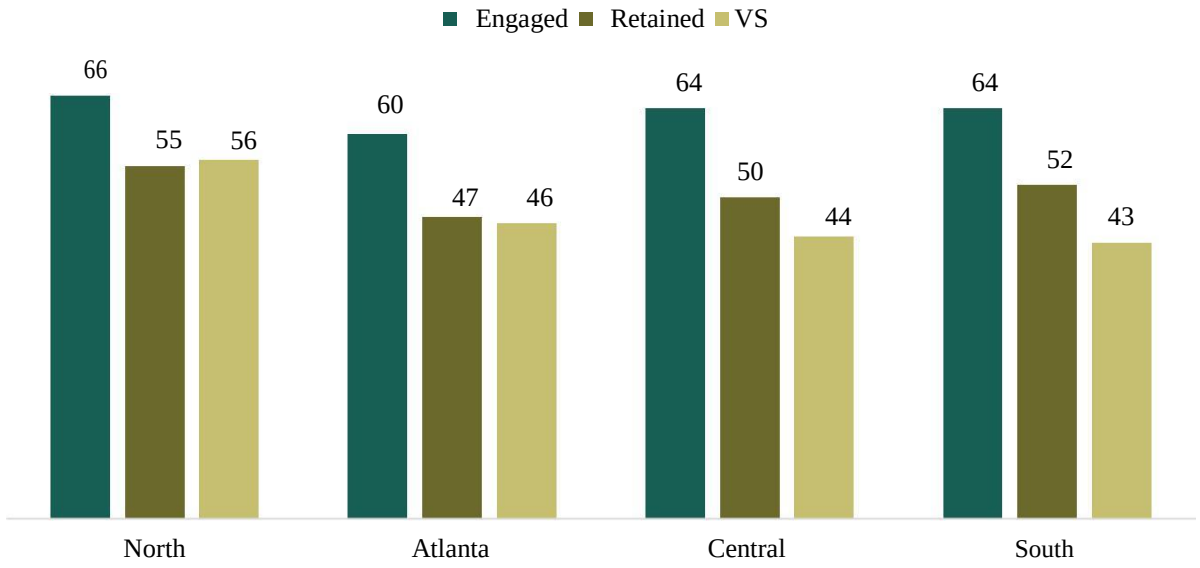
Overall, among persons diagnosed in 2014, 52% and 74% were linked to care within 30 days (excluding and including same day labs, respectively). Within the EMA, when same day labs are excluded, the proportion linked to care within 30 days was lower for Blacks/African Americans and Hispanics, for persons 20-29, and for IDU and MSM/IDU; outside of the EMA the proportion linked in a timely was lower for males, for Blacks/African Americans and Hispanics, and for MSM and MSM/IDU. Patterns were similar when same day labs were included. The number diagnosed in 2014 was too small to provide a measure of linkage to care.

Among PLWH in Georgia in 2014 60% were engaged, 48% were retained, 46% were virally suppressed and among those retained in care, 81% were virally suppressed. Retention was lower among Blacks/African Americans than among Whites and Hispanics, and viral suppression was lower among both Blacks/African Americans and Hispanics than Whites. Retention and viral suppression were lower among persons 20-39 than among older persons, and retention and suppression were lower among IDU and MSM/IDU than MSM and high risk heterosexuals. Among 143 transgender PLWH, 64% were engaged, 52% retained, and 45% virally suppressed. The number of transgender persons outside of the EMA was too small to provide a separate estimate.

Among MSM, engagement, retention and viral suppression were highest among Whites and lowest among Blacks/African Americans (13 percentage point gap in viral suppression between Blacks/African Americans and Whites), and values were intermediate for Hispanic MSM. Patterns were similar in the EMA and outside the EMA; however, the proportion achieving viral suppression was lower outside the EMA, and the proportion of Hispanic MSM achieving viral suppression outside the EMA was the same as for Black/African American MSM.

Care Continuum outcomes varied by geographic region, with the proportion engaged, retained and virally suppressed highest in northern Georgia, and lowest in southern Georgia. Although engagement and retention were slightly lower in the southern health districts, viral suppression was markedly lower, with a 13 percentage point gap between viral suppression in the health districts in the north and the south of Georgia (Figure 16).

Figure 16. HIV Care Continuum by Region, Georgia, 2014



North: Rome, Dalton, and Gainesville
Atlanta: Fulton, Cobb-Douglas, Gwinnett, DeKalb and Clayton
Central: LaGrange, Macon-Athens, Columbus, Dublin and Augusta
South: Albany, Valdosta, Waycross, and Coastal

Figure 17. Care Continuum for persons with at least one visit: Ryan White Part A and Part B, 2014.

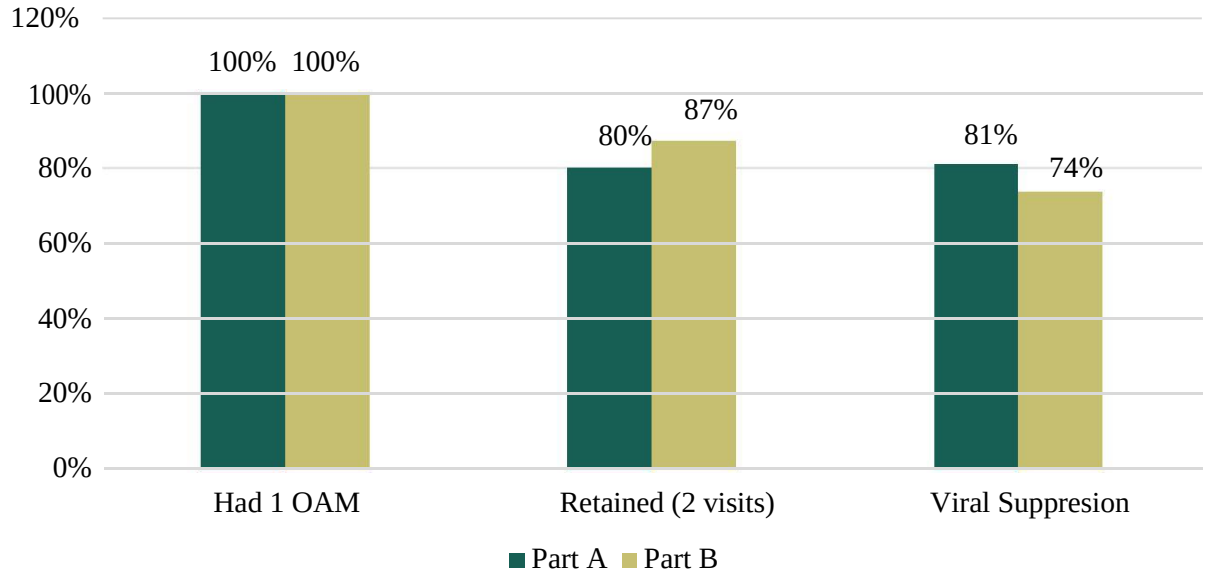


Figure 17 shows the Care Continuum for persons who received at least one Ryan White Part A or B outpatient/ambulatory medical service (OAM).
Within the EMA, the proportion linked to care within 30 days was lower for Blacks/African Americans, for persons 20-29, and for IDU and MSM/IDU; outside of the EMA the proportion linked in a timely manner was lower for males and for Blacks/African Americans.

The proportion on ART is not included in the HIV Care Continuum because the number estimated to be on ART, based on the MMP weighted estimate, is lower than the number of persons achieving viral suppression based on eHARS. Based on aggregated data from 2009-2013, 92% of MMP participants were on ART at the time of the interview, 77% were virally suppressed at most recent viral load test, and 61% were virally suppressed at all viral load tests in last 12 months. Results likely changed during that time period, at least in part due to changes in treatment guidelines in 2012, but year by year analysis has not yet been completed.

b. Disparities in engagement among key populations:

Tables 13 – 18 reflect engagement along the HIV Care Continuum for each of the Georgia jurisdictions.

Table 13. HIV Care Continuum, Georgia, 2014

		Engaged %	Retained %	Virally Suppressed %	VS among Retained %
Males	(28,418)	61	47	45	82
Females	(12,293)	63	50	45	78
Transgender	(143)	64	52	45	80
White	(9,900)	62	50	52	88
Black/AA	(33,188)	61	47	43	77
Hispanic	(2,859)	57	48	46	84
Asian	(183)	65	52	55	92
AI/AN	(23)	39	35	39	--
Multiracial	(1,739)	78	64	59	81
13-19	(243)	72	58	52	78
20-29	(5,700)	61	43	36	68
30-39	(10,212)	70	45	42	77
40-49	(14,681)	62	48	47	82
50-59	(13,796)	62	50	49	85
60+	(5,290)	59	49	48	86
MSM	(28,924)	62	48	47	82
IDU	(3,873)	55	43	40	79

Table 13. HIV Care Continuum, Georgia, 2014					
		Engaged %	Retained %	Virally Suppressed %	VS among Retained %
IDU/MSM	(2,279)	57	46	41	78
Heterosexual	(12,338)	64	51	46	78

Table 14. HIV Care Continuum, Fulton/DeKalb, 2014					
		Engaged %	Retained %	Virally Suppressed %	VS among Retained %
Males	(19,382)	59	46	45	83
Females	(4,103)	61	48	43	78
White	(4,322)	60	49	52	91
Black/AA	(16,238)	59	45	42	78
Hispanic	(1,142)	58	48	44	82
Asian	(84)	76	62	65	94
AI/AN	(<5)	--	--	--	--
Multiracial	(842)	75	62	58	83
13-19	(88)	72	58	55	82
20-29	(2,622)	62	43	35	66
30-39	(5,029)	60	45	41	76
40-49	(6,966)	60	47	47	84
50-59	(6,460)	58	48	47	86
60+	(2,333)	55	46	47	89
MSM	(15,640)	61	47	46	82
IDU	(797)	49	39	36	81
IDU/MSM	(1,237)	54	44	39	79
Heterosexual	(4,102)	62	49	44	78

Table 15. HIV Care Continuum, Atlanta EMA, 2014					
		Engaged %	Retained %	Virally Suppressed %	VS among Retained %
Males	(27,375)	60	47	47	84
Females	(7,145)	62	49	47	81
Transgender	(132)	64	54	45	78
White	(6,729)	63	51	54	91
Black/AA	(22,966)	60	46	44	80
Hispanic	(2,095)	58	49	47	85
Asian	(157)	69	55	59	92

Table 15. HIV Care Continuum, Atlanta EMA, 2014					
		Engaged %	Retained %	Virally Suppressed %	VS among Retained %
AI/AN	(13)	--	--	--	--
Multiracial	(1,255)	77	63	60	83
13-19	(171)	75	61	57	81
20-29	(3,951)	62	43	37	68
30-39	(17,427)	61	45	43	78
40-49	(10,423)	62	48	49	85
50-59	(9,279)	57	49	50	88
60+	(3,342)	57	48	49	90
MSM	(21,930)	62	48	48	84
IDU	(2,277)	52	41	40	82
IDU/MSM	(1,698)	56	45	42	80
Heterosexual	(7,014)	63	49	47	81

Table 16. HIV Care Continuum, Georgia excluding EMA, 2014					
		Engaged %	Retained %	Virally Suppressed %	VS among Retained %
Males	(10,160)	61	48	42	77
Females	(5,148)	63	51	43	74
White	(3,171)	61	49	47	82
Black/AA	(10,222)	64	51	42	73
Hispanic	(764)	55	46	42	82
Asian	(26)	--	--	--	--
AI/AN	(10)	--	--	--	--
Multiracial	(484)	80	66	58	78
13-19	(72)	64	53	39	71
20-29	(1,749)	60	44	34	66
30-39	(2,785)	58	45	38	74
40-49	(4,258)	63	50	43	74
50-59	(4,517)	63	52	46	79
60+	(1,948)	62	51	47	80
MSM	(6,933)	63	50	44	77
IDU	(1,595)	59	47	40	75
IDU/MSM	(582)	61	47	41	74
Heterosexual	(5,324)	65	53	44	74

Table 17. HIV Care Continuum among MSM, by Race/Ethnicity, 2014					
		Engaged %	**Retained %**	**Virally Suppressed %**	**Suppressed among Retained %**
Georgia					
White	(7,408)	64	52	54	90
Black/AA	(18,466)	61	46	43	78
Hispanic	(1,794)	58	48	46	84
Fulton/DeKalb					
White	(3,719)	62	50	54	92
Black/AA	(10,379)	60	45	42	78
Hispanic	(839)	60	49	46	82
Atlanta EMA					
White	(5,449)	64	52	56	92
Black/AA	(14,087)	51	45	43	79
Hispanic	(1,405)	59	49	48	85
Georgia excluding EMA					
White	(1,959)	63	51	49	83
Black/AA	(4,379)	63	49	41	74
Hispanic	(388)	53	43	41	82

Table 18. Proportion linked to care within 30 days of HIV diagnosis, excluding (A) and including (B) same day labs*								
	Georgia		Fulton/DeKalb		Atlanta EMA		GA excl. EMA	
	A	B	A	B	A	B	A	B
Male	52	75	55	76	54	77	47	71
Female	55	76	63	79	56	77	54	75
White	60	83	66	87	64	85	53	81
Black/AA	51	82	53	73	52	74	48	68
Hispanic	60	73	69	75	60	74	59	72
Asian	71	88	78	89	82	--	--	83
AI/AN	--	--	--	--	--	--	--	--
Multiracial	56	71	53	74	52	72	63	69
MSM	52	--	55	74	54	75	47	68
IDU	55	--	53	74	51	76	60	78
MSM/IDU	46	--	49	69	49	74	--	65
Heterosexual	55	--	62	79	57	77	53	74
13-19	56	68	64	72	64	73	43	59
20-29	47	69	50	72	49	72	45	64
30-39	54	80	58	79	55	79	54	79

40-49	55	79	54	79	57	76	53	77
50-59	57	79	72	87	65	87	43	78
60+	56	79	62	83	55	83	57	79

***** Linkage to care can be calculated by including or excluding CD4 counts and viral load tests done on the same day as confirmatory diagnostic tests. It is unclear whether labs done on blood drawn on the same day as diagnosis represent true linkage to care.

c. HIV Care Continuum is currently utilized in (1) planning, prioritizing, targeting, and monitoring available resources, and (2) improving engagement and outcomes in each of the HIV Care Continuum:

The HIV Care Continuum is currently being utilized to plan, prioritize, target and monitor available resources in response to needs of PLWH and in improving engagement at each stage in the HIV Care Continuum. The HIV Care Continuum was taken into consideration when developing the Integrated Plan Goals and Objectives, making sure that initiatives align with each step of the Continuum.

The Georgia DPH HIV/AIDS Epidemiology Surveillance Section recently released district-level HIV Care Continuums. This information allows local health departments and partners to target its activities and set benchmarks. The district Care Continuums help prioritize activities and populations for the purpose of service delivery and client engagement. In Georgia's HIV Prevention Program, two of the focus areas include using district-level HIV Care Continuums to aid in planning and promotion of HIV testing and linkage to care. By increasing HIV diagnosis, and linking PLWH to care, the state will achieve higher rates of viral suppression overall, and eliminate disparities in HIV testing, treatment and care. Late diagnosis of HIV infection contributes to poorer outcomes for infected individuals and impedes HIV prevention efforts. Early diagnosis provides opportunity for viral suppression for the benefit of the individual and for reduced HIV transmission for the benefit of the community.

Planned activities to target the African American population will be centered on linkage to care and retention efforts through Minority AIDS Initiative (MAI) funding. The Ryan White Part B MAI Program will continue to focus on African Americans as one of the priority populations. The program will continue working with the Anti-Retroviral Treatment and Access to Services (ARTAS) intervention in six Part B funded health districts with high HIV prevalence: Albany, Augusta, Clayton, Columbus, Savannah, and Waycross. The agencies will continue to use an evidence-based intervention, ARTAS, to conduct outreach, educate, and link Black/African American clients into medical services, specifically ADAP.

Since the discovery of HIV/AIDS, MSM have been disproportionately impacted. Estimated to be two to four percent of the population, they exceed 50% of HIV prevalence (total cases) and nearly two-thirds of new diagnoses. The risk landscape MSM navigate is complicated by a host of diseases fostering and negatively interacting with HIV, such as mental illness, substance use and abuse, as well as other sexually transmitted infections. Further complicating the landscape are a host of structural factors, such as stigma and victimization. With MSM's HIV disparity and its broad landscape in mind, the DPH Office of HIV, led by the Coordinators for MSM/Lesbian, Gay, Bisexual,

and Transgender Activities, has developed an MSM/Transgender strategy. The strategy intends to move Georgia forward in achieving, even exceeding goals of the National HIV/AIDS Strategy 2020 (NHAS). To meet these goals, bold action is necessary. The following describes some of the planned initiatives put forth in the MSM/Transgender strategy.

At its core, the strategy means to shift our response systems to better attend to MSM and transgender people. By changing how funded programs work (more targeted and from a patient/client-centered approach), we can, and will, reduce new infections and improve treatment outcomes. For example, the strategy calls for the promotion and improved access to pre-exposure prophylaxis (PrEP), expanded condom distribution pathways, a test to treat process so the newly diagnosed gain access to treatment in a more timely manner, and adherence tools to help people living with HIV achieve viral suppression.

To help inform DPH's response, a number of additional tasks are included in the strategy. First, in a study being conducted jointly with Emory University-Rollins School of Public Health, DPH is assessing MSM living in rural areas of Georgia's HIV prevention service needs as well as the barriers to accessing these services. This initiative will help the HIV Office determine what is working and not working in these underserved areas. The second initiative is a multi-tiered approach to mitigating stigmas attached to HIV and sexuality. Like geographical dispersion, stigma also hinders engagement in prevention and care services. This initiative shall mobilize a community-based advisory group to recommend actionable steps. The MSM/Transgender strategy maps out over 30 activities to address eight NHAS goals.

The DPH HIV Prevention Program has created elevated strategic priorities to support our ultimate vision and direction with the Georgia Statewide MSM Strategic Plan which is to reduce new infections, improve access to care, and enhance standards of care. These priorities will guide decision making, the allocation of resources, and clarify the office's overarching plan of action to address the needs of men who have sex with men in Georgia with a specified focus on African American and Latino MSM who carry the highest burden in the state. The Elevated Strategic Priorities are as follows:

1) Ensure that 50% of MSM are tested every year by December 31, 2018, with an emphasis on young MSM 18-24.
2) Ensure that 90% of all MSM have access to condoms by December 31, 2018.
3) Link 90% of all positive MSM found through public health testing to medical care within 14 days by December 31, 2018.
4) Increase the percentage of at risk MSM taking PrEP to 50% (with an emphasis on the 18-24 age group) by December 31, 2020.

The HIV Care Continuum has an important role in the Atlanta EMA/Part A Program's annual priority setting process. On June 17, 2015 the Director of the DPH's HIV/AIDS Epidemiology Section briefed the Priorities Committee of the Metropolitan Atlanta HIV Health Services Planning Council (Planning Council) on the HIV Care Continuum for the State of Georgia and the 20-county EMA. Data for 2014 were presented for adults

and adolescents living with HIV and the stages of the HIV Care Continuum broken-down by sex, age, and race/ethnicity. Data were also provided to compare viral suppression among those retained in care by race/ethnicity. These data, among others, were used to inform decisions on the rankings and funding allocations among priority service categories. For example, $1,275,184 was allocated within the OAHS category to initiate ART while working to have coverage picked up by ADAP or Patient Assistance Programs. This led to increases in the case management non-medical category from FY14 to FY15 and again for FY16 to support ADAP coordinators to assist clients with accessing coverage for medications.

HIV/AIDS Bureau (HAB) performance measures were used by the Assessment Committee, Quality Management and Comprehensive Planning Committee to assess the efficacy of programs and to analyze and improve gaps along the Continuum.

The HIV Care Continuum is used to target funds to high-risk and high need areas. African Americans have lower levels of linkage, retention and viral suppression. In addition to targeting Minority AIDS Initiative (MAI) funds to OAMC, funds were allocated to support a HIV clinic in a targeted underserved area with high morbidity levels. Additionally, funds were allocated to expand evening clinic hours at another site to allow clients more options for accessing care.

To improve antiretroviral use and viral load suppression, new options for providing medications have been implemented at several sites which allow clients to continue to receive medication at the agency, through home delivery, or through contracted pharmacies.

Part A quality management staff and data staff assist each primary care provider in developing an agency Continuum to evaluate performance and success in meeting quality standards.

The needs of persons **not in care** were considered**.** During the priority setting process, Atlanta EMA HIV/AIDS Consumer Survey which included service gap information for persons who know their HIV status but were not in care. In addition to allocating funds for mental health and substance abuse services to support individuals in preparing to enter care, the Committee recommended continued funding for the AAOI – a community education program. It is also important to note that there is a higher percentage of persons virally suppressed than the percentage in care – due to the fact that many clients who are virally suppressed and generally healthy have medical visits less frequently than two times a year at least three months apart. Funds were allocated to support these clients in maintaining their health through such services as case management non-medical to assist clients with ADAP recertification, and medical case management.

C. Financial and Human Resources Inventory

a. See Jurisdictional HIV Resources Table included as Appendix A.

b. HIV Workforce Capacity and its impact on the HIV prevention and care service delivery system:

The distribution of providers across the state continues to impact access to care, creating a service gap among PLWH, particularly for residents of rural areas and especially for those who require specialty care. There are many providers in urban areas and not enough in rural parts of the state. According to HRSA, as of March 2015, 141 of the 159 counties in Georgia were designated as Medically Underserved Areas, and seven counties were designated as having Medically Underserved Populations. Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. Specialty care is more limited, and generally located in areas with academic medical centers (i.e., Atlanta, Augusta, Macon, and Savannah) leaving large portions of the state with very limited access to this care.

Georgia also has several Health Professional Shortage Areas (HPSAs) and unmet need for care. As of August 2014, 59% of the primary health care need in Georgia was being met and Georgia had 193 primary care HPSAs. Only 45% of the need for mental health care services and 28% of the need for dental services were being met, and the state had 92 mental health and 181 dental HPSAs. There are five medical schools in Georgia, with ten teaching hospitals and over 2,300 residency positions within the state. As of 2011, Georgia ranked 41st in the country for the ratio of residents to 100,000 population (20 in GA, compared to 35.8 nationally). However, nearly half (49%) of physicians completing their graduate medical education in Georgia remain in-state to practice – a rate similar to the national average of 48%. Georgia is one of 12 states with laws restricting the autonomy of nurse practitioners in at least one area of their practice.

The HIV prevention workforce capacity is influenced at the local level. Since 2012, Georgia's prevention program has received significant decreases in funding, following CDC's decision to directly award jurisdictions. This decrease has led to a reduction in the number of staff designated to carry out targeted testing, linkage to care and other high impact prevention activities. In addition to the limitation in human resources, the lack of funds also contributes to a reduction in the program's capacity to perform at local level.

The Black AIDS Institute conducted a nationwide survey of the knowledge, attitudes, and beliefs of the HIV workforce. The HIV/AIDS workforce, which for more than three decades has provided essential guidance and support for people living with HIV and those most at risk of HIV infection, has a pivotal role to play in maximizing the use and impact of the powerful treatment and prevention tools now at our disposal.

The data summarized in the Institute report suggest that the HIV/AIDS workforce does not have the science and treatment knowledge it needs to respond to the challenges and opportunities presented by these new scientific developments.

The state of Georgia was one of 48 states, the District of Columbia, and US territories that completed a 62-question web-based survey. Georgia's summary was very

concerning. On average Georgians only answered 60% of the survey questions correctly—essentially getting an "F" grade on HIV science and treatment issues. The state received a "C" on basic science questions and an "F" on treatment-related questions.

Action agenda: Build Strong HIV Science and Treatment Literacy
What will it take to build the skills of Georgia's HIV workforce to address the HIV/AIDS epidemic?

1) Increase HIV science and treatment literacy among non-medical HIV/AIDS workforce
2) Establish a clear and specific set of core competencies
3) Establish a state certification program for the HIV/AIDS workforce
4) Require that HIV/AIDS staff pursue continuing education on HIV science and treatment issues
5) Dramatically increase the number of people living with HIV/AIDS in the HIV/AIDS workforce

State and Atlanta EMA Healthcare Workforce Capacity: HIV treatment can help PLWH live longer and healthier lives. Benefits of linkage to primary care include alleviating and/or controlling symptoms as the disease progresses, preventing and/or delaying disease progression, and reducing the chance of spreading the HIV infection to others (http://benefitof.net/benefits-of-hiv-treatment/). Georgia specific HIV Workforce Capacity data describing the Atlanta EMA's care continuum capacity is limited, particularly capacity outside of Ryan White funded providers. In its *2015 Physician Workforce Profile*, the American Association of Medical Colleges (AAMC) ranked Georgia 39th in active patient care physicians per 100,000 population, 2014 (198.0 per 100,000) and 43rd in active patient care primary care physicians (71.1 per 100,000). Five of the 20 counties in the Atlanta EMA are designated as single city (Bartow), low income (Clayton) or partial (DeKalb, Fayette and Fulton) Health Professional Shortage Areas (HPSAs).

The *Physician Workforce Profile* indicates that there were 260 active infectious disease (ID) specialists (38,836 people per physician) in Georgia in 2014. The majority of these ID specialists (estimated 200) were located in the Atlanta EMA. The number of ID specialists that provide care for people living with HIV is not known. Barriers to ID care by a specialist include lack of insurance coverage, limited funding, and providers that do not accept Medicaid or Medicare.

There is a high incidence of oral health problems among PLWH. According to HRSA Ryan White Program estimates that "between 32 and 46 percent of PLWH will have at least one major HIV-related oral health problem— bacterial, viral, and fungal infections as well as cancer and ulcers—in the course of their disease…and 58 to 64% do not receive regular dental care" (http://hab.hrsa.gov/abouthab/files/oral_health_fact_sheet.pdf). Although not specific to HIV, the U.S. Department of Labor, Bureau of Labor Statistics' 2015 state occupational employment statistics indicate that as of May 2015, Georgia had 2,450 general dentists, 50 oral and maxillofacial surgeons, 130 orthodontists, and 310 dentists, all other specialists. Bureau of Labor Statistics are also available for the Atlanta-Sandy Springs-

Roswell, Georgia metropolitan statistical area (28 county area that includes all of the 20 counties in the Atlanta EMA served by the Ryan White Part A program). According to the Bureau, 1,420 (57.9%) of the state's dentists are located in the 28-county Atlanta region. However, six of the EMA's 20 counties are low income (Barrow, Bartow, Clayton, Newton, Spalding, and Walton) or partial (Douglas) dental HPSAs. Barriers to dental care for PLWH include lack of dental providers who do not accept patients with HIV infection, lack of dental insurance, limited income, and stigma.

The Bureau of Labor Statistics report also provides information on the number of other employed healthcare practitioners in Georgia. In May 2015, there were 3,170 physician assistants, 68,980 registered nurses, 3,920 advanced practice nurses, 1,810 dietitians and nutritionists, 8,850 pharmacists, 760 optometrists, 5,230 physical therapists, 2,930 occupational therapists, and 25,360 licensed practical and licensed vocational nurses. For the Atlanta-Sandy Springs-Roswell statistical area, there were 1,960 (61.8%) physician assistants, 36,200 (52.4%) registered nurses, 1,940 advanced practice nurses, 800 (44.1%) dietitians and nutritionists, 4,760 (53.7%) pharmacists, 360 (47.3%) optometrists, 2,970 (56.7%) physician therapists, 1,750 (59.7%) occupational therapists, and 10,450 (41.2%) licensed practical and licensed vocational nurses in May 2015. Both statewide as well as in the Atlanta EMA, some counties have greater health workforce coverage than others. In addition, some individuals seeking healthcare services may experience difficulties because of lack of insurance coverage and limited income.

Georgia has chosen not to expand its Medicaid coverage. Further, some physicians do not accept or limit their number of patients with Medicaid or Medicare coverage. The Division of Medical Assistance, the Department of Community Health's largest division, administers the state's Medicaid program which provides health care for approximately 1.7 million low-income children, pregnant women and people who are aging, blind and disabled. Pregnant women and their infants with family incomes at or below 200% of the FPL are eligible for Right from the Start Medicaid for Pregnant Women and Their Infants (RSM Adults and Newborns). Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. Almost six in ten births (59%) in Georgia are covered by Medicaid.

Ryan White Funded HIV Workforce Capacity: The Ryan White programs provide care for low-income, uninsured and underinsured individuals and families affected by HIV in Georgia. Funds support clients as they progress through the HIV Care Continuum and core medical and support services. The table below shows the client to staff ratio calculated utilizing funded personnel (FTEs) and number served by category for Parts A, B, and D.

Table 19. Client to staff ratio in the Ryan White-funded Programs									
	Part A		Ratio	Part B		Ratio	Part D		Ratio
	Staff FTE	Number Served	Clients to Staff	Staff FTE	Number Served	Clients to Staff	Staff FTE	Number Served	Clients to Staff
Case Management/ Social Work	38.89	19,921	512	33.5	16,706	499	4	1,491	373
Case Managers	32.3			26			4		
Service Plan Coordinator	1.58								
Social Worker	4.02			6.5					
Self Mgmt. Coord.	0.99								
Case Management Asst.				1					
Program Management/ Coordination									
Program Mgr./Coord.	7.42			5					
Program Dir.	1.74			2					
Quality Dir.	0.4								
Program Associate/Asst.				7					
Client Data/Records/ Admin									
Data Adm./Manager	1.56			1					
Data Entry Clerk/Tech	3.75			4					
Adm./Acct./Clerk/ Rec.	13.52			7.5					
Client Services							5.5	2358	429
Patient Navigator	7								
Patient Benefits/ ADAP	6.16			2					
Financial Counselor	0.86			1					
Intake/Registrar/Sched	7.37								
Eligibility Specialist	3.25								
Peer Couns/Educator/ Advocate	5.756	2283	397	6	135	23	3		
Linkage Specialist							2.5		
Mental Health and Substance Abuse	28.54	3,471	122	4	305	76			
Psychiatrist	2.68								
MH Counselor	8.65			1					

Table 19. Client to staff ratio in the Ryan White-funded Programs									
	Part A		Ratio	Part B		Ratio	Part D		Ratio
	Staff FTE	Number Served	Clients to Staff	Staff FTE	Number Served	Clients to Staff	Staff FTE	Number Served	Clients to Staff
Behavioral Health Asst.	2								
SA Counselor	5.95								
MH/Dual Diagnosis Clinicians	5.61			2					
Psychologists	2.13								
Continuing Care Provider	0.52			1					
Psychosocial Support	1								
Clinicians/Clinic Support	100.46	11,170	111	53	14,323	270	5.35	1,066	199
Clinic Mgr./Admin./ RN Mgr.	1.68			4					
MD	12.26			9			1		
Pediatrician							0.3	493	
Physician Asst.	1.3						0.55		
Advanced Practice Provider	8.25			3					
Nurse Practitioner	4.15			8					
RN	22.99			14			1.5		
LPN	1.6			5					
Medical Asst.	4.38			5					
Clinic Asst.	3.4			1					
Medical Secretary	2.7								
Pharmacist	2.36								
Pharm. Tech	3.84			1					
Lab Tech/Supv/ Phlebotomist	5.85			2			1		
PH Tech	1.2			1					
PH Educator/Health Educator	1						1	976	
Health Coordinators	12								
Radiology Tech	9.9								
Client Adherence/ Retention Mgr.	1.6								
Oral Health Services	15.82	3,174	201		1,091				
Dentist	4.86								

Table 19. Client to staff ratio in the Ryan White-funded Programs									
	Part A		Ratio	Part B		Ratio	Part D		Ratio
	Staff FTE	Number Served	Clients to Staff	Staff FTE	Number Served	Clients to Staff	Staff FTE	Number Served	Clients to Staff
Dental Hygienist	5.35								
Dental Asst.	5.61								
Nutrition Services/ MNT									
MNT Dietitians	3.12	1,120	359	4	1,487	372			
Support Services Food	0.95	962	1.013		369				
Food Service Manager/RD	0.2								
ENSP Coordinator	0.75								
Legal	2.01	113	56						
Attorneys	1.76								
Paralegal	0.25								
Interpretation/Trans	0.96	299	311		23				
Translator	0.96								
Child Care	1	126	126						
Babysitter	1								
Medical Transportation	0.5	2,858	n/a		2689				
Medical Trans Coord.	0.5								

Ryan White Funded HIV Workforce Impact: The Atlanta EMA served a greater number of clients in FY 2014, including an increase in the number of clients receiving care and treatment, positively impacting unmet need and increasing access to care. During FY 2014, 14,032 unduplicated clients received a Ryan White Part A service which represented a 3% increase over CY 2013 (n=13,626). Of these clients, 87% (n=12,247) received at least one Outpatient/Ambulatory Health Services visit (a 3% increase over CY 2013; n=11,874) with the average number of visits per client equaling 5.2.

The Georgia Ryan White Part B program served a total of 15,232 unduplicated clients during 2014. Of those clients 14,323 (94%) received at least one outpatient/ambulatory health service visit. This represents an overall increase from 2013, during which a total of 14,425 unduplicated clients were served, 13,685 (95%) of which received at least one outpatient/ambulatory health service visit.

Table 20: People Served by the Ryan White Part A & Part B Programs in FY 2014		
Core Medical Services	**Number Served**	
Service	***Part A***	***Part B***
Outpatient/Ambulatory Medical Care	11,170	14,323
Oral Health Services	3,174	1,091
Health Insurance Premium & Cost Sharing Assistance	0	38
Home Health Care	0	1
Mental Health	2,487	305
Medical Nutrition Therapy	1,120	1,487
Medical Case Management	7,540	8,845
Substance Abuse – Outpatient	984	0
Support Services	**Number Served**	
Service	***Part A***	***Part B***
Case Management – non medical	12,207	6,730
Child Care Services	126	0
Emergency Financial Assistance – Utilities	162	1,131
Food Bank/Home Delivered Meals	962	329
Health Education/risk reduction	0	2,376
Housing	12	5
Legal Services	113	0
Linguistics Services	299	23
Medical Transportation	2,858	2,689
Outreach Services	0	467
Psychosocial Support Services	2,283	135
Treatment Adherence Counseling	0	88

Through the Atlanta Family Circle Ryan White Part D Network in CY 2015, 1,777 women, infants, children, and youth received Part D funded services. Approximately two-thirds of all children, adolescents and young adults with reported HIV/AIDS in Georgia are cared for at the Grady IDP Family and Youth Clinic, which also provides the majority of care for HIV-exposed infants throughout the state. In CY 2015, 176 HIV-indeterminate infants (0 to 2 years), 70 HIV infected infants children (0-12 years of age), and 423 youth (13-24 years of age) received primary care and treatment adherence services and 976 women (25+ years of age) received treatment adherence services. Twenty-five youth received transition to adult medical care services. In addition, 393 youth were screened for mental health problems and 376 received substance abuse screening services; 515 children and youth received medical case management services. Additional services provided included:

- 2,460 prenatal patients were tested with 19 pregnant women identified as HIV+.
- 80 women received services through the OB HIV High Risk Clinic
- 742 high risk African American women and youth received HIV counseling and testing and prevention education services.
- 125 women ages 25 and above received case management services

c. Different funding sources interact to ensure continuity of HIV prevention, care, and treatment services:

The organizational structure of the Georgia DPH, Office of HIV/AIDS allows for collaboration and coordinated efforts among three funding sources in the Prevention, CAPUS (Care and Prevention in the United States) and Care Programs. These efforts decrease the duplication of efforts by streamlining the way funding is utilized in order to ensure the continuity of prevention, care and treatment services.

Georgia's Prevention Program maximizes CDC funding by leveraging existing resources through Ryan White Part B and CAPUS programs. One example of this coordination includes, the designation of CDC prevention funding to support the expansion of linkage activities in seven health districts. These funds support full-time District Linkage Coordinators that work closely with Ryan White Part B clinics to promptly link individuals to care. During this process, the prevention linkage staff maintains communication with the client and clinic staff to ensure successful coordination of care. This system of coordination is further exemplified throughout the state, as the Prevention Program expanded opt-out HIV testing in local health departments throughout the state. Under opt-out testing, any diagnosed individual is linked to a Ryan White Part B Program. The Ryan White Part B program incorporated language into the policies and procedures that eliminates the need for a confirmatory test in order to begin the linkage process with an aim at shortening any wait times for clients to begin receiving care.

Georgia DPH is a CAPUS Demonstration Project recipient. The purpose of this CDC funded demonstration project is to reduce HIV and AIDS-related morbidity and mortality among racial and ethnic minorities living in the U.S. Georgia CAPUS goals include creating more efficient and effective systems to increase HIV testing, linkage to, retention in, and re-engagement with care, treatment, and prevention; enhancing navigation services; using surveillance data and data systems to improve care and prevention; and addressing social and structural factors directly affecting HIV testing, linkage to, retention in, and re-engagement with care, treatment, and prevention. One significant CAPUS component is the Resource Hub. The Resource Hub has four components: 1) an eligibility portal to help determine pre-eligibility for Ryan White services and facilitate more timely linkage to needed care; 2) mapping and testing to easily identify locations for HIV, STD, TB and Viral Hepatitis testing throughout Georgia; 3) an online resource directory to locate HIV medical services, housing assistance, mental health services and other support services in local communities for people living with HIV/AIDS; and 4) medical information for people living with HIV/AIDS, HIV service providers, and people wanting more information on HIV/AIDS. Development of the Resource Hub included collaborations with Ryan White Parts A and B, Metro and Rural area health department staff, academic partners, FQHCs, non-profit health providers and community members. The CAPUS Resource Hub serves as a primary conduit to promote prevention activities, information and services for HIV/AIDS available throughout the state.

Examples of this interaction include linkage services to Ryan White clinics provided to newly diagnosed individuals through the Prevention programs. The Ryan White Parts A and B programs incorporated language into the policies and procedures that emphasizes that clinics do not need a confirmatory test in order to begin the linkage process with an aim at shortening any wait times for clients to begin receiving care. As eligibility documentation is often a major obstacle to enter care, an
Eligibility Portal was built into the Resource Hub to facilitate entry into the Ryan White Program and pre-screen potential clients. If identified as pre-eligible for Ryan White services, users can provide their contact information and request to be contacted directly by a trained linkage staff member in their local area who will determine final eligibility. They are also provided with a checklist of key documents that will be needed to complete the eligibility verification process. This will help reduce barriers to program enrollment and expedite clinic admission for patients. The anticipation is that linkage to care will increase, and the time to linkage will decrease. The CAPUS team has worked closely with Ryan White staff and case managers to make sure that the Eligibility Portal aligns with their process.

In addition, the Georgia DPH, Office of HIV/AIDS created one cohesive HIV/AIDS planning body called the Georgia Prevention and Care Council (G-PACC). G-PACC membership includes representatives from major stakeholders, including but not limited to: Ryan White Parts A, B, C & D; State HIV Prevention and Fulton/DeKalb HIV prevention programs; consumers; Department of Corrections; HOPWA; Hepatitis; HIV Surveillance; etc. G-PACC's role in this process is to work together to provide strategies for action in the development of a coordinated system of care for PLWH in accordance with the Integrated Plan. The body will review and revise the Plan to ensure there are clear goals, objectives and approaches for action as well as mechanisms for assessing progress.

Another example includes the interaction of funding to the Georgia Department of Corrections (DOC). The Georgia DOC conducts HIV testing upon intake and release. HIV positive inmates are provided with HIV medications and treatment while incarcerated. The Ryan White Part B Program provides funding to the Georgia DOC for pre-release and case management planning in order to link HIV positive inmates to services upon release.

The Ryan White Statewide Part B Quality Management (QM) Core Team includes representation from all Ryan White Parts. Part B QM personnel attend local Ryan White Part A Program QM Meetings to share updates, best practices, and to identify opportunities for collaboration, e.g. quality training.

At the local level, 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 (Savannah, Waycross and metro Atlanta); and Primary Care and Counseling & Testing are provided

through Part C funds. 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.

There are 19 Ryan White Part C recipients operating in Georgia, providing early intervention and primary care services. Fourteen 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. Five of the Part C-funded sites are also the recipients of Part A funds in the EMA.

Georgia has three Part D-funded programs located in the EMA (The Grady Health System, Infectious Disease Program), Savannah, and Waycross. All Part D funded programs also receive Part B funding. The Grady Health System, Infectious Disease Program 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. Savannah and Waycross cover the southeastern portion of the state. Savannah provides services to Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, and McIntosh counties. Waycross provides services to Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware, and Wayne counties.

Ryan White Part D funds are used to fill in the gaps in services to Atlanta's HIV affected and infected children, youth, and women and their families. The Grady IDP serves the vast majority of children and adolescents in the 20-county EMA because other sites do not have the expertise on-site to provide that care. The IDP also enrolls their HIV+ mothers and follows them all in the Family Clinic (FC) which combines WICY patients all on a separate floor of the building.

IDP Family and Youth Clinic staff work closely with High Risk OB Nurse in the Grady Women's Health high risk OB Clinic for HIV+ Women to ensure pregnant women living with HIV receive coordinated services. A Grady IDP social worker provides case management services onsite at the weekly OB clinic. In addition, two of the Physician Assistants (PAs) from the Family Clinic visit the HIV OB clinic on the first and third Wednesday of the month (the clinic is held weekly on Wednesdays) so that the PAs can meet with future patients and establish a relationship with them. It also allows the PAs to help the Grady Women's Part D nurse and the Grady IDP social worker in addressing enrollment issues that the women in the OB clinic may encounter in enrolling for services at the IDP postpartum. To facilitate enrollment, joint maternal and infant six week appointments are made at the IDP Family Clinic.

It is critical to note that DPH HIV Prevention and Ryan White programs are working closely to implement data to care activities in collaboration with HIV/AIDS Epidemiology Surveillance Section's Health Information Exchange (HIE) and other similar efforts. As the HIV/AIDS Epidemiology Surveillance identifies clients out of HIV

care, prevention linkage coordinators work with the Ryan White clinics to re-engage clients.

Georgia DPH Health Districts receive a very descriptive annex that details the services to be provided; however, they are given the flexibility of identifying how these services will be implemented within their districts. Services are aligned with the NHAS and CDC's High Impact Prevention Approach. Districts are eligible for tiered funding based on burden of disease. At a minimum, all Health Districts are required to implement routine, opt-out testing in clinical settings, often at local health departments. Additionally, all Districts must implement structural level condom distribution and participate in community mobilization efforts. As funding increases, additional requirements include the implementation of prevention for positives and high-risk negatives, including the facilitation of CDC's evidence-based interventions.

Georgia's HIV Prevention Program supports routine opt-out and targeted testing among 16 eligible Health Districts (with 13 receiving direct funds) in healthcare settings and in non-healthcare settings to reach people at greatest risk who are unaware of their HIV status. HIV Testing activities conducted under our PS12-1201funding included general testing in pharmacies, correctional facilities, outreach events, colleges/universities, community based organizations/AIDS service organizations (CBO/ASO), substance abuse treatment facilities, health department and other clinics. Linkage to care is a provision of all HIV testing efforts which is fostered by collaborations with Ryan White Programs. Among the more than 72,000 test events conducted under PS12-1201 in 2015, 99.8% of clients who tested positive received their test results. 82% of test events occurred in healthcare settings and 12% occurred in non-healthcare settings. Ongoing efforts within Georgia's HIV Prevention Program is to continue encouraging and supporting expansion of HIV testing activities to non-traditional and non-healthcare settings to better reach high risk populations and rural areas. Statewide testing efforts will be further enhanced by incorporating new testing technologies where feasible and promoting routine, rapid-HIV screening for all pregnant women in the first and third trimester. Capacity Building activities for HIV Testing include ongoing Pre/Post Counseling and Testing trainings for applicable staff throughout Georgia, distribution of testing protocols, HIV case report training, analytic methods and data management. Capacity Building activities have resulted in improved data collection methods and overall data reporting of HIV outcomes.

Dependent on HIV epidemic burden in respective Health Districts, funds under Georgia's HIV Prevention PS12-1201 grant also supports Comprehensive Prevention for Positives. Health Districts implement the following components: 1) Linkage to care, treatment and prevention services for those testing positive for HIV and not in care; 2) Retention in care, lost to care and reentry into care services, 3) Providing ongoing Partner Services for HIV positive persons and their partners in collaboration with Georgia DPH STD program; 4) Support behavioral and clinical risk screening followed by risk reduction intervention for PLWH and HIV-discordant couples; 5) Support implementation of behavioral, structural and biomedical intervention for PLWH; and 6) Conduct activities in partnership with Georgia DPH Maternal and Child Health Program that identify

perinatal HIV prevention opportunities utilizing the Fetal and Infant Mortality Review (FIMR)-HIV Prevention Methodology.
Condom distribution as a structural intervention is also supported and conducted throughout Georgia by all funded Health Districts to target PLWH, persons at highest risk of acquiring HIV and persons unaware of their status. Condom distribution goals include 1) increasing knowledge of correct condom use among priority populations and 2) decreasing stigma and negative perceptions around condom use. In 2015, more than 1 million condoms were distributed to HIV-positive persons and to populations at highest risk of HIV. 60% were distributed to Ryan White Part B clinics. Other settings for distribution includes college and universities, CBOs/ASOs and other health department locations. Use of Condom Dispensers was also found to be effective for reaching populations in high burden areas.

Support and promotion of Social Marketing, Media and Mobilization is targeted among Health Districts outside of Fulton and DeKalb counties. Since 2009, DPH has had a partnership with the Kaiser Family Foundation, "Georgia Greater than AIDS" initiative for the development of localized Social Marketing campaigns and materials that target relevant audiences. The most recent campaign 'We are Family' features Georgia residents and provides education and information for the general population and Black/African American MSM based on local needs and are linked to other funded HIV prevention activities which incorporate print messages and the Georgia HIV/STD Infoline. This includes hosting community engagement sessions. Social Marketing and Community Mobilization activities create environments throughout Georgia, and in rural areas, that support HIV prevention by actively involving community members in efforts to raise HIV awareness, confront stigma, build support for and involvement in prevention efforts.

Georgia's "Speak Out HIV" campaign was developed to empower young, gay and bi-sexual men to reduce the stigma associated with HIV, particularly the stigma around getting tested, disclosing status and remaining engaged in care. Speak Out Ambassadors use their story and presence to engage peers via participation at outreach and special events, social media and other outlets. Additional campaigns include "Ask the HIV Doc", a YouTube series featuring three well-known HIV physicians who address popular topics and answer question posed by channel subscribers. In addition, the "Empower Trans" series was released in Spring 2016 and features six transwomen who share everyday experiences from living with HIV to using PrEP. This popular series can also be viewed on YouTube.

DPH continues work to increase awareness of Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (nPEP) Services by supporting community engagement sessions and educational campaigns among health service providers. These efforts serve to enhance community involvement in the growing landscape and availability of PrEP and nPEP in Georgia. In 2014, DPH Office of HIV/AIDS developed a toolkit for clinical providers and consumers giving guidance on how PrEP can be combined with comprehensive, sustained medical care and behavioral interventions to ensure adherence, minimize risk and monitor side effects. The toolkit includes a

description of PrEP, principles for prescribing PrEP and frequently asked questions about its use. The toolkit is designed to educate and improve patient – provider communications when discussing preventative options in clinical settings. Additional efforts to increase awareness involve use of the CAPUS Resource Hub – Resource Directory which identifies locations throughout Georgia where PrEP is offered. This also serves to identify areas where PrEP resources are limited and efforts are needed for additional training among local clinic sites.

Prevention funding also supports the G-PACC, a community group representative of stakeholders invested in HIV care and prevention throughout Georgia. This group became integrated in January 2015 and serves as the model example of integrated prevention, care and treatment services. Members of the integrated group provide recommendations to the Georgia DPH in its efforts to prevent and treat HIV/AIDS.

In 2012 CDC HIV prevention funding was directly awarded to the Fulton County Department of Health and Wellness (FCDHW) to implement the High Impact Prevention Program (HIPP) for Fulton and DeKalb Counties. the FCDHW subcontracted with the DeKalb County Board of Health to perform HIV prevention activities to reduce the number of new HIV infections in DeKalb County. FCDHW and DeKalb receive Part A funding for the provision of care and treatment services.

Prevention activities within the EMA, and the state as a whole, facilitate identifying individuals unaware of their status and promote linkage to primary care. Due to the availability of HIV testing through the CDC HIV Prevention funding and other funding sources, Part A funds are not allocated to this purpose. Nonetheless, Part A staff work closely with prevention testing resources, including working with disease investigators responsible for partner notification to assist them in contacting individuals who have not received their confirmatory HIV results. In addition, for 16 years Part A has supported the AAOI which has focused on educating persons living with HIV on the need to access care, remain in care, and become virally suppressed. In 2014, the CDC-funded HIPP co-sponsored the AAOI and incorporated HIV and STD testing, linkage to care, and education on treatment as prevention. The AAOI is a day-long session focusing on persons who are living with HIV, are aware of their status, but are not in care or have been lost to care. This initiative seeks to facilitate access to care, and also serves as a mechanism for evaluating barriers which have kept these individuals from care. AAOI expanded its focus to include consumer education on insurance eligibility and enrollment in 2014.

Similar to the expansion of opt-out testing throughout the state, Fulton County has established opt-out HIV testing in the emergency room of the largest public hospital in the EMA. Under both processes, persons testing HIV positive are connected with linkage coordinators who assist in accessing care in Ryan White and non-Ryan White funded facilities.

Patient Navigators assist clients with linkage to care and work closely with HIV testing teams to help connect newly diagnosed individuals to care. The EMA funds Patient Navigators at seven sites to facilitate seamless engagement into Outpatient Ambulatory

Health Services through collaboration with linkage coordinators and case managers. Patient Navigators also work with Linkage to Care Coordinators funded by CDC, Part B, and private entities such as The Merck Foundation.

There are well established relationships among the Part A, Part B, Part C, and Part D Ryan White programs in the EMA as well as in Georgia along with other programs that provide prevention and care services for individuals living with HIV/AIDS. 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. Atlanta Ryan White Part A (the only Part A program in Georgia) funds the majority of services in the 20-county EMA, with Parts B, C, and D contributing a small percent.

Part A primary care sites are co-located with counseling and testing sites to promote seamless access to care. In an effort to facilitate access to and retention in care by People of Color, all Minority AIDS Initiative (MAI) funds are allocated to the Primary Care service category.

Newly infected individuals, and those who may have been infected for a longer period but have only recently been tested, are supported in accessing care by linkage coordinators, case managers, intake staff, patient navigators, and peer counselors. Available support services, such as medical transportation, childcare, psychosocial support, and translation services reduce barriers to care and promote retention in care. Patient navigators are co-located at 7 primary care sites with linkage coordinators and medical case managers ensuring enrollment and retention in care.

Due to the large demand for primary care in the EMA, primary care services are provided utilizing a triage model of service delivery. Asymptomatic patients with CD4 $\geq$ 200 are treated in the HIV/STD programs of local health departments or community health clinics. Once a patient's CD4 measures < 200 and/or the patient is symptomatic, he or she is typically referred to Grady's Infectious Disease Program (IDP) for treatment of the advanced symptoms of HIV disease. Patients with active TB are triaged to local health departments for treatment of HIV/TB to help reduce the rate of TB transmission. Upon completion of therapy, and upon proof that active TB has cleared, patients are triaged back to the original primary care site.

The EMA currently operates a centralized client-centered case management system. The centralized system ensures accountability for service delivery, parity regardless of point of entry, and improves the quality of service delivery. The Part A-funded agency outstations medical case managers at: Counseling and Testing facilities; primary care clinics including the VA; AIDS Service Organizations (ASOs); community-based organizations (including minority Community Based Organizations (CBOs); local jail pre-release programs; and HIV/AIDS housing facilities.

Case manager aides assist eligible clients with enrolling in the Health Insurance Market, State ADAP, HICP, and the Patient Assistance Programs of pharmaceutical companies (PAP). On-call case managers are available after normal business hours, at the funded

case management agency to assist clients in identifying or locating care and treatment resources, including assistance with bilingual and sign language needs. These include persons who have relocated to the EMA or individuals referred by the statewide AIDS Information Line.

The Part A-funded Health Insurance Program supports medication co-insurance for those unable to pay to ensure access to vital medications. Additional funding is provided to the State of Georgia to pay health insurance premiums for eligible clients. Part A funds support "stop gap" medications which provides clients an avenue to access ADAP formulary medications while waiting for final ADAP approval, and covers those clients who are not taking antiretroviral medications and are, therefore, ineligible for ADAP.

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 PLWH in substance abuse treatment funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for HIV/AIDS services through BHDD. The required 5% set-aside for HIV is $2,517,908.

HIV/STD Programs are co-located in health departments in the EMA. Persons who test positive in the STD clinics are counseled and escorted to the Ryan White clinic so that they are not lost in the system. Part A and D providers use health department disease investigators for partner notification and assistance in directing clients to primary care sites.

Georgia Division of Family and Children Services (DFCS) programs, including foster care, may be accessed on-site at the Grady IDP and three other Part A primary care sites, for enrollment in general assistance and food stamp programs. DFCS programs throughout Georgia are often co-located with public health clinics.

Grady IDP receives Part B funding to provide care for infants and children living outside the 20-county EMA. All primary care clients within the EMA are screened for ADAP eligibility. If eligible, applications are submitted to DPH to complete the enrollment process. 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 IDP (Part D grantee as well as one of the Part A funded primary care providers). IDP clients within the Atlanta EMA can pick up their ADAP medications.

Coordination of services is also facilitated by participation of Part B and Part D representatives on the Part A Quality Management Committee and Part A and Part D representatives on the Part B Statewide Quality Management Committee. This has facilitated sharing of information on quality management measures used by each program as well as Plan, Do, Study, Act (PDSA) and also quality management initiatives undertaken by Ryan White Programs.

The Fulton/DeKalb HIPP is 100% federally funded and provides coordinated prevention and testing activities for the jurisdiction as described below.

Testing: To ensure a strategic and coordinated approach to routine and targeted testing throughout Fulton and DeKalb Counties, the HIPP launched its *Test Atlanta* initiative. Test Atlanta is a jurisdiction-wide community-government partnership designed to increase efficiency and effectiveness of HIV testing in metro Atlanta. Test Atlanta is a mobilization initiative coordinated by FCDHW with the goal of increasing the proportion of Fulton and DeKalb County residents who know their HIV status and are connected to care, if needed. Test Atlanta is comprised of seven strategic focus areas: Business, Community, Education, Entertainment, Faith, Government and Healthcare. The three overarching objectives are:

- to make HIV screening a routine part of all medical care in Atlanta;
- to increase the coordination and coverage of HIV testing efforts within Atlanta; and,
- to raise awareness and inform the public about HIV testing and HIV care.

HIV Testing - Aggregate - Healthcare Setting: In 2015, all clinical aggregate testing was accomplished by former FOCUS (Frontlines of Communities in the United States) Projects. The primary objective of Gilead's HIV FOCUS Program was to make HIV Testing a routine part of medical care. The development of collaborative partnerships to extend or expand FOCUS projects at Grady, Emory and Mercy Care, where Gilead funding had been discontinued or reduced in 2015, was responsible for nearly one-third of the Category A tests performed. Each of these agencies operates high volume clinics and each serves a large proportion of the jurisdiction's most vulnerable populations who are at high risk for HIV infection. In August 2015, Grady Healthcare and Mercy Care each received funding from carryover to continue clinical testing. Emory received funding to do the same in October 2015. Altogether, these agencies were contracted by HIPP to conduct over 10,000 tests in total. By the end of 2015, these agencies reported testing double this amount.

Grady conducted HIV testing in its Emergency Department and primary care centers and had a target of 5,000 tests in 2015. As reflected in Table 2 above, the hospital far exceeded its target; reporting over 13,000 tests, 260% of its testing goal. Mercy Care conducted testing in its health clinics and had a testing target of 2,500; of which, close to 1,400 tests (55%) were conducted. Emory was funded to test in Fulton and DeKalb County jails with a target of 3,000 tests. Emory tested about twice that amount, 5,671 tests or 189%. Collectively, HIPP's support of FOCUS Projects in 2015 garnered over an additional 20,000 HIV tests. This coupled with the increased testing of the CBO's helped to make testing a huge success in 2015.

Test Atlanta: The Test Atlanta 2015 HIV Testing Week Kick-off included, in partnership with the Kaiser Family Foundation and Walgreens, free rapid HIV testing June 25-27th at seven area Walgreens. In addition, the program provided testing and promotional support for the National Baptist Congress at the Atlanta Marriott Marquis Hotel from June 21-26th.

The program held its first annual **Test Atlanta** *"Testers Brunch"* on June 26, 2015. The theme of the brunch, *"Until Everybody Knows"*, was a celebration of the jurisdiction's successful HIV testers, partnerships and collaborations. The event was attended by more than 150 guests, with representatives from Fulton and DeKalb Counties, Georgia DPH Health, OraSure Technologies, WellCare and various HIV/AIDS community based organizations. It is part of FCDHW's strategy to improve community engagement, strengthen collaborations, and foster increased partnership development.

DeKalb County Board of Health (DCBOH): DeKalb County Board of Health (DCBOH) achieved testing events beyond the 2015 target of 1,000 routine tests in non-healthcare settings. DCBOH reached 1,193; 119% of its goal. DCBOH made significant impact among Hispanic/Latino clients residing in North DeKalb. This has been evident as Consultorio Medico Hispano (CMH), a trusted Hispanic/Latino partner, has been diligent in providing rapid health assessments to bolster HIV testing among Hispanic/Latino clients. CMH along with Consulate General of Mexico in Atlanta, courtesy of Emory's Rollins School of Public Health Ventanilla de Salud (Window to Health) program and Buford Highway Hispanic/Latino population-based participants promoted more integrated service. The integrated service has been held at Plaza Fiesta on Buford Highway as a routine HIV test event.

HIPP supports several non-funded Community-Based and AIDS Services Organizations, however, the corresponding testing data was not being reported under PS12-1201. Therefore, the program had not received credit for a significant number of tests. On June 2, 2015, the management team met with the CDC Project Officer to clarify how to capture data for supported-only agencies. For HIV tests conducted beginning January 2015, data is now being captured for any non-funded agency that receives support-only from FCDHW to implement, scale up or sustain HIV testing, including test kits and technical assistance. Clarifying the capture of these tests has helped the program better its reporting of tests that have been conducted within the jurisdiction with support from HIPP. This change aids the program in reflecting HIV testing beyond directly funded CBO's; to illustrate testing more broadly in the jurisdiction.

Testing for acute HIV infection in persons from areas of high HIV prevalence who seek STI services will be performed because it has been shown that concurrent STI increases the susceptibility and transmissibility of HIV. FCDHW seeks to augment the existing HIV screening algorithm with enhanced testing to identify and treat highly-infective persons with acute HIV who would otherwise not be detected due to the "window period" of standard HIV testing, followed by partner notification and directed community outreach to prevent other new infections in high prevalence areas. FCDHW will implement new specimen pooling strategies to reduce the cost of NAAT without compromising capacity to detect acute HIV infection.

Condom Distribution: Total number of condoms distributed overall (to HIV-positive individuals and high-risk HIV-negative individuals) during 2015: 2,327,774. HIPP exceeded the 2015 condom distribution goal of 2,170,068. Approximately 549,000 (24%)

of all condoms distributed went to individuals and to organizations that serve HIV Positive clients only.

As a part of program collaboration and service integration within FCDHW, a public health educator attends every Ryan White new client orientation and provides condom education and demonstrations to each new client. The public health educator also discusses other risk reduction materials such as dental dams, proper lubrication, and STI prevention methods. In addition to the Ryan White new client orientation, the public health educators also provide risk reduction materials and condom demonstrations in the Tuberculosis clinic at the Aldredge location. Also, a public health educator conducts a condom program overview and demonstration as a part of new employee orientation. The condom overview for new employee orientation is to ensure all staff in the health department are aware of the types and brands of condoms offered and where the staff person can retrieve the condoms if a client asks for a specific type or brand of condom in a clinical setting.

Evidence-Based Interventions (EBIs) for High-Risk HIV Negative Individuals: A rotating schedule for Public Health Educators (PHEs) has been implemented. Staff rotate responsibilities for conducting educational sessions in conjunction with the EBI entitled Safe in the City (SITC) within the large clinic waiting area, TB waiting area, and the small waiting room of the Aldredge Clinic; taking advantage of the captive audience within these waiting areas as they wait to be seen by a Disease Investigator Specialist or clinician. The PHEs conduct individual level interventions (ILI) with one-on-one conversations with clients on condom distribution and HIV prevention services.

Social Marketing, Media and Mobilization: Since 2014, the Fulton County Department of Health and Wellness has worked with the Kaiser Family Foundation to expand public information about HIV/AIDS in Fulton County as well as neighboring counties that encompass the Atlanta metro area with Greater Than AIDS messaging. The partnership localized and placed "We Are Family" media assets for television, radio, billboards, transit, digital and community promotions, including outreach materials and events. Ads began running in November 2015 and pre-paid placements extended through March 31, 2016.

Pre-Exposure Prophylaxis (PrEP): FCDHW officially launched a PrEP clinic the first quarter of 2016. The PrEP clinic is operated out of the STD clinic and offers appointments throughout the week. Clients are able to have labs drawn, be examined/receive a prescription from a clinician, and apply for assistance with the cost of the medication, if needed. The *PrEP Clinic Eligibility Questionnaire* is evaluated for each client that arrives at the clinic, and if a client is found eligible for PrEP, then an appointment is made to speak with the PrEP Clinic Coordinator, and subsequently the PrEP clinician.

Epidemiologic and Surveillance Data: Enhanced HIV/AIDS Reporting System (eHARS): HIPP has begun using surveillance data to generate choropleth maps of high morbidity zip codes and testing "hot spots" within the jurisdiction. These maps are being

discussed periodically in management and JPPG/CBO meetings in order to improve program planning and targeted testing efforts. The Community Epidemiologist has also developed several reports and PowerPoint presentations for community stakeholders that compare PS12-1201 testing numbers and positivity rates against those areas in the jurisdiction with high morbidity (as based on surveillance data). In Q2 2015, the department also began determining the accuracy of clients' self-reported HIV status on the Part One forms compared to eHARS lab data.

This information is being used to update the surveillance question on the Part Two forms and will also be utilized to assess the FCDHW Care Continuum for both previously positive and newly positive clients. The action item moving forward into Year 5 is the formulation of a re-engagement plan for those who are identified as out-of-care using the eHARS data and to develop an internal database to track all positive clients identified through HIPP and verified through eHARS, as well as the various surveillance databases listed below. Fulton and DeKalb County staff will be granted full access to the database. Access to eHARS will allow the health departments to more accurately determine a client's HIV history in real-time and also provide the DPH surveillance team with more up-to-date residence and risk data.

EvaluationWeb: HIV counseling, testing, and referral surveillance data being captured by EvaluationWeb is routinely reported to FCDHW management staff based on the targets and measures outlined in the Comprehensive Program Plan. This allows for management staff responsible for overseeing PS12-1201 funded sites to collaboratively develop action plans to address gaps and barriers with program implementation. Those reports, along with joint analyses of EvaluationWeb and eHARS data, are then disseminated to the external agencies in order to improve service provision within the community.

Perinatal HIV Transmission Prevention: FCDHW has updated the service delivery plan for pregnant moms and babies. Along with this update comes a proposed name change "Perinatal Response Team". This name change reflects a new model serving to transpose barriers to care into collaborative efforts with social service partners at the onset of client care. The assessment of care is an overall evaluation to determine client needs and to channel all social services needs to case management services so that connections are maintained throughout the continuum of care from when the mother links to primary care during and after the birth of the baby and also until the baby has been tested within the first 14 to 21 days of life, at age 1 to 2 months and age 4 to 6 months. The core components of the new model are to:

- create infrastructures supportive of internal and external information exchange
- renew networks that are supportive of social services to address barriers to care
- expand provider reporting and expanded services collaborations

Integration of Prevention and Care and Treatment Planning at the Part A Level: A number of activities have been implemented by the Atlanta EMA to integrate prevention and care planning.
Some specific activities include:

- Participation of Part A recipient and Planning Council member on the DPH G-PACC and Fulton County prevention program's JPPG.
- Part A Planning Council Members and the Director of the Ryan White Program serve on the "Fulton County HIV Task Force" which is developing a roadmap for the elimination of new cases of HIV in Fulton County.
- Cross-pollination between the Part A Planning Council and the Fulton/DeKalb JPPG. Six of the eight committees of the Planning Council have members who also serve on the JPPG; and four of five committees of the Prevention planning body have members who also serve on the Planning Council.
- The Department of Public Health and Fulton County Department of Health and Wellness presented information to members of the Quality Management Committee and shared information and identified opportunities to coordinate services to avoid duplication.
- The Part A Planning Council Project Officer and Planning Council members participate on the HIPP and DPH Community Planning Committee in order to keep the Planning Council apprised of activities so that initiatives can be combined, i.e., counseling, testing, and linkage activities at AAOI.
- The EMA shares epidemiological data with prevention funders to assist with targeting of counseling and testing in high-risk populations and geographical locations.
- The EMA's annual AAOI has fully integrated a prevention component in both the planning and delivery of educational sessions.
- During FY15 the Housing Committee of the Planning Council worked with the JPPG to develop a series of two Housing Forums designed to meet the goal of the National HIV AIDS Strategy by increasing the number of Ryan White clients with permanent housing from 82% to 86%.

Regular meetings with DPH and Part B leadership to monitor client enrollment into the Health Insurance Marketplace and its impact on current system of care within the EMA including ADAP and HICP, and the Health Insurance Program (HIP).

d. Resources and/or services needed which are not being provided and steps taken to secure them:

The top needed resources identified in the Part B Program include increased access to housing and transportation services, the need for culturally sensitive health care providers, and additional health care professionals located in primarily African-American communities.

In order to address the needed support services, the Part B program will explore the option of establishing a statewide transportation contract to serve Ryan White Part B clients in areas where there are limited transportation options. The program will strengthen relationships with HOPWA through the Georgia Prevention and Care Council (G-PACC) in order to identify ways to collaborate to increase housing options for clients. At the local level, funded agencies will be provided technical assistance on how to

engage and build relationships with community partners that may be providing housing services through other funding streams.

In order to address provider needs, the Part B program will allocate additional funds to Part B clinics that have identified a need for additional providers. The program will continue collaborations with the Georgia AIDS Education and Training Center (GA AETC) and work to provide cultural competency trainings to educate providers on how to best serve clients who may have different needs based on race/ethnicity, gender identity, sexual orientation or socioeconomic backgrounds.

The Georgia Prevention Program recognizes the need for resources to support the delivery and expansion of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) among persons at increased risk for HIV infection. Current CDC guidelines restrict the use of prevention funds for medication, including PrEP. PrEP and PEP are widely promoted public health and National HIV/AIDS strategies that can nearly eliminate risk of infection. The availability of such resources would have a significant impact on HIV incidence in Georgia.

Currently the Fulton County Department of Health and Wellness is operating a PrEP clinic with existing resources augmented with volunteer clinician time. The Prevention program provides staff support and HIV testing; STD offers screening and labs; the state has supported the clinic with a nurse. Currently accepted clients to the program must be insured, have ability for self-pay, or qualify for the patient assistance program with Gilead. This model is not sustainable without additional resources to support the infrastructure and client assistance for medication.

HRSA Ryan White funds may not be used for the purchase of PrEP medications either. Local providers have worked with insurance companies, when available, and patient assistance programs of pharmaceutical companies to obtain the medications. Ryan White Programs are reviewing HRSA's policy to determine feasibility of leveraging funds to support PrEP education.

Additional resources are needed to address stigma. Part A agencies are working with the Georgia DPH to coordinate with their statewide anti-stigma campaign.

Efforts are being undertaken to rapidly link newly diagnosed individuals to care. The plan is for individuals to meet with a clinician within 72 hours. Some of the clients have not completed all of the paperwork necessary to become a Ryan White client and are being seen based upon presumptive eligibility. These individuals are not yet eligible for ADAP for ART, nor are they eligible for stop-gap medications provided by Part A until a client is picked-up by ADAP. These individuals will be connected to HarborPath -- the purpose of the nonprofit is to rapidly put free ART (within 24-48 hours) in the hands of either a newly diagnosed or re-engaged chronically infected uninsured HIV+ patient by streamlining multiple pharma companies drug assistance programs into one simple form, with support staff off-site.

Sub-recipients are expected to vigorously pursue third party payer sources including ACA. In an effort to increase the skills of enrollment staff and case managers, the Part A Program Office worked with Affordable Care Enrollment (ACE) TA Center and John Snow, Inc. (JSI) for a series of trainings including *Talking with RWHAP Clients About Health Insurance: Helping them Enroll, Use, and Maintain Coverage, Strategies to Help People Living with HIV Enroll in Health Insurance, Understanding and Making the Most of Health Insurance: Workshop for Peer Leaders.*

D. Assessing Needs, Gaps, and Barriers

a. Process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed):

The Part A Planning Council provided input on the needs of people at higher risk for HIV and PLWH. The Planning Council has 55 Voting Members of which 51% are consumers (40% non-aligned consumers (n=22); 71% of all members are African American and 82% of all non-aligned consumers are African American; 55% of all members are male as are 69% of non-aligned consumers; Females represent 42% of the Council and 23% of non-aligned consumers; and, 4% of the Planning Council is comprised of Transgender individuals with 9% of non-aligned consumers being Transgender. In addition, comments were solicited from the Consumer Caucus which is made up of consumers of Ryan White services as well as persons living with HIV who are not consumers of Ryan White services. The Atlanta EMA collected data on service needs, gaps and barriers to care through a consumer survey (including focus groups) that was conducted in 2011 and augmented by data from a partial assessment in 2014. A total of 715 PLWH in the EMA completed the 2011 survey and 329 completed the 2014 survey. The surveys are diverse in terms of race, ethnicity, gender identity, sexual orientation, age, mode of transmission, housing status and county of residence. *The Consumer Survey*, a component of the EMA needs assessment, includes questions to collect information about types of services identified as needed but not necessarily received among individuals eligible for Ryan White services. Needs assessment data help increase understanding of issues experienced among HIV-positive persons at various stages of the HIV Care Continuum. Needs assessment data are directly related to HIV Care Continuum stages II. Linked to Care, III. Retained in Care, IV. Prescribed Antiretrovirals, and V. Viral Suppression. Data from a Statewide Client Satisfaction Survey conducted in 2013 relate to the Retained in Care stage of the HIV Care Continuum. Satisfaction of services was 94% or higher among survey respondents.

Clients who express high levels of satisfaction with their services may be more likely to be compliant with medication regimens and achieve positive health outcomes (stages IV and V). The EMA will continue to monitor the potential correlation between satisfaction and positive health outcomes.

Anecdotal information is obtained by members who work in local health departments and emergency rooms as well as Substance Abuse providers all of whom speak to the needs of persons who may be living with HIV, but whom are undiagnosed.

In addition to the entire Planning Council including chairs of all other Part A Committees (e.g., Assessment, Quality Management, Housing, Public Policy committees), consumers, and at least 25 other entities were invited to participate in a day long Stakeholder's meeting, held January 29, 2016 to, among other purposes, solicit input on the goals, objectives and activities to include in the Integrated Plan. Approximately 80 people participated in the one-day session.

The primary method of determining needs, unmet needs, and barriers to care for Part B has been through collaborative relationships with other entities, including the HIV/AIDS Epidemiology Surveillance Section, the GA AETC, district-level Part B Consortia, other Ryan White programs such as the Atlanta EMA Part A Program, and the Prevention Programs at the state and jurisdictional levels.

The Part B program utilizes funded agency data to update statewide activities and prioritize the key areas of focus for the funding year. In addition to working with each funded agency and consortium to develop a needs assessment, the state also collaborates with other Ryan White Program recipients and providers to ensure that identified disparities in health care infrastructure are addressed.

Specific to the development and implementation of the Integrated HIV Prevention and Care Plan, the program reached out to each of the 16 Consortia for feedback for the integrated plan. They were asked to provide insight as to the advantages of plan integration, areas of interest, types of guidance/tools that would be helpful, characteristics of the communities, and goals/objectives they would like to see included in the plan. District prevention programs were given an opportunity to contribute to the goals of the comprehensive plan during a statewide meeting in January 2016. State staff provided an overview of the planning process and facilitated an exercise to gain input and ideas.

The Fulton County Department of Health and Wellness (FCDHW) is committed to developing HIP programming that is tailored to the needs of the entire Fulton County community. In this effort, FCDHW partnered with the Black AIDS Institute (BAI) and Greater Than AIDS to host a series of community engagement sessions. The sessions were designed to 1) offer technical assistance through community engagement, 2) discern gaps in service, 3) assess community knowledge, beliefs, and attitudes around HIV prevention and care, and 4) provide community insight as a framework for developing strategies to reach specific, targeted communities. The engagement sessions focused on four Key Populations: HIV providers, Black faith leaders, Black women, and Black transgender women. Participants were selected to include members and leaders of the targeted community. During the sessions, individuals shared what they felt should be done to improve HIV/AIDS treatment, adherence, and prevention efforts. A report was completed and documents the findings, conclusions, and recommendations of those engagement sessions.

In addition, the HIPP engaged Community Advisory Groups (CAGs) to provide a forum to ensure key stakeholder involvement in the jurisdiction's ongoing prevention planning

to reduce HIV disease in Fulton and DeKalb Counties and that priority populations, including persons who represent these populations, are actively engaged in the process.

Membership includes community members living with HIV/AIDS and other consumers, healthcare providers, health educators, youth, representatives from diverse racial and ethnic communities, advocacy groups, faith- and community-based organization representatives, and other people affected.

Based on JPPG recommendations, the following populations will have a CAG to represent them:

- African American
- Men who have sex with Men (MSM)
- Transgender
- Young Adults (17-25)

b. HIV prevention and care service needs of persons at risk for HIV and PLWH:

HIV Prevention and Care Service Needs of Persons at Risk for HIV: Persons at risk for HIV are in need of HIV prevention education and the availability of resources to support the establishment of PrEP clinics and the provision of PrEP services (medication and clinical follow-up). Georgia Part B Consortia reported service needs related to prevention education, testing, and promotion in the form of advertisements (media, billboards, etc.) outside of the EMA area, with a specific focus on Black/African American, MSM and Transgender populations. The need for improved collaborations between the Ryan White and HIV Prevention programs at the local level, streamlined education, and referrals were also identified.

Knowledge of HIV status is the first step toward empowerment over HIV. Individuals who know they have HIV can take control of their health by getting HIV care, including ART. Undiagnosed persons forego the benefits of ART and often present to care with advanced disease, including opportunistic diseases indicative of AIDS. Data show that persons who learn that they have HIV are more likely to change their behavior so that they are less likely to spread HIV to others [Marks, 2005]. In addition, suppressing HIV through the use of ART greatly decreases HIV transmission [Cohen, 2011].

Decreasing the number of persons who have HIV but are unaware of their status will require expansion of routine opt-out testing in healthcare settings, coordinated and strategic use of non-healthcare setting testing targeted toward disproportionately affected populations, as well as expansion of partner services to provide testing and education to partners and sexual networks of persons with HIV. Increased identification of acute HIV infection will require widespread use of new “4th generation” HIV tests that are able to detect HIV infection earlier than older tests, including during the acute phase. Point-of-care rapid 4th generation tests are available but are not widely used in Fulton County. State and County data systems must be modified to classify correctly persons identified with acute infection, and to use these data in a timely manner for maximal impact on prevention and care. While these systems are being developed, both providers and public

health staff need education on the proper management of persons with acute infection, and the need to rapidly link them to medical care and other services to support retention in care.

People who are newly diagnosed with HIV are likely to have had sexual or needle-sharing contact with one or more partners while being unaware of their status, thus putting others at risk for HIV transmission. Simply notifying partners, in a safe and confidential manner, without releasing information about the newly diagnosed person, can have an important impact on serostatus awareness. Partner services can enhance their prevention education, access to social and medical services, and linkage to HIV care if needed. Partner services are often thought of as "partner notification" only. Partner services for newly diagnosed persons with HIV are tracked by FCDHW. Outcomes of linkage and retention services, especially for individuals out of care, are not easily accessed. To optimize the benefit of partner services, it is essential to broaden current definitions and job descriptions to include intensive rapid linkage services for persons who are newly diagnosed, as well as rapid reengagement services for those who are out of care. At the same time, FCDHW partner services personnel should play an important role in assessing other needed services and providing true linkage, not just referrals, to critical services such as housing, transportation, and substance use and mental health treatment. Access is also needed for HIV seronegative individuals to biomedical prevention services such as PrEP when indicated. Education, training, and customer satisfaction feedback are necessary to ensure that partner services staff is perceived to be culturally competent by the individuals they serve. In addition to expanded provision of partner services, outcomes should be monitored and evaluated to ensure that these services enhance progress through the HIV Care Continuum.

In the era of Treatment as Prevention (TasP) and PrEP, condoms are still an important tool for the prevention of HIV and STIs, and that condom education and availability must be not only sustained but also enhanced as part of combination prevention. It will be important to develop the necessary partnerships with clinics that see PLWH and CBOs that serve at risk populations, to ensure that they have condoms available for distribution, and to ensure that coordination among them occurs so that there is synergy rather than duplication of effort.

Fulton's JPPG has four CAGs: African American, MSM, Transgender, and Young Adults (17-25). Each CAG is used to discuss pertinent topics, concerns, and trends within their respective communities, events and gatherings, and brainstorm prevention ideas, and each CAG is responsible for at least one HIV/AIDS prevention event/program per year. Recommendations from each of the CAGs are provided below.

- The African American CAG's recommendations included collaborations and partnerships with faith-based organizations, recruitment from a more non-traditional, diverse age group, and an event that required a collaboration and involvement of all CAG groups. The year event will be a Flash Mob HIV awareness Experience that will occur in local malls. A flash mob is a large public gathering at which people perform an unusual or seemingly random act and then

disperse, typically organized by means of social media channels. During the Flash Mob HIV awareness experience, participants will be wearing T-shirts displaying HIV prevention messages.

- The MSM CAG's recommendations consisted of forming a subcommittee for event planning, participating in Black Pride and Atlanta Pride activities annually, and supporting the Undetectables Conference by forming abstract and community award nomination committees. Additionally, the MSM CAG had a special listening session with the Fulton County HIV Task Force, which was also part of the PBS News Hour show "Why the South is the Epicenter of the AIDS Crisis in America" which aired on July 12, 2016. The MSM CAG has three events planned for the year. During Black Pride, the "PrEP for Pride" event will be organized, which is an educational social geared towards African American MSM that focuses on HIV prevention, community support, and providing information on PrEP. During Atlanta Pride, the CAG will participate in the parade on a float and pass out condoms and HIV prevention educational material. The third event, "Take Back the Night", is a call to higher awareness of homelessness in the Lesbian, Gay, Bisexual, Transgender (LGBT) community. It will be a coordinated approach, inclusive of other cities, during the week of Gay Men's Health Day. The purpose is to coordinate media in addition to other cities across the south where homelessness in LGBT communities is high.

- The Transgender CAG's recommendations are comprised of changing the composition of the CAG by reaching out to other groups in the Atlanta Area that serve the transgender community, creating more incentives CAG participants, and being more inclusive to the overall transgender community, and changing the meeting location in order to be more convenient to public transportation. The annual project for the Transgender CAG is establishing a Trans Health Wellness Center that not just focuses on HIV, but the overall health care of the Transgender community.

- The Young Adult CAG's recommendations included changing the time of the meeting that is more convenient to college students, providing outreach at large campus events, and provide HIV testing in dormitories. The year event will be a Young Adult HIV Prevention & Sexual Health Conference: "Be the Change" for the purpose of increasing the knowledge and skills among young adults in order to promote healthy behavior. The Young Adult CAG also disseminated a survey to obtain information on sexual behaviors, attitudes and beliefs about sex and sexual health pertaining to young adults and desired Young Adult CAG future activities and topics.

HIV Prevention and Care Service Needs of PLWH: Early initiation of ART and retention in HIV care are central to achieving viral load suppression and reducing mortality and progression to AIDS [Mugavero, 2012; Mugavero, 2009]. Linkage to care is the first step in this process. Nationally and locally, there are large disparities in linkage to care by race, gender, age, and transmission risk. Understanding the

relationship between local geographic factors and initial linkage to care for PLWH and identifying solutions is critical for planning public health interventions. All laboratories are required to report positive HIV screening tests, CD4 cell counts, and HIV viral load assays to the Georgia DPH HIV epidemiology unit. DPH is working closely with hospitals and commercial laboratories to improve the timeliness and completeness of reporting. Linkage to care estimates are based upon this surveillance data set. A person is defined as "linked to HIV care" if they have received a CD4 or viral load within 90 days. This definition is based on the assumption that if a person has had a CD4 cell count or viral load, the patient is in a setting and/or in contact with a provider familiar with HIV and with the expertise to provide ART. RWHAP-funded providers point out, however, that getting a single laboratory test does not mean that patients have actually received medical visits. Patients entering RWHAP-funded clinics may have labs drawn on the day they are enrolled, but may not see a healthcare provider until weeks later, or may not return to care at all after the initial enrollment visit.

Increasing the proportion of people living with HIV who achieve and maintain viral suppression will require improved linkage to care, retention in care, early prescribing of ART, and medication adherence. Providing ART as quickly as possible, and ensuring continuous drug supply, will require substantial improvement to current processes that sometimes delay access to initial ART by weeks or months. The final step to achieve viral suppression requires HIV positive persons to take their ART daily, without interruption. In order to achieve this, strategies to minimize barriers to medication adherence must be developed.

Having excellent therapies for HIV is meaningless without adequate healthcare systems to deliver them. Decreased numbers of HIV-trained care providers threatens to undermine HIV care programs and add additional barriers to fulfilling care obligations for the increasing numbers of persons living with HIV. Unfortunately, even when funding is available, clinics report difficulties in finding physicians, nurses, including advanced practice nurses, and physician assistants. Difficulty in hiring staff results in fewer patient care slots, and lower clinic and private practice capacities. Public clinic sites often cannot match salaries that can be earned in the private sector. Physician training in HIV is often suboptimal, and many infectious disease (ID) programs are unable to fill their programs. Morehouse School of Medicine, Georgia's AIDS Education and Training Center has agreed to provide training of additional providers to address training needs.

Needs assessments conducted by the 16 funded Ryan White agencies show that, in order of importance, the six most needed services for PLWH are: Primary Care, ADAP, Medical Case Management, Oral Health, Non-Medical Case Management, and Medical Transportation Services. These six 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 PLWH reside. Rural populations identified transportation and housing as higher ranked needs while suburban and urban regions ranked mental health and emergency financial assistance as greater needs.

Core medical and support services needs of PLWH identified by the EMA during its priority setting process were based on consumer needs assessments, surveillance data, and input from care providers and are included below:

- Outpatient Ambulatory Health Services
- Oral Health Services
- Medical Nutrition Therapy
- Medical Case Management
- Mental Health Services
- Substance Abuse Services
- Health Insurance Premium Assistance
- Case Management Non-Medical
- Food Bank/Home-Delivered Meals
- Psychosocial Support
- Medical Transportation
- Legal Services
- Linguistics Services
- Child Care Services

c. Service gaps identified by and for persons at higher risk for HIV and PLWH:

Gaps in HIV prevention services were based on community engagement sessions. Some of the strategies and recommendations are as follows:

- Identifying point of entry sites to develop a network of service providers offering HIV testing
- Strategic social media messaging for HIV prevention services
- Peer navigators to link HIV infected clients to care services
- Routine HIV testing offered across populations and locations
- On-site confirmatory HIV testing
- Multi-lingual service option
- Culturally competent providers and service delivery for all clients
- Routine HIV testing in healthcare settings
- Additional time allotted with physicians during appointments
- Integrated community education about value of testing for HIV and other STIs
- Health literacy of client
- Client adherence to HIV treatment
- Lack of services for transgender population
- Medicaid restrictions, other treatment funding challenges
- Lack of patient navigators to guide clients through healthcare system
- At-risk individuals require more tailored prevention education
- Lack of comprehensive sexual health education
- Lack of access and availability of health care
- Knowledge of healthcare providers regarding HIV/AIDS and HIV/AIDS treatment

The gaps identified by PLWH in the 16 funded Georgia Health Districts included housing and transportation services. Housing options and shelters are usually scarce throughout the state posing difficulties for agencies to place clients who need housing or shelter as a basic necessity before they are able to fully engage in care. PLWH in rural areas of the state identified several issues with transportation, including lack of public transportation, and higher costs due to traveling for longer distances for their medical appointments.

According to the 2013 Statewide Client Satisfaction Survey, additional service gaps included cultural competency training for staff, as well as the need for additional providers. Clients expressed that clinic staff should be trained to improve communication challenges which were perceived as barriers to care. It was expressed that having additional providers would decrease any wait times they may experience when attempting to utilize services provided at the clinics.

Consumer surveys identified the following gaps in services for PLWH in the Atlanta EMA:

- Oral Health Services - In the 2011 Consumer Survey, treatment for dental problems was the #1 service needed among core services but not received with a gap of 28%, followed by emergency dental care ranked #2 with a gap of 25%, followed by preventative dental care ranked at #3 with a gap of at 24%. In the 2014 survey, there was an identified gap of 33% between those needing the service and those receiving the service; a gap of 28% for preventative dental care; and, 31% for non-emergency dental care.
- Medical Nutrition Therapy - Needs Assessment: Ranked #5 in gaps in services with a 14% gap between those reporting a need for the service and those who received the service in the 2011 survey. Ranked #3 among males of all races with a gap of 30% and #1 among Latinos (39%). The gap increased to 26.6% in the 2014 survey and the gap for nutritional supplements was 37.6%).
- Medical Case Management - Needs Assessment: Ranked #9 in gaps in core services with a 7% gap between those reporting a need for the service and those who received the service (2011); the gap increased to 10.7% in the 2014 survey. The 2012-2015 State of Georgia Statewide Comprehensive HIV Services Plan lists Medical Case Management as the 2nd among the five most needed services.
- Mental Health - Needs Assessment: In the 2011 survey, 31% of respondents (n=223) reported having received substance abuse-outpatient services. Of those, 43% reported having multiple services, 35% received group counseling, 12% received 1-on-1 counseling, and 3% received group counseling. Ranked #10 in core services needed but not received with a gap of 7%. The gap increased to 14.8% for individual counseling and 16.7% for group counseling in the 2014 survey.
- Substance Abuse - Needs Assessment: in the 2011 survey, 31% (n=223) reported having received substance abuse services since becoming HIV-positive. Of those, 43% had received multiple services, 35% had received group counseling and 12% had received 1-on-1 counseling. The need for 1-to-1 or group substance abuse counseling ranked as the #10 highest core service needed but not received with a gap of 7%. In the 2014 survey, there was a gap of 15% between those needing individual counseling and those receiving it and a gap of 17% for group counseling.

- Health Insurance Premium Support - Needs Assessment: In the 2011 survey, 51% had some type of health insurance (of those, 60% had Medicaid). The need for pharmaceutical assistance was ranked #6 with a gap of 11%. In the 2014 survey, 54.6% had some type of insurance coverage – 15% had signed-up for insurance via the ACA. 36.7% reported having a need for Premium Assistance (n=117) with 35.9% having that need unmet. When asked of the need for Medication Co-Pay Assistance, 46.4% (n=147) indicated a need with 23.8% indicating the need was not met.
- Case Management Non-Medical - Needs Assessment: In the 2011 Consumer Survey, the need for benefits counseling (a component of case management non-medical) ranked at #6 of gaps in need for support services (15%). In the 2014 survey, 37.4% indicated need for the service with 19% indicating an inability to get the service.
- Food Bank/Home Delivered Meals - Needs Assessment: In the 2011 Consumer Survey, food vouchers was the #1 service needed but not received among support services with a gap of 40%, followed by food pantry ranked #4 with a gap of 19%, followed by home delivered meals at #7 with a gap of at 14%. The gap in need for food vouchers was ranked #1 among males (39%) and females (44%), #1 among African Americans (39%), #2 among Latinos (38%), #1 among Whites (42%), #3 among young MSM (40%), and #1 among persons over 50 years old (34%). The gap in need for food pantry was ranked #2 among transgender (50%).
- Psychosocial Support Services - Needs Assessment: In the 2011 Consumer Survey, the need for patient navigation services (a component of psychosocial support) was the #10 support service needed but not received with a gap of 11%. In the 2014 survey, there was a gap of 29% for peer counseling/support groups and a gap of 28% for patient navigation services.
- Medical Transportation - Needs Assessment: Medical transportation was not identified as one of the top 10 gaps in service for support services in the 2011 survey. In the 2014 survey 28.8% of all respondents identified a need for the service; there was a gap of 32.6% between those identifying a need for the service and those who received the service.
- Legal Assistance Services - Needs Assessment: In the 2011 Consumer Survey, the need for legal assistance services was the #5 support service needed but not received with a gap of 19%. In the 2014 survey, there was a gap of 51%.
- Linguistic Services - Needs Assessment: In the 2011 Consumer Survey, the need for linguistics services did not rank among the top 10 gaps in services. In the 2014 survey, there was a gap of 12%.
- Child Care Services - Needs Assessment: In the 2011 Consumer Survey, the need for child care services did not rank among the top 10 gaps in services. In the 2014 survey, there was a gap of 20%.

d. Barriers to HIV prevention and care services:

Identified barriers to HIV prevention and care services are listed in the table below. In identifying barriers, a wide range of stakeholders were involved. However, in the Atlanta EMA domestic violence and injection drug user communities were invited, but did not

participate in the process and provide input. The EMA will continue to work to engage these entities and individuals.

Table 21: HIV Prevention and Care Services Barriers	
i. Social and structural barriers	Social: • Lack of awareness of risk for general population • Stigma related to behaviors of HIV risk for infection • Socioeconomic conditions • Discrimination • Health disparities including lack of affordable housing • Quality education and job training Structural: • Lack of information and uniformity of HIV service provision • Location of services • Rural locations with limited resources • Lack of community-based resources • Lack of quality, affordable housing • Lack of access to healthy foods • Lack of or limited transportation options • Systems and technologies issues
ii. Federal, state or local legislative/policy barriers	Federal/State: • Changing healthcare coverage landscape • Lack of funding for clean syringe exchange • Funding restrictions related to providing PrEP State: • Lack of Medicaid expansion – even after implementation of the Affordable Care Act, Georgia continues to have high rates of uninsured people due to lack of income and because Georgia has chosen not to expand Medicaid. • HIV criminalization laws • Classification of hypodermic needles as illegal drug paraphernalia • Data sharing Local: • Lack of uniformity in lab reporting,

Table 21: HIV Prevention and Care Services Barriers	
	• Delays in lab reporting impacting monitoring • Difficulties in matching lab report data to a case in eHARS • Abstinence only education in schools • Criminal history preventing access to housing • Limited routine opt-out testing
iii. Health department barriers	• Lack of effective Electronic Medical Records (EMR) systems • Staff shortage for partner services and specialized providers • Lack of specialized providers • Staff retention • Limited local community resources and workforce
iv. Program barriers	• Challenges in examining CAREWARE data specific to each Ryan White funded program from multiply-funded sub-recipients. • Lack of interconnections among the CAREWare systems (Part A and Part B), State Electronic Notifiable Disease Surveillance System (SendSS) and eHARS • Lack of trained HIV-care providers to address expanding caseload • Lack of centrally coordinated plan for geographic or population targeted HIV testing.
v. Service provider barriers	• Lack of resources to build provider capacity to serve more clients • Need for cultural competency training among service providers • Need for HIV education/updates for all providers • Competitive salaries for service provider staff • Lack of specialized providers
vi. Client barriers	• Financial barriers (co-pay and co-insurance assistance) • Health information privacy for adult and youth dependents utilizing private insurance for HIV services • Access to affordable housing and/or emergency/ transitional housing • Untreated mental health and substance abuse issues • Lack of/or inadequate transportation • Access to PrEP • Co-morbidities that add to the complexity of providing HIV care and may impact HIV-related health outcomes

E. Data: Access, Sources, and Systems

a. Main sources of data and data systems used to conduct needs assessment and the development of the HIV Care Continuum:

Primary sources of data and data systems included:

- CAREWare to collect client level data, generate the Ryan White HIV/AIDS Program Services Report (RSR), and prepare Ryan White Unit Cost Analysis.
- Surveillance Laboratory Data Base and eHARS for developing Unmet Need and HIV Care Continuum.
- EvaluationWeb to capture HIV testing data and provide reports on success of testing strategies for target populations.
- Electronic questionnaire to complete the Statewide Client Satisfaction Survey.
- Electronic consumer surveys to produce the needs assessments identifying barriers to and gaps in services.

b. Data policies that facilitated and/or served as barriers to the in developing the needs assessment and the HIV Care Continuum:

Georgia's HIV/AIDS Epidemiology Surveillance Section provides epidemiologic data to facilitate the development of needs assessments and produces the HIV Care Continuum for Part A, Part B, local health districts, and planning bodies.

Since January 1, 2004, Georgia has had a dual reporting system that legally requires HIV/AIDS reporting by both health care providers and laboratories (O.C.G.A. §31-12-2(b)). All health care providers diagnosing and/or providing care to a patient with HIV have the obligation to report the case using the HIV/AIDS Case Report Form. Case report forms are mandated to be completed within seven days of diagnosing a patient with HIV and/or AIDS or within seven days of assuming care of an HIV positive patient who is new to the provider, regardless of whether the patient has previously received care elsewhere. All laboratories certified and licensed by the State of Georgia are required to report laboratory test results indicative of HIV infection, such as positive Western Blot results, all detectable and undetectable viral loads, all CD4 counts, and all viral nucleotide sequence results to the Georgia DPH HIV/AIDS Epidemiology Program.

Recent improvements in the Georgia electronic laboratory reporting (ELR) system have facilitated use of laboratory-based measures for linkage and retention in care. Although other measures such as missed appointments, health care visit consistency, and gaps in care may be assessed at individual health care facilities, it is difficult to accurately gather these measures on a statewide basis in Georgia. For these reasons, Care Continuum measures in this report rely on laboratory data-driven definitions. In addition, multiple measures, such as linked to care within three months of diagnosis, minimally engaged in care (at least one CD4 or viral load in 12 months) as well as the HRSA medical visit performance measure (at least two CD4 or viral load measures at least three months apart within a 12 month period) can be useful to various stakeholders in monitoring impact of effort to improve outreach, testing, and care.

c. Data and/or information the planning groups would like to have used but were unavailable:

The main data sources and data systems that were most appropriate for the development of the Plan were readily available and utilized.

Data that would be beneficial to use in the future in order to continue the development of the HIV Care Continuum and the Integrated Plan include information from FQHCs, Medicaid, Medicare, Veteran's Affairs (VA), the Department of Behavioral Health and Developmental Disabilities, and data from private providers. Data from these sources could help HIV programs achieve a whole view of a given patient.

To construct the most effective Care Continuum possible, it will be necessary to bridge clinical visit information from various clinical providers (not just Ryan White and CAREWare) with Laboratory and Surveillance pictures available through eHARS and SendSS.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The meaningful involvement of Persons Living with HIV/AIDS is a foundational cross-cutting principle which is inherent in all Goals, Strategies, Objectives, and Action Steps of this Plan. Documents of the Joint United Nations Programme on HIV/AIDS (UNAIDS) lay out principles that uphold the rights and responsibilities of PLWHIV, including the right of self-determination and participation in decision-making processes that affect their lives (UNAIDS, 2007).[8] These documents echo the Denver Principles of 1983 that boldly affirmed the rights of people with AIDS (Denver Principles, 1983).[9] PLWH will be included in all aspects of planning, design, implementation, and evaluation of programs for HIV testing, prevention, and care.

In all that we do in furthering the goals of the NHAS, we will operate through an overarching framework of cultural and linguistically appropriate services which respect the heterogeneous community of persons living with HIV.

Health inequities are well documented in communities across the nation and across the State of Georgia. Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern.
Health inequities are directly related to the existence of historical and current discrimination and social injustice; one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of

8 http://data.unaids.org/pub/BriefingNote/2007/jc1299_policy_brief_gipa.pdf
9 http://data.unaids.org/pub/ExternalDocument/2007/gipa1983denverprinciples_en.pdf

and responsive to the cultural and linguistic needs of all individuals. It is important to recognize and respect cultural differences wherever they exist including HIV status, gender identity or expression, race, ethnicity, national origin, sexual orientation, religion, education, language, and socioeconomic status. By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve our ability to address health care disparities.

The US Department Of Health and Human Services, Office of Minority Health had developed National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services".[10] Toward that end, we will ensure that efforts to address HIV prevention, care and treatment service goals are infused with cultural competency and cultural sensitivity in harmony with national CLAS standards.

a. The **Integrated HIV Prevention and Care Plan** is attached as **Appendix B** and includes the information requested in **a.-d.**

e. Anticipated challenges or barriers in implementing the Plan:

Potential challenges and/or barriers in implementing the Plan include the inability to find additional service providers. While additional funding can be allocated to hire additional providers, or for housing and transportation services, the potential barrier lies in identifying individuals or entities that can or are willing to provide the service. Rural areas in particular have challenges attracting providers to work in the areas, and in many cases limited resources exist that can provide services such as transportation and housing (two of the most commonly identified service needs/gaps).

Anticipated challenges or barriers implementing the Integrated HIV Prevention and Care Plan:

- Sustainability of the implementation of the Plan, which includes prevention and care goals, objectives and strategies that link together and require integrated implementation and monitoring by a number of partners.
- Insufficient funding to fully implement the statewide Integrated Plan
- Integrated Plan absent of integrated policies and procedures
- Resistance from providers due to the implementation of a new systemic process
- Surveillance data and Care Continuum data collection and analysis issues
- Interoperability of electronic health records and systems
- CAREWare data matching issues between Part A and the State

[10] https://www.thinkculturalhealth.hhs.gov/content/clas.asp

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Specific contributions of stakeholders and key partners to the development of the Plan:

Collaborations, partnerships and stakeholder involvement were critical to the development and success of the Integrated Care and Prevention Plan. Given the size of each respective planning bodies for the various entities to be included within the Integrated Plan (Georgia Prevention and Care Council, the Part A Planning Council, and the Fulton and DeKalb Joint Prevention Planning Group), each planning group was charged with identifying representatives to serve as the "writing team." The Georgia DPH took the lead in arranging for a consultant to meet with the writing teams, to guide their creation of the Integrated Plan and to compile one statewide plan for the state of Georgia. Agreements were reached by the various jurisdictions on the manner in which the Plan would be created; assignments; and the timeline involved - including writing, compiling and drafting the total document, reviewing, receiving feedback, final editing, approval and submission.

Each team worked with their respective bodies to identify the objectives, strategies and prioritized activities/interventions, target populations, responsible parties, and resources needed to accomplish NHAS goals.

Feedback for the Integrated Plan was gathered from the 16 regional Ryan White Part B Consortia. Each was asked to participate in an exercise to provide insight as to the advantages of plan integration, areas of interest, types of guidance/tools that would be helpful, characteristics of the communities served, and goals/objectives to be included in the Plan. Participation included medical providers, consumers, Ryan White Part A, B, C, D and F representatives, HIV/AIDS prevention representatives, community and religious leaders, community-based organizations, and AIDS service organizations, among others. Data from the 2013 Georgia Statewide Client Satisfaction Survey was also utilized. This information, along with state staff feedback laid out the foundation for the goal and objectives related to HIV care.

The Georgia DPH, Office of HIV/AIDS began planning for integrated Care and Prevention activities mid-2014, with discussions and work centered around creating one cohesive planning body. The end result of this work was the Georgia Prevention and Care Council (G-PACC). The G-PACC was created in such a way as to include representatives from major stakeholders, including but not limited to: Ryan White Parts A, B, C & D; State HIV Prevention and Fulton/DeKalb HIV prevention programs; consumers; DOC; HOPWA; Hepatitis; HIV Surveillance; etc. for the purpose of reaching the goals of the NHAS through collaboration and leveraging of resources to foster improved outcomes among persons living with HIV throughout Georgia.

The Atlanta EMA is committed to providing an integrated continuum of core and essential support services based on an assessment of the needs of the EMAs HIV population, those in care, out of care, and at high risk for HIV infection. Contributors to

this Plan included representation from the Metropolitan Atlanta HIV Health Services Planning Council, Ryan White Part A agencies, the Fulton/Atlanta Jurisdiction Prevention Planning Group, State of Georgia Part B Recipient, consumers, PLWH, health departments, HOPWA grantee/agencies, youth organizations, academic institutions and other key partners along the HIV Care Continuum. Statistical data, epi analysis, needs assessments, emerging trends, agency level data, and anecdotal information were presented by participants to achieve a comprehensive strategy for addressing the needs within the EMA. The Fulton County Government Task Force on HIV/AIDS, through a series of community meetings involving stakeholders, PLWH and high risk populations, was instrumental in providing data and objectives which proved to be an integral part in the development of this Plan.

Key focus areas included the following:

- HIV Testing
    - Knowledge of HIV Status
    - Routine Opt-Out Testing in Healthcare Settings
    - Targeted Testing for Disproportionately Affected Populations in Non-healthcare Settings
    - Partner Services
    - Program Collaboration and Service Integration: HIV, STI, Viral Hepatitis, and TB
    - Systems Issues
- Preventing HIV Infection
    - Biomedical Prevention: PrEP, PEP, TasP
    - Prevention for People Who Inject Drugs
    - Condom Distribution
- Care and Treatment for Persons Living with HIV
    - Linkage to Care
    - Retention and Reengagement in Care
    - Viral Suppression
    - Quality of Care
- Social Determinants of Health
    - Structural Issues Affection Healthcare Access and Delivery
    - Structural Issues

In developing Georgia's Integrated Plan, the Metropolitan Atlanta (Part A) HIV Health Services Planning Council's Comprehensive Planning Committee began discussing the joint HRSA/CDC guidance for the Integrated Plan in July 2015.

Initial discussions broadened from the topic of how the process would unfold, responsibilities and concerns, to going through each NHAS goal, objective and step to identify where we have already made progress and how to maintain activities which serve our population well; and where we need to improve, what resources and activities are needed in order to reduce new infections, improve linkage and access to care, reduce disparities and health inequities, improve health outcomes, work in a more coordinated

fashion in order to make best use of limited resources, and effectively communicate progress toward achieving NHAS goals.

As has been the Part A Planning Council Comprehensive Planning Committee's practice, in addition to the work accomplished during the internal monthly meetings, a broad invitation was issued to other stakeholders to participate in a brainstorming session so their ideas and input would inform Part A's part of the Integrated Plan. Invitees for the day long Stakeholder's Meeting, held January 29, 2015, at the Loudermilk Center included the entire Planning Council (membership as well as the chairs of all other Part A Committees (e.g., Assessment, Quality Management, Housing, and Public Policy committees). Invitations were also extended to at least 25 other Atlanta EMA stakeholder entities, including representatives from: Atlanta Harm Reduction; youth advisors for metropolitan Atlanta HIV services; SisterLove; Center for Black Women's Wellness; discharge staff from jails in City of Atlanta, Fulton County and DeKalb County; Someone Cares of Atlanta; Transgender Individuals Living their Truth; and others. A total of 78 persons registered to attend the Stakeholder's session. Participants included the entities/persons indicated above as participating in Comprehensive Planning Committee meetings, the state's Integrated Plan consultant and other stakeholders.

In addition, unaffiliated persons or others whose contact information does not identify their affiliation with invited entities took part in the meeting. Participants were provided with an overview of the requirements for the Integrated Plan and need for their input in the process. Following presentation of an epidemiologic profile by the Director of the State's HIV Surveillance Office, participants broke into groups for table discussions to develop objectives and activities, with ten participants serving as facilitators. Group reports of highlights from their discussions were shared with all assembled and provided to the Comprehensive Planning Committee Chair for later transcription and utilization in subsequent committee work on the draft. A session on monitoring and evaluation was also included as an introduction to the required indicators and measurable targets to be included within the objectives. Participants indicated they would like updates on the information resulting from their work.

The Comprehensive Planning Committee held five meetings during the two months following the January 2015 Stakeholder's Meeting to draft measurable objectives and strategies for each NHAS and borrowed from the 225+ ideas shared during the stakeholder table discussions to prioritize those activities with the greatest chance of yielding improved access to care and health outcomes for the EMA.

b. Stakeholders and partners not involved in the planning process needed to more effectively improve outcomes along the HIV Care Continuum:

Stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum include private providers, FQHCs, Medicaid, Veterans Affairs, and the Department of Community Affairs (housing).

A comparison of the list of entities/persons invited to participate in Part A's Stakeholder's Meeting versus attendees indicates that most of those not typically involved with Ryan White programs/consumers did not attend this session. As part of our efforts to extend our reach to persons/groups that may particularly assist in reaching PLWH who inject drugs, are victims of domestic/sexual violence, experience stigma in their community, or otherwise represent target groups with disparate health outcomes, we will continue to keep them informed of our Plan and our progress, as well as continue to extend an invitation for their participation in order to help serve their constituents.

- Veterans Administration
- SAMHSA funded programs
- Georgia American College of Obstetrics and Gynecology (ACOG) (HIV perinatal transmission)
- Federal/State representation for HUD
- State CLIA office
- County School Superintendents

In order to involve and mobilize stakeholders, the implementation level should be coordinated effectively to ensure that variables associated with HIV are included in the planning process. During the implementation process of constructing a statewide integrated planning body Georgia carefully sought to embody a planning council that aims to keep differing interests balanced and focused on the NHAS, involving those who support HIV and promoting public health. Through this process it has been determined that key stakeholders such as: Veterans Affairs, Medicaid, Mental Health, Domestic Violence, Substance Abuse, Corrections, and Individuals with Physical and Developmental Disabilities are not involved in the planning process but needed to improve the needs of PLWH and to increase the progression of building a comprehensive integrated planning body.

c. Letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan is included as **Appendix C**.

C. People Living with HIV and Community Engagement

a. People involved in developing the Plan are reflective of the epidemic:

Georgia has elected to provide comprehensive planning documents to our federal partners CDC and HRSA. Establishing a united foundation for HIV prevention and care is essential to the coordination that is necessary to successfully accomplish the goals of the NHAS. The G-PACC understands the responsibility and importance of including PLWH throughout the development of the integrated planning process. The community planning process involves representatives of populations at greatest risk for HIV infections and PLWH. The fundamental tenets of community planning in Georgia are parity, inclusion and representation. An inclusive community planning process includes representatives of various races, ethnicities, genders, ages, sexual orientations, other characteristics

including educational backgrounds, and professional expertise. The community planning process also encourages community participation.

Currently, G-PACC has 44 council members who serve as voting and non-voting members. G-PACC adheres to the support of statewide goals for HIV prevention and care by emphasizing populations and communities most affected by the epidemic. To date, 51% of Georgia's statewide integrated planning body (G-PACC) are consumers who serve as Co-Chairs to facilitate planning meetings, monthly committee activities, conference calls, and stakeholder engagements

The people involved in developing the Integrated HIV Prevention and Care Plan included medical providers, consumers, Ryan White Parts A, B, C, D and representatives, HIV/AIDS prevention representatives, community and religious leaders, community-based organizations, and AIDS service organizations, among others. Involvement from these stakeholders is reflective of the epidemic because it encompasses both individuals who provide services as well as those who utilize the services.

Membership for the Ryan White Part B Consortia is required to reflect the diversity of the local community and affected populations. An emphasis is placed on recruiting service providers and persons living with or affected with HIV/AIDS. Additionally, several members of the Ryan White Part B QM Core Team represent stakeholders, sub-recipients, consumers, and/or a combination of positions. Currently, the QM Core Team includes one male and one female consumer, state office staff, Part B-funded health district representation, and the recipients or designees of other Georgia Ryan White Parts. The QM Core Team reviews performance measurement data, and plays a key role in selecting performance measures and developing quality priorities. Consumers and funded agencies are also represented on the ADAP/HICP and Case Management Subcommittees.

PLWH have been involved throughout the Integrated Plan development process. Part A Planning Council members and its committees and workgroups include community representatives, consumers of services, community based organizations, and service providers. Currently 52% (23 male, 7 female and 2 transgender female) of the Planning Council are consumers. Consumers serve as both voting and non-voting members. The Council is open to anyone who wishes to participate. During the Council's annual membership drive, information about how to become a member is widely disseminated to encourage consumers and other stakeholders to participate. Voting members are selected by the Membership Committee and decisions are made based on federal representation requirements. All members, voting and non-voting, serve on a Council committee.

Consumers serve in positions of leadership including serving as co-chairs of all Council committees. The Planning Council Consumer Caucus, which meets monthly, provides the opportunity for consumers to provide valuable input to the Council and Part A Program, including Integrated Plan development. The G-PACC, Consortia, JPPG, and Fulton County HIV Task Force also include consumers. In addition, in inviting participants to the January 2015 Integrated Plan Stakeholder's meeting, emphasis was placed on inviting consumers that were reflective of the Atlanta EMA epidemic.

In order to ensure that the Fulton/DeKalb HIV Jurisdictional Planning group (JPPG) was reflective of the epidemic the Executive committee assigned the task of conducting a needs assessment to the membership committee in the spring of 2015. Over the course of 4 months the membership committee looked at the composition of the current members paying particular attention to demographics such as: age, gender, sexual orientation, race, HIV status and location of residence. Among the findings of the committee included that the planning body was composed of a majority of African American persons who overwhelmingly represented Fulton County. The report also indicated that African American males and females were overwhelming represented by the body with females representing just a slight majority of participants. In terms of sexual identity a slight majority of participants identified as heterosexual. At the time of the assessment there were two persons who were identified as YMSM along with individuals who are transgender.

The membership committee recommended that during the next recruitment cycle that the body make an effort to recruit and retain more YMSM, transgender persons, people who reside in DeKalb county zip codes, along with more persons who reported an HIV positive status. The recommendations were accepted and the additional task was given to the membership committee to seek out persons who could fill the reports gaps. By the fall of 2015, a recruitment effort was underway to both replace some members who dropped out and to fill in new membership slots which the body voted to bring aboard. The result of the recruitment effort was that the Fulton/DeKalb JPPG was more representative of the epidemic that existed in the jurisdiction. An additional three men of color were recruited with two of these persons having disclosed a positive HIV status and all residing in DeKalb county zip codes. Efforts to recruit additional Male to Female transgendered persons to the planning body have fallen short, yet the body is finding ways to engage and solicit the feedback from this community through a small transgender advisory group.

As the writing of the Plan got underway in the winter of 2015, the City of Atlanta (Fulton/DeKalb Counties) Jurisdictional HIV Prevention Planning Group (JPPG) was fairly composed of representatives which represented the epidemic. To ensure that these individuals were constantly abreast of the Integrated HIV Prevention and Care Plan, a check and balance process was created. The process consisted of the writing team collecting data and composing first drafts to the report requirements. Once the first drafts were completed, the drafts were shared with the members of the planning group to solicit feedback, input, comments, or/and recommendations and for discussion as to whether they agreed with what the writers of the Plan were proposing. Upon majority agreement, the first drafts were accepted either as is or with revisions.

Table 22: Demographics of the Atlanta EMA Planning Council

Demographic	Living with HIV/AIDS in the Atlanta EMA		Members of the Planning Council		Non-Aligned Consumers on Planning Council	
	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
Race/Ethnicity						
White, not Hispanic	6,116	19.76%	15	27.27%	4	17.39%
Black, not Hispanic	21,545	69.62%	37	67.27%	18	78.26%
Hispanic	3,286	10.62%	1	1.82%	0	0.00%
Asian/Pacific Islander		0.00%	2	3.64%	0	0.00%
American Indian/Alaska Native		0.00%	0	0.00%	0	0.00%
Multi-Race		0.00%	0	0.00%	1	4.35%
Other/Not Specified		0.00%	0	0.00%	0	0.00%
Total	30,947	100%	55	100%	23	100%
Gender						
Male	10,597	77.83%	31	56.36%	15	68.18%
Female	3,018	22.17%	22	40.00%	5	22.73%
Transgender		0.00%	2	3.64%	2	9.09%
Unknown		0.00%		0.00%	0	0.00%
Total	13,615	100%	55	100%	22	100%
Age						
<13 years	135	0.99%	0	0.00%	0	0.00%
13-24 years	1,437	10.49%	0	0.00%	0	0.00%
25-44 years	8,254	60.27%	11	20.00%	15	65.22%
45-64 years	3,673	26.82%	22	40.00%	8	34.78%
65+ years	182	1.33%	5	9.09%	0	0.00%
Unknown	15	0.11%	17	30.91%	0	0.00%
Total	13,696	100%	55	100%	23	100%

Note: Risk factor is not included as this information as it has not been requested by the Planning Council.

Table 23: Demographics of the Atlanta (Fulton/DeKalb Counties) Jurisdictional HIV Prevention Planning Group

Demographic	Number	Percent
Gender		
Male	16	59%
Female	10	37%
Transgender (MTF)	1	4%
Transgender (FTM)	0	0%
Total	27	100%

Demographic	Number	Percent
Status		
Negative	12	44%
Positive	7	26%
Unknown/Unreported	8	30%
Total	27	100
Race/Ethnicity		
White, not Hispanic	2	7%
Black, not Hispanic	24	89%
Hispanic	1	4%
Asian/Pacific Islander	0	0%
American Indian/Alaska Native	0	0%
Other Multi-race/Unknown	0	0%
Total	27	100

Georgia's statewide integrated planning council known as the Georgia Prevention and Care Council (G-PACC) is comprised of 44 members. An important objective was to foster an integrated planning process that encourages parity, inclusion, and representation among all community members. Members of G-PACC reflect the epidemic in Georgia while simultaneously involving stakeholders who reflect the comprehensive need to address service delivery systems, unmet needs and gaps in care, and perceived barriers. G-PACC includes 34 voting and 10 non-voting members.

G-PACC membership categories include the following:

- Academia
- ADAP Pharmacy
- African American Female
- Agency Representatives
- City of Atlanta Jurisdictional Planning Group
- Consumer
- Corrections
- Emerging Populations
- Faith Based
- Federally Qualified Health Center
- Health Department
- Hepatitis
- Heterosexual Male
- HIV Prevention
- HIV Surveillance
- HOPWA
- Hospital
- Infectious Disease Medicine
- Infectious Disease Research
- Medicaid
- Mental Health
- MSM- African American
- MSM- Latino
- MSM – White
- Outreach
- Perinatal
- Public Health Policy
- Ryan White Part A
- Ryan White Part B
- Ryan White Part C
- Ryan White Part D
- Senior Citizen
- STD
- Veteran Affairs
- Youth

Table 24: Demographics of the Georgia Prevention and Care Council

Demographic	Living with HIV/AIDS excluding EMA		Members of G-PACC		Non-Voting Members of G-PACC	
	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
Race/Ethnicity						
White, not Hispanic	3,341	21%	13	29.54%	3	30%
Black, not Hispanic	10,876	67%	27	61.36%	7	70%
Hispanic	805	5%	2	4.545%	0	0.00%
Asian	30	<1	--	0.00%	0	0.00%
Asian/Pacific Islander	<5	**	2	4.545%	0	0.00%
American Indian/Alaska Native	12	<1	--	0.00%	0	0.00%
Multi-Race	503	3%	--	0.00%	0	0.00%
Other/Not Specified	727	4	--	0.00%	0	0.00%
Total	16,298	100%	44	100%	10	100%
Gender						
Male	10,876	67%	21	47.73%	6	60%
Female	5,386	33%	23	52.27%	4	40%
Transgender	25	<1	--	0.00%	0	0.00%
Unknown	11	<1	--	0.00%	0	0.00%
Total	16,298	100%	44	100%	10	100%
Age						
<13 years	0	0.99%	0	0.00%	0	0.00%
13-24 years	1,437	10.49%	0	0.00%	0	0.00%
25-44 years	8,254	60.27%	12	27.275%	3	30%
45-64 years	3,673	26.82%	30	68.18%	5	50%
65+ years	182	1.33%	2	4.545%	2	20%
Unknown	15	0.11%	0	0.00%	0	0.00%
Total	13,696	100%	44	100%	10	100%

b. Inclusion of PLWH contributed to the Plan development:

Membership for the Ryan White Part B Consortia emphasizes recruitment of persons living with or affected with HIV/AIDS. The Ryan White Part B QM Core Team includes one male and one female consumer. Consumers are also represented on the ADAP/HICP and Case Management Subcommittees. Feedback from PLWH was integral in Plan development, especially when assessing behavioral decisions made related to care, and the quality of health care delivery. The inclusion of PLWH assisted in the development of

goals and objectives that can create more stable relationships with health care providers, improved compliance with medical advice and treatment, and increased retention in care.

PLWH participate in all Part A Planning Council committees, including the Comprehensive Planning Committee. All Planning Council members, including consumers, were invited to participate in Comprehensive Planning Committee meetings and in the Stakeholder's meeting, and are provided a copy of the draft document for their comments, prior to being asked to approve the Integrated Plan for submission to HRSA/CDC.

The Georgia Prevention and Care Council (G-PACC) is an inclusive integrated planning group that includes 44 representatives of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise. To date, 51% of members within the council are PLWH. It was imperative to convene a community process to discuss proposed content within the integrated plan and stakeholder engagement. During each planning meeting, council members and PLWH were given the opportunity to provide input and suggestions to the Plan. Two representatives from G-PACC were also placed on the integrated writing team to serve as a voice for the entire planning body, including PLWH. The opportunity to provide suggestions at every meeting was made available with open discussions regarding the Integrated Plan's structure, objectives and goals.

The G-PACC also utilized its Comprehensive Plan Committee to also review the goals and objectives of the plan and to provide feedback as a separate activity. There was also a presentation on the progress of Georgia's Integrated Plan provided at each planning meeting.

In terms of P-I-R, the meeting leading up to the final draft of the Plan included representation of the highest burdened populations in Georgia: African American MSM, White MSM, at-risk heterosexuals, African Americans, and Latinos.

All G-PACC members were provided a copy of the draft Plan for review to submit comments and suggestions before accepting the HIV Integrated Prevention and Care Plan.

The Fulton/DeKalb JPPG is composed of a total of 30 members. Every effort is made to ensure that these individuals are reflective of the epidemic in the jurisdiction as the body values parity, inclusion, and representation of its membership. A key component to the success of the body is the involvement of PLWH. PLWH provide first-hand knowledge as to how the jurisdictions efforts can better be tailored to address various needs and gaps that exist in the community. They are also valuable in tailoring the jurisdictions prevention with positive strategies as well as instrumental in proving insightful voices to the shaping of the Integrated Prevention and Care Plan.

Of JPPG's 30 members, approximately one-third of these persons have reported that they are living with HIV. Throughout the development of the Plan, both the writers as well as

the program administrators, made sure that PLWH contributed to its development. This involved creating a process whereby the writing of the Plan was devised incrementally. As the writing took place, drafts were shared with the members of the Jurisdictional JPPG; among the persons in that group are PLWH. Moreover, members of the group were encouraged to edit the draft while providing feedback and constructive criticism as to how and where their "voices" are included and integrated in the writing of the Plan. Upon collecting feedback from the group, the writers of the Plan made any necessary adjustments as to reflect the opinions and values of the persons contributing to the editing. The end product is a Plan which is written with thoughtful consideration to the various members of the JPPG. Among this group is a cohort of PLWH who actively participate by providing insightful recommendations shaping the outcome of the Plan.

c. Methods used to engage communities, PLWH, and those at risk to ensure activities are responsive to the needs in the service area:

Communities and PLWH are engaged through the 16 Ryan White Part B consortia, which allow each funded area to build a coalition of health care and support service providers, CBOs, and interested community members including persons infected and affected with HIV. The consortia act as advisory bodies and help to determine specific service needs and plan service delivery in each region.

Another method of engaging communities and PLWH includes participation in the G-PACC. Current membership includes representatives from major stakeholders, including but not limited to: Ryan White Parts A, B, C & D; State HIV Prevention and Fulton/DeKalb HIV prevention programs; consumers; Department of Corrections; HOPWA; Hepatitis; HIV Surveillance; etc.

The Part A Planning Council is the legislatively mandated planning body for the Atlanta EMA Ryan White Part A Program. The Planning Council plans for the comprehensive delivery of HIV/AIDS services and allocation of resources for the EMA. Planning Council responsibilities include identifying the needs of PLWH, preparing a comprehensive plan to guide the delivery of Part A services, setting priorities for the allocation of funding, and evaluating how well services meet community needs within the 20-county EMA. Planning Council members include community representatives, consumers of services, community based organizations, and service providers. Council members serve on committees and task forces that guide Part A work. The Planning Council, as described above, uses a variety of methods to engage impacted groups and individuals. The EMA conducts consumer surveys to obtain input on service needs and gaps. The 2011 and 2014 consumer survey findings informed the development of the Integrated Plan goals, objectives and strategies.

Other engagement activities include needs assessments such as the recent health disparities assessment conducted by the Planning Council Assessment Committee, client satisfaction surveys, and stakeholder meetings (e.g., January 29, 2015 Stakeholder meeting) as well as the valuable work of the Planning Council's Consumer Caucus, Assessment Committee, Quality Management Committee, and Comprehensive Plan

Committee. The annual AAOI helps the EMA engage with PLWH and those at highest risk. In 2015 the AAOI was joined by with the Fulton/DeKalb High Impact Prevention Program. The AAOI seeks to improve individual and community health outcomes by facilitating access to care through HIV prevention, linkage, care and retention. This educational forum focuses on getting individuals who are not in care linked to care as well as further prevention efforts. Event attendees have access to HIV testing, screening for STDs, exhibits, workshops, information on PrEP, linkage coordination, and other activities to inform and help our community defeat this epidemic. The AAOI meeting evaluation findings provide information that helps identify needed services. The Fulton County Government was the recipient of a National Association 2015 Achievement Award in recognition of the initiative.

The Fulton/DeKalb JPPG considers a variety of strategies and methods to interact and engage with those communities who are at substantial risk for acquiring HIV infection within the jurisdiction. These strategies include, but are not limited to, forming strategic partnerships and alliances with community based organizations that specialize in reaching targeted communities, employing the use of large scale mass media campaign, utilizing the JPPG as a resource to gather and collect information and feedback, establishment of stakeholder advisory committees, as well as conduct direct community engagement sessions.

AIDS Service Organizations (ASOs) throughout Fulton and DeKalb Counties are generally located in zip codes and areas where HIV is heavily concentrated. Through their outreach, testing, and linkage activities these organizations have access to, and the trust of, many of the sub-populations which the Health Departments aim to reach for HIV prevention and care activities. One method of engaging disproportionate populations is engaging the organizations who provide services to the aforementioned population. The jurisdiction accomplishes engaging these organizations by providing direct financial support and by serving as a conduit for technical assistance by providing training and other learning opportunities to the staffs at the organizations. The relationship between ASOs and the Health Departments is vital to reaching impacted communities and to addressing the epidemic in the area.

Another method to engage high-risk communities throughout the jurisdiction is the utilization of mass media campaigns, in partnership with the Kaiser Family Foundation, which focuses on addressing HIV stigma, HIV testing, and access to care related issues. The campaigns, “Atlanta Greater Than AIDS” and “We Are Family” can be seen on billboards and bus kiosks throughout the jurisdiction within those zip codes with high HIV prevalence. The campaigns show representations of the epidemic as told through the stories of local individuals who are living with an HIV diagnosis. The campaigns promote the need for social and family support of those living with HIV as well as viewers increasing HIV awareness.

In addition to partnering with ASOs and the development of mass media campaigns to engage communities in the jurisdiction, another method soliciting input has been through the use of the JPPG, which is composed of members who represent the epidemic in the

jurisdiction including young men who have sex with men, HIV positive persons, women, formerly incarcerated, gay and heterosexual men. Moreover, Fulton/DeKalb JPPG has established four community advisory groups (CAGs), which meet monthly: African American, MSM, Transgender, and Young Adult (ages 17-25).

Each CAG creates an opportunity that offers free information sharing and a real chance for those that have been affected and/or infected by HIV to truly have a voice and be a part of the process, be a leader in the planning and participate in and offer feedback on how Fulton/DeKalb Counties carry out prevention services. Respective of each CAG, the goal is to provide Fulton and DeKalb Counties with a better understanding of why each population is disproportionately infected by HIV. The CAGs will provide recommendations for decreasing new infections, how HIV prevention and care is delivered, identifying best practices to address needs, creating new strategies to advance HIV prevention and care and identifying key issues that impact the quality of HIV-related prevention in for each population.

d. Impacted communities are engaged in the planning process to provide insight into developing solutions to health problems to assure the availability of resources:

The Ryan White Part B consortia serve as the local points of contact for accessing information on funding in each respective service area. The consortia allow each region to determine specific service needs. The funded agencies utilize reported needs to determine the services to be provided and how to best allocate funding.

Data provided by Ryan White Part B funded agencies enables the Part B program to update statewide activities and prioritize the key areas of focus for the funding year. Examples of data collected include but are not limited to data entered into CAREWare, local needs assessments, and client satisfaction surveys. In addition to working with each funded agency and consortium to develop a needs assessment, the state also collaborates with other Ryan White Program recipients and providers to ensure that identified disparities in health care infrastructure are addressed.

Members of impacted communities and PLWH are welcomed and encouraged to participate in and serve on the Part A Planning Council and its committees, including the AAOI, Assessment, Comprehensive Planning, Council Procedures, Evaluation, Housing, Membership, Public Policy, Quality Management Committees and workgroups. As part of orientation for all new Planning Council members, training on planning is included and a refresher is also offered at other meetings. Several Planning Council members also participate in HOPWA provider meetings and on the Fulton County HIV Task Force's committees.

All Planning Council members, including consumers, as well as persons/entities from other impacted populations were invited to participate in Comprehensive Planning Committee meetings and in the Stakeholder's meeting, and are provided a copy of the draft document for their comments, prior to being asked to approve the Integrated Plan and submission to HRSA/CDC.

The JPPG, the planning body which is responsible for HIV prevention efforts in the jurisdiction, engages impacted communities in order to provide critical insight to the development of solutions to health problems and addressing social determinants of health. These activities mainly derive from two sources: community advisory groups (CAGs) and community engagement sessions with representatives from these communities.

The planning body coordinates and operates four distinct advisory groups which represent specific target populations that experience HIV disproportionately. While the advisory group meetings are facilitated by a FCDHW representative, persons participating in the meetings are members of the community who are vested in the process of providing feedback in the administration of the program. In order to solicit feedback, the meeting facilitators pose open ended questions seeking information regarding the improvement of prevention services along with questions pertaining to barriers to prevention and care while also probing the group about the social determinants that might also be impacting the delivery of services. Participants are also asked to respond to questions regarding social determinants of health along with the availability of community resources that support positive health outcomes. After collecting responses, the planning body makes efforts to communicate the needs of impacted HIV communities to community stakeholders who are typically not a part of the HIV care continuum. These efforts are achieved through information sharing, through referrals and linkages, and by involving and incorporating outside partners into the HIV prevention realm.

In addition to the CAGs providing insight to developing solutions to health problems to assure the availability of necessary resources, the jurisdiction also engages in the facilitation of community engagement sessions which use a town hall type of format where invested persons have come to voice their opinions and provide insight to the implementation of program and services. The community engagement sessions were held in partnership with the Black AIDS Institute and provided feedback from African American Transgender women, African American women, faith communities, and HIV providers.

Section III: Monitoring and Improvement

A. Process for regularly updating planning bodies and stakeholders on the progress, soliciting feedback, and using feedback for Plan improvement:

Integrated Plan activities and outcomes will be shared with Ryan White and HIV Prevention funded agencies through program web pages and email correspondence. Agencies will be encouraged to disseminate the Plan to consumers and local stakeholders, including local Ryan White Part B consortia. In addition, the Plan will be shared with the statewide integrated planning body, G-PACC. G-PACC's role will be to provide strategies for action in the development of a coordinated system of care for PLWH in accordance with the Integrated Plan. The body will provide feedback to the Plan to ensure goals, objectives and approaches

for action are being met. As the Integrated Plan is considered a living document, feedback garnered will be used to strengthen/edit the Plan as needed during the five year period. With the input from Part A staff and relevant Planning Council committees and workgroups, the Council's Comprehensive Planning Committee will be responsible for updating EMA progress on Plan implementation. Plan updates will be provided quarterly at Planning Council meetings and feedback solicited. This feedback along with progress and success in meeting established strategy timelines will be used to make Plan improvements if needed. EMA Integrated Plan progress will be also shared at regularly scheduled G-PACC and JPPG meetings.

The DPH, HIV Prevention Program has Regional Prevention Coordinators who serve as contract monitors, provide technical assistance, and deliver capacity building to 16 of the 18 health districts within the state of Georgia. Regional coordinators are also tasked with providing updated feedback on the planning process and next steps.

Additionally, a member of each jurisdictional planning body serves as a representative for their respective planning body within G-PACC. Membership with G-PACC provides the opportunity for jurisdictional planning bodies to distribute feedback and next steps on the progression of the Plan and strategic placements for improvements, as needed.

An annual meeting of the planning bodies will be held to share all information and receive input from the participants to further the success of the Integrated Plan.

B. Plan to monitor and evaluate implementation of the goals and SMART objectives:

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. 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 meetings to establish the Plan.

The Ryan White Part B Program 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 reports generated in CAREWare continue to become more accurate and useful for quality improvement activities. RSR reports as well as performance measure reports are reviewed by the Part B Program staff and the Quality Management Core Team to identify opportunities for quality improvement. Key Ryan White Part B staff who will be involved in Integrated Plan monitoring and evaluation include the following:

- **Ryan White Part B Manager and Assistant Manager**: Responsible for grant oversight and management, allocation of resources, and ensuring the development and implementation of the Ryan White Part B Integrated Plan components.

- **Quality Management Team**: Responsible for coordinating Ryan White Part B Core Team activities, and ensuring quality medical care and supportive services for people living with HIV/AIDS in Georgia
- **CAREWare Team**: Responsible for monitoring and maintaining the Ryan White Part B CAREWare database, cleaning and quality assuring data, and providing training & technical assistance.
- **District Liaison Team**: Responsible for monitoring compliance with programmatic, state, and federal regulations, and providing technical support and assistance to funded agencies.

The EMA employs continuous quality management (CQM) to monitor Ryan White Part A progress. The current CQM process will be revised to incorporate monitoring of the Integrated Plan and achievement of its goals and SMAART objectives. Part A staff who will be involved in Integrated Plan monitoring and evaluation include the following:

- **Quality Management Coordinator**: responsible for coordinating the work of the CQM Committee with the Recipient's HRSA requirements; monitoring progress of the data evaluation and reporting activities; developing and monitoring contractual requirements including data collection and presentation of data results to the QM Committee Priorities Committee, Assessment Committee and the full Council; coordinating QM Team meetings; coordinating systems-level CQI projects in collaboration with the Planning Council Quality Management Committee; ensuring the development, implementation, and evaluation of the QM plan and Work Plan; ensuring revision of the QM plan at least annually, and the Work Plan at least quarterly; ensuring QM/QI and other HIV-related training is available to subrecipients and staff; providing technical assistance to the RW Program Part A-funded agencies in the development of QM plans; developing and revising QM guidelines/polices as indicated; attending educational conferences to maintain current knowledge of Quality Management; developing and distributing quarterly quality management newsletters highlighting successes and new initiatives; and, participating in statewide Continuous Quality Improvement (CQI) efforts in partnership with Part B.
- **Assistant Director**: responsible for reviewing agency QM plans, assessing results of EMA-wide chart reviews and working with sub-recipients on corrective action plans, participating in Part A quality-related committees and activities; attending Planning Council QM Committee meetings and identifying consultant(s) and managing contract for EMA-wide clinical chart reviews.
- **Senior Health Researcher**: responsible for analysis of CAREWare utilization and Ryan White cost data; providing technical assistance, attending meetings, and producing data for the Priority-Setting, Quality Management and Assessment Planning Council Committees; generating quarterly data reports on the Ryan White Part A program; preparing and distributing quarterly Quality Management newsletter. This position is also responsible for annual Unmet Need; and providing ongoing data analysis and support to consultants and Chart Review analysis, reports and presentations.
- **Database Specialist**: responsible for managing the CAREWare database; monitoring agency compliance with RDR submissions; providing technical assistance and training; preparing data reports; submitting CAREWare Data Report to HRSA; coordination

with the County's Information Technology Department and with contracted Data Analyst and data consultants.

In addition, Part A will implement contracts, as needed, for the provision of quality management activities including data collection from chart reviews at primary care sites, reporting of findings to QM Committee and Planning Council, training of committee and Planning Council members, and preparation and analysis of utilization and unit of cost data for the Atlanta EMA. Quality of service indicators are also measured through data collection from chart reviews and/or CAREWare annually. Other data that will inform monitoring of Integrated Plan progress will include HIV surveillance data as well as EvaluationWeb data.

Georgia's HIV Prevention Program will focus on those related goals and objectives around prevention efforts to ensure activities are implemented effectively and monitored ongoing to determine areas that need revisions or enhancements. Best practices for prevention activities will facilitate planning around strategies that directly address factors which affect knowledge and attitudes about HIV/AIDS, HIV screenings, risk factors for STD coinfections, linkage to and re-engagement in care, and risk reduction. Evaluation focus will include both formative assessment to determine effectiveness and summative assessment to determine the impact of proposed activities. Quantitative data from Georgia DPH program data sources will incorporate HIV Surveillance, HIV Counseling and Testing data via CDC-sponsored EvaluationWeb, STD Surveillance, CAREWare, Performance Measure reports from State Regional Coordinators and other related sources. Qualitative data will be available from narrative reports submitted to State Regional Coordinators, community focus groups, training and TA surveys, and G-PACC engagement sessions. The data collection design will allow for monthly, quarterly or annual ongoing monitoring and evaluation of the Integrated Plan.

Through its role providing review and feedback of the Integrated Plan, the G-PACC subcommittees will have the responsibility of ensuring the level of services delivered across the continuum represent equity when examined across the jurisdictions and regions. Particular focus will include the following:

1. Support of broad-based community participation
2. Identify priority HIV Prevention and Care need across jurisdictions
3. Ensure that HIV Prevention and Care resources target ***priority populations***
4. Ensure that HIV Prevention and Care resources target ***appropriate activities***
5. Ensure Integrated Plan goals and objectives progress is shared with ***key stakeholders***

Key Georgia HIV Prevention staff involved in monitoring of the Integrated Plan include the following:

- HIV Program Manager and Assistant Manager: Responsible for managing funding allocations, contract development and required activities.
- Regional Prevention Coordinators, Training and Development Specialist: Responsible for contract monitoring and coordination of technical assistance.
- Statewide Linkage Coordinator: Responsible for coordinating linkage and retention efforts throughout Georgia, with a particular focus on health districts and agencies supported by DPH.

- Data Team: Responsible for managing HIV Counseling and Testing database EvaluationWeb, prevention linkage data systems, facilitating collaborations with related data systems outside of the HIV program, and evaluation of HIV Program data.

C. Strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum and impact the quality of the HIV service delivery system, including strategic long-range planning:

Georgia's Ryan White Part B Program uses funds for the provision of core medical and support services based on documented need by local public health districts and consortia. The activities described in the Integrated Plan provide increased access to care by encouraging the development of new, innovative outreach, education, and retention programs to expand strategies for identifying and targeting at-risk populations who are not fully accessing comprehensive primary care and supportive services. The program will utilize data pulled from CAREWare, HIV Prevention, and HIV surveillance to plan, prioritize, target and monitor available resources in response to needs of PLWH and in order to improve engagement at each stage in the HIV Care Continuum.

The Planning Council's Quality Management, Assessment, and Comprehensive Planning Committees will work together with Part A QM staff to compile and use surveillance and program data (e.g., HAB measures, CAREWare, chart review data, surveillance data) to assess and improve health outcomes along the Continuum. A monitoring plan will be developed that identifies needed monitoring metrics for all strategies and activities and assigns responsibility for the collection and reporting of that data. Data will be collected at least quarterly to determine progress toward strategy and individual activity achievement by established deadlines as well as to identify areas that require improvement. A template will be developed to record progress data for strategies and activities and progress will be entered quarterly or more frequently as needed. The progress report section will also identify barriers and concerns and plans to address these identified issues. A plan of action will be developed for all activities that are identified as needing improvement. The Plan, Study, Do, Act cycle will be used, as needed, to guide quality improvements.

Georgia's HIV Prevention Program will continue collaboration with HIV Surveillance to incorporate HIV prevalence data to assist with program planning of activities to aid in targeted outreach and screening among those geographic regions with the highest burden of disease. These efforts will help to better reach those populations at greatest risk and identify individuals who are unaware of their positive status thus, impacting the HIV diagnoses rate and ensuring linkage to care as well as other support services for newly diagnosed persons. In addition, data to care activities supported by Georgia's HIV Prevention and Ryan White Part B Programs utilizing HIV surveillance data will equip linkage coordinators and case managers with supportive tools to initiate active re-engagement efforts for individuals who are not receiving HIV medical care but presenting to health clinics for non-HIV related services. This presents a key opportunity for provider outreach to increase the number of persons linked to or re-engaged into HIV medical care, promote retention and reduce HIV transmissions through improved health outcomes of ongoing care.

Reports on Integrated Plan progress will be generated at least quarterly from the Part A Recipient and provided to the Planning Council as well as to Plan partners including G-PACC, JPPG and the Fulton County HIV Task Force. Progress reports will also be shared with stakeholders including the participants in the January 2015 Stakeholder's Meeting. Feedback will be used to improve implementation of the Integrated Plan, as needed.

GLOSSARY OF TERMS

AA: African American
AAMC: American of Medical Colleges
AAOI: Atlanta Area Outreach Initiative
ACA: Affordable Care Act
ACOG: American College of Obstetrics and Gynecology
ADAP: AIDS Drug Assistance Program
AETC: AIDS Education and Training Center
ART: Antiretroviral Therapy
ARTAS: Antiretroviral Treatment and Access to Services
ASO: AIDS Service Organization
BAI: Black AIDS Institute
BHDD: Georgia Department of Behavioral Health and Development Disabilities
CAG: Consumer Advisory Group
CAPUS: Care and Prevention in the United States
CBO: Community Based Organization
CDC: Centers for Disease Control and Prevention
CHIP: Children's Health Insurance Program
CLAS: Culturally and Linguistically Appropriate Services
CMH: Consultorio Medico Hispano
CQI: Continuous Quality Improvement
DCBOH: DeKalb County Board of Health
DFCS: Georgia Division of Family and Children Services
DOC: Georgia Department of Corrections
DPH: Georgia Department of Public Health
EBIs: Evidenced-Based Interventions
eHARS: Electronic HIV/AIDS Reporting System
EMA: Eligible Metropolitan Area
FCDHW: Fulton County Department of Health and Wellness
FOCUS: Frontlines of Communities in the United States
FPL: Federally Poverty Level
FQHC: Federally Qualified Health Center
FTEs: Full Time Equivalents
G-PACC: Georgia Prevention and Care Council
HICP: Health Insurance Continuation Program
HIE: Health Information Exchange
HIPP: High Impact Prevention Program
HOPWA: Housing Opportunities for Persons with AIDS

HPSAs: Health Professional Shortage Areas
HRSA: Health Resources and Services Administration
ID: Infectious Disease
IDU: Injection Drug User
JPPG: Jurisdictional HIV Prevention Planning Group
PrEP: Pre-Exposure Prophylaxis
KFF: Kaiser Family Foundation
LGBT: Lesbian, Gay, Bisexual, Transgender
MAI: Minority AIDS Initiative
MMP: Medical Monitoring Project
MSA: Metropolitan Statistical Area
MSM: Men Who Have Sex with Men
MSW: Men Who Have Sex with Women
NHAS: National HIV/AIDS Strategy
NHBS: National HIV Behavioral Surveillance
nPEP: Non-Occupational Post-Exposure Prophylaxis
PAP: Patient Assistance Program
PLWH: Persons Living With HIV
PWID: Persons Who Inject Drugs
QM: Quality Management
SAMHSA: Substance Abuse and Mental Health Services Administration
SCSN: Statewide Coordinated Statement of Need
TasP: Treatment as Prevention
VL: Viral Load
WSM: Women Who Have Sex with Men

Appendix A

Funding Source	2016Budget		Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services–Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	**Outreach**	Psychosocial Support Services	Substance Abuse Services–Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	**%**																												
Part A	**$22,685,509**	**9.06**																												
AID Atlanta			X			X					X	X	X							X	X									II-V
AIDS Healthcare			X			X							X							X	X									II-V
Aniz, Inc.									X				X								X			X						III
Atlanta Legal Aid																			X											III
Clarke County			X			X															X									II-V
Clayton Co. BOH			X			X							X								X									II-V
Cobb & Douglas PH			X			X			X											X										II-V
DeKalb Co. BOH			x			X			X	X										X	X									II-V
Emory (Midtown)			X										X			X					X									II-V
Fulton Co. DHW			X			X			X	X		X	X			X					X									II-V
Grady IDP			X			X			X	X		X	X	X						X	X									II-V
Here's to Life												X	X			X		X			X									II-V
NAESM									X			X	X																	II-III
Positive Impact HC			X			X			X			X				X				X	X			X						II-IV
Project Open Hand										X						X														II-III
Recovery Consultants																					X									II-IV

Funding Source	2016Budget		Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium / Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
St. Joseph's Mercy Care			X			X							X			X														II-V
Part B	**$57,050,221**	**22.79**		X				X																						II-V
Chatham County – Health District			X			X			X	X	X		X		X		X				X									
Clarke County - Health District			X			X		X		X	X		X		X	X					X									
Clayton County – Health District			X			X							X		X						X		X							
Cobb County – Health District			X			X					X		X																	
Columbus County – Health District			X			X					X		X		X					X										
Dalton County – Health District			X										X		X															
Dougherty County – Health District			X			X		X			X	X	X		X	X	X					X		X		X					
Floyd County – Health District			X			X			X	X	X		X								X									
Positive Impact – Duluth			X			X					X		X		X															
Hall County – Health District			X							X	X		X		X	X				X	X									
Laurens County – Health District			X			X		X		X	X		X		X	X		X			X									
Lowndes County – Health District			X			X					X		X		X	X	X						X							

Funding Source	2016Budget		Outpatient Ambulatory HealthServices	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-SharingAssistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Macon County – Health District			X						X		X		X		X						X									
Richmond County – Health District			X			X			X		X		X		X		X	X			X		X							
AID Atlanta – LaGrange			X			X					X		X		X						X									
Ware County – Health District			X			X		X		X	X		X		X		X				X				X					
Georgia Department of Corrections											X																			
Fulton/DeKalb Hospital Authority			X																											
Time Logistics			X																											
Georgia State Laboratory			X																											
Part C	**$10,566,756**	**4.22**																												II-V
Albany Area Primary Health Care, Inc. - Albany			X																											
Specialty Care Clinic – Clarke County - Athens									X		X		X								X									
AID Atlanta, Inc. - Atlanta			X								X				X						X									

Funding Source	2016Budget		Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Output.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Emory University – Atlanta			X								X																			
St. Joseph's Mercy Care – Atlanta			X																											
Georgia Regents University – Augusta			X																											
Columbus Department of Public Health			X			X				X											X									
North GA Health District – Dalton			X			X			X	X		X																		
DeKalb County Board of Health – Decatur			X																											
Laurens County Public Health – Dublin			X																											
Positive Impact Health Centers – Duluth			X							X	X		X																	
Hall County Public Health – Gainesville			X						X	X	X				X															
Clayton County Public Health – Jonesboro										X			X																	
Houston County Board of Health –			X						X		X				X															

Funding Source	2016Budget		Outpatient Ambulatory HealthServices	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Macon																														
Cobb County Board of Health – Marietta			X			X				X	X																			
Floyd County Health Department – Rome			X						X	X											X									
Chatham County Board of Health – Savannah									X			X	X																	
Lowndes County Health Department – Valdosta			X								X		X			X														
Ware County Board of Health – Waycross			X						X		X	X	X		X	X	X				X									
Part D	**$1,560,039**	**0.62**																												**II-V**
Chatham County Health Department - Savannah			X			X			X	X	XXX									X										
Ware County Health Department - Waycross			X			X					X						X			X	X									
Grady Infectious Disease Program			X																		X									

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
- Atlanta																														
Part F																														
SPNS	-0-																													
AETC	$284,014	0.11																												
Morehouse School of Medicine																														
Dental Program	$184,972	0.07																												
Georgia Regents Research Institute, Inc. - Augusta																														
MAI																														
Part B MAI	$557,798	0.23																												II-V
Chatham County – Health District																	X					X								
Clayton County – Health District																	X					X								
Columbus County – Health District																	X					X								
Dougherty County – Health District																	X					X								

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Richmond County – Health District																	X					X								
Ware County – Health District																	X					X								
Part A MAI	**$2,338,289**	**0.93**																												II-V
Grady Infectious Disease Program			X																											
CDC																														
Directly Funded	**$3,902,274**	**1.56**																												
Georgia Dept. of Public Health – Surveillance																														
Georgia Dept. of Public Health - MMP																														
St. Joseph's Mercy Care																									X					
AID Atlanta, Inc.																									X					
Positive Impact Health Centers																									X					
Georgia Dept. of Public Health – NHBSS																														
Emory University																														

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Georgia Department of Public Health	**$4,764,651**	**1.90**																												**i-ii**
District 1-1 Rome																										X	X			
District 1-2 Dalton																										X	X			
District 2 Gainesville																										X	X			
District 3-1 Cobb/Douglas																										X	X	X		
District 4 LaGrange																										X	X			
District 5-1 Dublin																										X	X			
District 5-2 Macon																										X	X			
District 6 Augusta																										X	X	X		
District 7 Columbus																										X	X			
District 8-1 Valdosta																										X	X			
District 8-2 Albany																										X	X			
District 9-1 Savannah																										X	X	X	X	

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
District 9-2 Waycross																										X	X			
District 10 Athens																										X	X			
AID Atlanta, Inc.																										X				
Comprehensive AIDS Resource Encounter, Inc.																										X	X	X		
Positive Impact Health Center																										X	X	X		
Someone Cares, Inc.																										X	X			
Fulton County Dept. of Health and Wellness	$8,032,822	3.21																												i-ii
AID Atlanta, Inc.																										X	X	X	X	
AIDS Research Consortium																										X	X	X	X	
Aniz, Inc.																										X	X	X	X	
Atlanta Harm Reduction																										X	X	X	X	
Center for Black Women																										X	X	X	X	
NAESM, Inc.																										X	X	X	X	

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Positive Impact Health Centers																										X	X	X	X	
Recovery Consultants																										X	X	X	X	
St. Joseph Mercy Care																										X	X	X	X	
Grady IDP																										X	X	X	X	
Emory Fulton and DeKalb County Jail Project																										X	X	X	X	
SAMHSA	**$6,618,139**	**2.64**																												
Albany State University – Albany																														
Savannah State University – Savannah																														
Morehouse School of Medicine, Inc. – Atlanta																														
Spelman College - Atlanta																														
Georgia State University – Atlanta																														

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																											
Morris Brown College - Atlanta																													
Recovery Consultants of Atlanta, Inc. – Atlanta																													
Positive Impact Health Centers – Duluth																													
Paine College – Augusta																													
West Care Georgia, Inc. – Atlanta																													
St. Joseph's Mercy Care Services, Inc. – Atlanta																													
HIV/AIDS Empowerment Resource Center – Atlanta																													
Georgia Regents Research Institute, Inc. – Augusta																													
Cobb County Community Services Board – Marietta																													

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost - Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
HUD/HOPWA																														
Department of Community Affairs	$2,256,003	0.90																X												
Augusta - Richmond County	$1,072,089	0.43																X												
City of Atlanta - HOPWA	$18,078,087	7.22																X												
AIDS Athens																														
AIDS Legal Project																														
Covenant House																														
Furniture Bank																														
Jerusalem House																														
Legacy House																														
Legacy Village																														
Making a Way Housing																														
Project Open Hand																														

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Positive Impact																														
The Edgewood Center																														
Bureau of Primary Health	**$6,887,100**	**2.75**																												
Albany Area Primary Health Care – Albany																														
Athens Neighborhood Health Center																														
Center for PanAsian Community Services – Atlanta																														
Christ Community Health Centers – Augusta																														
Coastal Health Services – Brunswick																														
Community Health Center – Wrightsville																														

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Diversity Health Center – Ludowice																														
East Georgia Healthcare – Swainsboro																														
Family Health Centers of GA – Atlanta																														
First Choice Primary Care, Inc. – Macon																														
Georgia Highlands Medical – Cumming																														
Good Samaritan Health Center – Marietta																														
J.C. Lewis Health Center – Savannah																														
McKinney Community Health Center – Waycross																														
Oakhurst Medical Centers, Inc. – Stone Mountain																														

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Palmetto Health Council – Atlanta																														
Primary Care of South-West GA - Blakely																														
Primary Care Center of Dade – Trenton																														
St. Joseph's Mercy Care Services – Atlanta																														
South Central Primary Care Center – Ocilla																														
Southside Medical Center – Atlanta																														
Southwest Georgia Healthcare - Richland																														
Tender Care Clinic – Greensboro																														
Valley Healthcare System - Columbus																														

Funding Source	2016Budget		Outpatient Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical .Assist	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpt.	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach	Psychosocial Support Services	Substance Abuse Services – Res.	Treatment Adherence Counseling	HIV Prevention and Testing	Condom Distribution	Prevention with Positives	Prevention with Negatives	HIV Care Continuum Impact
	Dollar Amount	%																												
Office of Minority Health	$415,000	0.17																												
Wholistic Stress Control Institute – Atlanta																									X				
Recovery Consultants of Atlanta - Atlanta																									X				
State Funds																														
Part B Match	$16,739,986	6.69	X		X																									
County Funds																														
Fulton County	$629,811	0.25																												
Medicaid	$85,669,910	34.23	X		X																									
TOTAL FUNDING	$250,301,521	100																												i-v

Appendix B				
2015-2020 NHAS Goal 1: Reducing new HIV Infections.				
2017-2021 SMART Objective 1: By December 2021, increase the percentage of people living with HIV (PLWH) who know their serostatus to 90%.				
Strategy 1: Intensify HIV testing efforts in the communities where HIV is most heavily concentrated.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	Georgia Department of Public Health (DPH) DeKalb County Board of Health (DCBOH) Fulton County Department of Health and Wellness (FCDHW) Funded Community Based Organizations (CBOs) Local Health Depts.	Increase HIV testing in geographical areas with high burden of disease among priority populations.	AA MSM MSM Transgender AA Women Hispanics	• Number of HIV tests performed • HIV positivity rate • Number linked to medical care
By December 2017 and ongoing:	DCBOH FCDHW Funded CBOs	Utilize mobile HIV testing units in zip codes with high HIV incidence and prevalence in Fulton and DeKalb Counties.	AA MSM MSM Transgender (MTF) AA Women Hispanics	• Number of HIV tests • Number of mobile units utilized and frequency • Positivity rates • Number of positives linked to care • Number of negatives

				linked/enrolled/ referred for PrEP
Strategy 2: Reduce barriers to prevention services for rural MSM.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	DPH G-PACC	Assess rural MSM prevention needs and barriers to accessing services.	MSM	• Number of participants completing assessment • Report on barriers
By December 2021:	DPH G-PACC	Establish HIV testing centers in post-secondary institutions where individuals are burdened with increased levels of infection.	General Population	• Number of new testing sites
By December 2017 and ongoing:	DCBOH FCDHW Funded CBOs	Provide population based interventions at health departments and CBOs.	AA MSM MSM Transgender (MTF) AA Women Hispanics	• Number of participants in each intervention • Number of participants reporting behavioral change including risk reduction
By December 2021:	DPH G-PACC	Increase testing sites in jails in areas of high burden.	Jails	• Number of new testing sites in jails
2017-2021 SMART Objective 2: By December 2021, reduce the number of new diagnosis by at least 25%.				
Strategy 1: Expand access to effective prevention services and intensify efforts, including pre-exposure prophylaxis (PrEP).				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and annually:	DPH Part B Recipient	Allocate State funding consistent with the geographic distribution of the epidemic for the provision of staffing for PrEP clinics.	People at high risk of HIV exposure	• Number of positions hired for clinics

By December 2017 and biannually:	DPH G-PACC	Utilize the CAPUS resource Hub to update PrEP clinical providers as well as increase the awareness of PrEP clinical providers by tasking the Georgia Planning and Care Council to provide an updated HIV resource manual every 2 years.	Clinical Providers	• Updated HIV resource manual
By December 2017 and biannually:	DPH G-PACC FCDHW DCBOH	Broaden community awareness of PrEP and nPEP prevention of HIV infection among high risk populations.	MSM AA Women Young AA MSM	• Number of media exposures • Number of persons on PrEP • Number of persons on nPEP
Strategy 2: Provide HIV perinatal services to reduce seroconversion.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	DPH G-PACC FCDHW Part D	Promote mental health and substance abuse services to mothers after delivery.	HIV positive mothers	• Number of HIV positive mothers offered services
By December 2017 and ongoing:	DPH G-PACC FCDHW Part D	Strengthen and expand the linkage process for HIV positive mothers who are in need of postpartum care for babies.	HIV positive mothers	• Number of HIV positive mothers linked to services
By December 2017:	DPH G-PACC FCDHW Part D	Collaborate with providers visiting delivery hospitals to link newly diagnosed women into care.	HIV positive mothers	• Number of HIV positive mothers linked to care

Strategy 3: Present perinatal cases to a case review team to identify gaps and missed opportunities to develop recommendations for improvements.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	DPH Part D	Ensure HIV positive mothers receive training to increase medical adherence.	HIV positive mothers	• Number of HIV positive mothers trained
By December 2017 and ongoing:	Parts A, B, and D Recipients FCDHW	Review no shows and appointment processes in local Ryan White clinics and strengthen processes to include follow-up with clients to ensure linkage.	HIV positive mothers	• Number of HIV positive mothers linked to care
2017-2021 SMART Objective 3: By December 2021, increase the number of persons provided accurate information about HIV risks, prevention and transmission.				
Strategy 1: Educate Georgians about the threat of HIV and how to prevent it.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
2017-2021:	DCBOH FCDHW DPH	Provide Comprehensive Training and Capacity Building Assistance to service providers in HIV-related work/services.	General population Service providers (i.e. CBO, ASO, etc.)	• Number of evaluations completed • Sign-in sheets • Pre-test/post-test
By December 2021:	DPH G-PACC	Expand marketing campaigns in health district neighborhoods burdened with increased levels of infection.	General population	• Number of marketing campaigns conducted
By December 2017:	G-PACC	Broaden community participation with Georgia Prevention and Care Council activities.	General population	• Number of new participants
Strategy 2: Ensure that opt-out HIV screening is provided as a standard of care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	DPH FCDHW DCBOH	Increase HIV testing in Federally Qualified Health Centers (FQHCs).	FQHCs	• Number of FQHCs providing opt-out HIV testing

Each year from 2017 - 2021, increasing the number of agreements in 17% increments:	FCDHW DCBOH Hospital Administrators Hospital staff	Enter into agreements with Fulton and DeKalb County hospitals and outpatient clinics.	MSM Transgender Hispanics General Population	• Number of HIV tests performed • HIV positivity rate • Number linked to medical care • Number of agreements in place
2015-2020 NHAS Goal 2: Increase access to care and improve health outcomes.				
2017-2021 SMART Objective 1: By December 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of HIV diagnosis to at least 90% and engage individuals identified as out of care (no medical appointment in last 6 months).				
Strategy 1: Establish seamless systems to link people to care immediately after diagnosis.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017:	Ryan White Recipients FCDHW DCBOH DPH	Evaluate administrative process and remove barriers including duplicative paper work to facilitate entry into Ryan White Programs (e.g., scanning eligibility forms). Standardize linkage protocols across programs to ensure clients have one provider appointment within 30 days of diagnosis.	AA MSM MSM Transgender AA Women Hispanics	• Linkage protocols standardized and implemented • Number of patients seen by medical provider within 30 days of diagnosis
Strategy 2: Establish rapid entry clinics to link clients to care and medications within 72 hours for newly diagnosed persons and 7 days for identified as out of HIV care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By February 28, 2017; and ongoing:	Part A Recipient and Subrecipients	Implement and maintain rapid entry clinic system that includes establishment of at least 2 rapid entry clinics. Link 90% of newly diagnosed persons to care within 72 hours through rapid entry care clinics and co-location of services to ensure the client is served until a slot	AA MSM AA Women Transgender Hispanics	• Number of HIV tests performed overall and for each target population • Number of people who tested positive

		opens at RW clinic of patient choice for on-going care and treatment. Enroll clients with preliminary HIV diagnosis in care within 72 hours to lessen the time between diagnosis and entry in care. Link identified out of care individuals living in the Atlanta EMA to HIV care within 7 days. Evaluate processes to remove barriers to rapid entry care.		overall and for each target population. • Number of people linked to care within 72 hours • Number of people lost to care who were linked to care within 7 days
Strategy 3: Provide HIV resources in communities/zip codes with the highest concentration of health disparities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish mobile clinics by February 28, 2017; ongoing service delivery through December 2021:	Part A Recipient and Subrecipients including Medical Case Managers	Identify communities/zip codes with highest concentration of health disparities. Assess disparities in communities/zip codes where HIV is most heavily concentrated to identify existing HIV service provider locations and services as well an HIV resource gaps and barriers. Based on assessment, establish the health resources to be provided through mobile clinic system. Develop partnerships with existing HIV service providers in targeted areas. Develop and implement communications plan to educate community and existing providers about the availability of mobile clinic HIV services and how to access these services. Implement system of at least two mobile clinics to serve identified zip codes with highest	AA MSM AA Women Transgender Hispanics	• Number of clients served in identified zip codes by mobile clinics • Number/percent of clients served in mobile clinics that are retained in care (two or more medical visits performed at least three months apart)

		concentrations of health disparities and improve access to care. Integrate HIV services in existing clinical practices.		
Strategy 4: Prioritize and evaluate gaps in knowledge and services along the care continuum.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Parts A and B Recipients and Subrecipients Part A Planning Council	Conduct Client Needs Assessment to identify gaps in and barriers to services and inform priority setting and resource allocation planning teams. Implement strategies to reduce barriers to care and increase linkage to core medical and support* services to address HIV-related co-occurring conditions and identified client challenges. Increase client awareness of available HIV services and how to access them via Part A Planning Council Atlanta Area Outreach Initiative (AAOI) Resource guide, CAPUS resource hub, Part A Website, etc. Implement annual Client Satisfaction Survey and a Consumer Survey every third year to assist with service delivery monitoring and Continuous Quality Improvement. *Support Services include medical transportation, housing, non-medical case management, food bank/home delivered meals, etc.	AA MSM AA Women Transgender Hispanics	• Needs Assessment report identifying gaps and barriers • Type/number of services clients receive • Client satisfaction and consumer update findings
Strategy 5: Provide funding for initiatives to improve linkages between HIV testing and HIV care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through	CDC and Part B Linkage to Care Coordinators	Establish partnership with Prevention to add medical provider to treat newly diagnosed after testing on mobile units.	AA MSM AA Women Transgender	• Number of people tested • Number/percent of people

December 2021:	Part A Patient Navigators, Case Managers (Non-Medical) Part A Planning Council CDC-funded High Impact Prevention Program, DPH Prevention Program FCDHW CDC funded sites	Collaborate with HIV testing teams to connect newly diagnosed and previously diagnosed positive persons to care. Allocate funding for Insurance Navigators to enroll HIV positive individuals in Health Insurance Marketplace. Continue funding for Psychosocial Support Services (Patient Navigation) in seven primary care sites to assist Linkage to Care Coordinators with enrollment and retention in care of newly diagnosed persons.	Hispanics	testing HIV positive • Number/percent of people linked to care • Number of people enrolled in Georgia Health Insurance Marketplace • Number of newly diagnosed persons receiving Psychosocial Support Services that are enrolled in care
Strategy 6: Reduce barriers for clients accessing care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017:	Ryan White Recipients Health Dept. Staff Supported CBO Staff Supported Hosp. Staff DPH Supported Health Districts	Utilize case management services to remove barriers. Expand ARTAS and other linkage resources.	AA MSM MSM Transgender AA Women Hispanics	• Number of clients who received support* services • Number and type of support services accessed
Strategy 7: Incorporate opportunities for client engagement into all aspects of service delivery.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end	Ryan White	Link and/or reengage individuals	AA MSM	• Number of

of 2017:	Recipients Health Dept. Staff Supported CBO Staff Supported Hosp. Staff DPH Supported Health Districts	who are "out of care".	MSM Transgender AA Women Hispanics	trained navigators • Number of clients reengaged
Strategy 8: Expand linkage processes in correctional facilities to ensure newly released persons are linked to a medical appointment within 30 days of release.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017:	Ryan White Recipients and Subrecipients Funded Discharge Linkage Teams FCDHW DCBOH Funded CBOs Department of Corrections	Ensure medical records are available. Provide pre-release linkage with 30 days of medicine. Provide effective transition via jail discharge linkage teams to ensure continuity of medical for discharged persons.	AA MSM MSM Transgender AA Women Hispanics	• Number linked to medical care within 30 days of release • Number released with 30 days of medicine
2017-2021 SMART Objective 2: By 2021, increase the percentage of people living with HIV/AIDS (PLWH) from 85% to at least 90% who are virally suppressed.				
Strategy 1: Prescribe antiretroviral medications for at least 90% of clients enrolled in medical care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December	Parts A and B Subrecipients Funded Health Care Teams,	Offer 100% of patients ART. Provide intensive treatment adherence counseling for 100% of clients prescribed ART.	AA MSM AA Women Transgender	• Number/percent of clients prescribed ART • Number/percent

2021:	Medical Case Managers, and Discharge Linkage Teams		Hispanics	of clients who are virally suppressed

Strategy 2: Deliver intensive treatment adherence counseling.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2017; ongoing through December 2021:	Part A Recipient and Subrecipients for OAHS and Medical Case Management, Training Consultants, and, Evaluation Consultants Part B Recipient and Subrecipients	Through training and chart documentation, ensure 100 % of clinicians follow published Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents and Guidelines for the Prevention and Treatment of Opportunistic Infections. During each clinic visit, provide clients with counseling by Medical Clinicians or Medical Case Managers on the importance of treatment adherence as needed. Identify clients with highest risk of non-treatment adherence, (e.g., detectable viral load, missed appointments, substance use and/or mental health disorders, etc.) and provide 100% of identified clients with intensive treatment adherence counseling and support.	AA MSM AA Heterosexuals Transgender Hispanics	• Clinical chart reviews of documentation • Number/percent of clients receiving counseling • Number of clients identified at risk by risk type • Number/percent of clients identified at risk that receive intensive treatment adherence counseling and support • Number/percent of clients that are virally suppressed after receiving counseling and support

Strategy 3: Implement systematic approaches to address gaps in antiretroviral use.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2017:	Parts A and B Recipients and Subrecipients	Provide rapid initiation of ART for 100 % clients and continue provision until ADAP or Patient Assistance Program coverage	AA MSM AA Women	• Number/percent of clients prescribed ART

	Medical Case Managers Non-Medical Case Managers	begins. Fund Medical Case Managers at primary care sites to provide treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatment. Through Non-Medical Case Managers, enroll clients in ADAP or Patient Assistance Programs. Complete ADAP electronic enrollment applications/ recertifications for 100% of eligible clients during medical appointments at care sites and Medical Case Managers office. Establish ADAP policy to allow presumptive enrollment with awaiting client documentation.	Transgender Hispanics	at first medical visit • Number of electronic ADAP applications completed • Number/percent of clients enrolled in ADAP • Number/percent of clients enrolled in Patient Assistance Programs • Number/percent of clients re-certified without an interruption in medications.
2017-2021 SMART Objective 4: By 2021, increase the number of PLWH retained in care to 90%.				
Strategy 1: Expand resources and clinic hours in underserved geographic areas to provide PLWH with more access to care options.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Part A Recipient and Subrecipients	Implement system of mobile units, satellite clinics, and expanded clinic hours (evening and Saturdays). Establish relationships with non-traditional partners including FQHCs.	AA MSM AA Women Transgender Females Hispanics	• Number of clients served by mobile units and satellite clinics • Number of clients served during expanded clinic hours • Number of non-traditional partnerships

				established
Strategy 2: Improve retention in care for people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high risk populations) have access to medical and support services.	PLWH	• Retention rate
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high risk populations) have access to antiretroviral therapy (ART).	PLWH	• Number of people on ART
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Review no shows and appointment processes in local Ryan White clinics and strengthen processes to follow-up with clients to reduce gaps in the delivery of services along the care continuum.	PLWH who are no shows to medical appointments	• Rate of no shows
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Identify clients that have fallen out of care and attempt to reengage them into care.	PLWH out of care	• Number of out-of-care persons linked
By December 2017 and ongoing:	Ryan White Recipients	Provide information, resources, and technical assistance to service providers to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided
Strategy 3: Increase the number of available providers of clinical care and related services for people living with HIV.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Part B Recipient and Subrecipients	Increase the number of available providers of HIV care.	Ryan White clinics PLWH	• Number of providers
By December 2021:	Part B Recipient and Subrecipients	Increase the current provider workforce to ensure the delivery of quality care.	Ryan White clinics PLWH	• Number of new medical and non-medical providers
By December 2021:	Ryan White Recipients and Subrecipients GA AETC	Provide training for the current provider workforce.	Ryan White clinics PLWH	• Number of providers trained

Strategy 4: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-morbidities and challenges in meeting basic needs.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Leverage available resources for primary care and support services.	PLWH	• Number of medical providers • Number of support services provided
Strategy 5: Reengage individuals identified as out of HIV care within seven days of identification implementing Data to Care models.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017, ongoing:	DPH Linkage Staff	Identify those out of HIV care persons accessing health care for reasons unrelated to HIV. Utilize "Data to Care" models to link 90% of individuals identified as out of care to HIV medical care within seven (7) days of identification.	AA MSM MSM Young AA MSM AA Women Transgender Females Hispanics	• Identify those out of HIV care persons accessing health care for reasons unrelated to HIV • Link 90% of individuals identified as out of care to HIV medical care within at least 30 days of identification • # of clients on out of care list re-engaged into care • # of sites implementing data to care model(s)

Strategy 6: Provide Health Insurance Premium Support				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017, ongoing:	Ryan White Recipients and Subrecipients	Identify RW clients who are eligible for Affordable Care Act (ACA) enrollment and vigorously pursue enrollment into a third party payer. Partner with enrollment agencies to help Ryan White Eligible clients who are 100% of federal poverty level or above to enroll in a 3rd party payer. Fund medication co-insurance payments for antiretroviral medications for clients enrolled in Health Insurance Exchange/Marketplace. Enroll eligible clients in Health Insurance Continuation Program (HICP) and Health Insurance Premium (HIP) program. Utilize Part A funding to assist with ACA enrolled clients' out of pocket costs such as deductible and co-insurance of outpatient medical care.	Ryan White Eligible Population	• Chart Reviews (Eligibility and Enrollment Files) • Number of clients uninsured versus insured • Number/ percent of eligible clients enrolled in Health Insurance Exchange • Number/ percent of clients enrolled in HICP/HIP
Strategy 7: Ensure availability of core and other support services to improve access to and retention in care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017, ongoing:	Ryan White Recipients and Subrecipients Part A Planning Council	Utilize Ryan White and other funding sources to provide core and support services for Ryan White eligible clients.	PLWH	• Type/number of services • Number/percent of clients receiving core services • Number/percent of clients receiving support services

				• Number/percent of PLWH linked to care • Number/percent of clients retained in care
2015-2020 NHAS Goal 3: Reduce HIV related health disparities and health inequities.				
2017-2021 SMART Objective 1: By December 2021, increase the percentage of persons diagnosed with HIV infection that are virally suppressed to at least 80%.				
Strategy 1: Support retention in care to achieve viral suppression and reduce transmission risk.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Parts A and B Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high risk populations) are retained in care and are receiving medical and support services.	PLWH	• Retention rate
By December 2021:	Parts A and B Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high risk populations) have access to antiretroviral therapy.	PLWH	• Number of people on ART
By December 2021:	Parts A and B Recipients and Subrecipients	Review no shows and appointment processes in Ryan White clinics and strengthen processes to follow-up with clients to reduce gaps in the delivery of services along the care continuum.	PLWH who are no shows to medical appointments	• Rate of no shows
By December 2021:	Parts A and B Recipients and Subrecipients	Identify clients that have fallen out of care and attempt to reengage them in care using the Data to Care model.	PLWH out of care	• Number of out-of-care persons linked
By December 2021:	Parts A and B Recipients GA AETC	Provide information, resources, and technical assistance to service providers to strengthen the delivery of services along the care continuum.	Ryan White clinics and providers	• Number of technical assistance sessions provided
Strategy 2: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-morbidities and challenges in meeting basic needs.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2021:	Ryan White Recipients	Provide eligible clients with HVC medications.	PLWH	• Number of clients receiving HVC medications

2017-2021 SMART Objective 2: By 2021, reduce disparities related to race, sexual orientation, gender, gender identity, and age to improve retention in care of targeted populations by 50%.				
Strategy 1: Establish mobile units to facilitate access to care.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Establish mobile clinics by February 28, 2017; ongoing service delivery through December 2021:	Part A Recipient and Subrecipients	Implement system of at least two mobile clinics to serve identified zip codes and improve access to care. Identify potential community clinic partners to provide HIV services collaboratively. Partner with existing community clinics to provide HIV services in the targeted areas. Expand evening and weekend clinic hours to allow more options for accessing care. Develop and implement awareness communications plan to inform PLWH in targeted communities about available HIV services.	AA MSM AA Women Transgender Females Hispanics	• Number/percent of clients receiving mobile clinic services • Number/percent of clients receiving HIV services through partnerships with community clinics • Number/percent of clients accessing care through evening clinic hours • Number/percent of clients accessing care through weekend clinic hours • Communication plan established
Strategy 2: Support access to continuous comprehensive care along the continuum to reduce disparities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Increase the number of Patient Navigators and maintain funding levels to provide Peer Counselors. Conduct ongoing awareness campaigns targeted at communities with greatest health disparities.	AA MSM AA Women Transgender Females Hispanics	• Number of Patient Navigators • Number of Peer Counselors

		Conduct outreach to Spanish speaking communities. Provide linguistic services to 100 % of Spanish speaking clients, including use of patient education materials in Spanish. Provide assistance for 100% of clients with vision and/or hearing impairments. Provide support services to decrease barriers to care, including medical transportation and translation assistance. Increase third party coverage for eligible clients. Explore innovative treatment options such as Telemedicine for clients.		• Number/percent of clients in communities with greatest health disparities that receive peer support services • Number/percent of clients receiving specified support services • Number/percent of clients enrolled in HIP/HICP
Strategy 3: Increase the provision of integrated services to reduce social determinants of health and reduce HIV-related health disparities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Part A Recipient and Subrecipients	Co-locate Behavioral Health services on site in at least six clinic sites. Screen 100% of new clients for behavioral health needs. Based on client assessment, schedule 100% of clients with identified behavioral health needs for same day behavioral health appointment as HIV primary care visit for clinics with co-located services. Based on client assessment, implement same day behavioral health referral for 100% of clients with behavioral health needs when behavioral health services are not available onsite.	PLWH	• Number/percent of clients identified with mental health needs • Number/percent of clients identified with substance use disorders • Number/percent of clients to onsite co-located mental health and/or substance use services

				• Number/percent of clients referred same day for offsite mental health and/or substance use services
By December 2017 and ongoing:	Ryan White Recipients and Subrecipients	Assess 100% of new clients for co-morbid conditions and other health related needs. Refer clients with identified co-morbidities to resources to provide education on healthy lifestyles. Provide resources provisions to treat clients with high rates of serious medical co-morbidities, significant oral disease, severe mental illness, neuropsychiatric conditions, chronic substance dependence and multiple psychological challenges.	PLWH	• Number/percent of clients assessed for co-morbid conditions and other health related needs • Number of clients referred to community resources and specialty clinics • Number of clients treated for co-morbid conditions
Strategy 4: Reduce stigma and discrimination based on HIV status, gender identity and expression, sexual identity and expression, race/ethnicity, and socioeconomic status among PLWH.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Ryan White Recipients Part A Subrecipients Part A Planning Council FCDHW DCBOH DPH	Conduct training for provider staff and partner agencies (i.e., pharmacies, specialty vendors, etc.) on: Office of Minority Health's National Culturally and Linguistically Appropriate Standards (CLAS); providing culturally and linguistically appropriate care for LGBT, gender identity and sexual identity and expression, non-English speaking populations, African American and Hispanics, precariously housed and homeless, formerly incarcerated, substance users, individuals with	Providers and partner agencies	• Number of trainings • Number/percent of Part A funded agencies with staff participating in training • Number/percent of partner agencies with staff participating in

	GA AETC	mental health problems, and lower socioeconomic populations; health disparities and impact of social determinants of health; the impact of stigma and discrimination; and state and federal laws on stigma, discrimination and criminalization of HIV.		training • Number of provider staff trained with training documented in personnel records • Pre/posttest training results
By December 2017 and ongoing:	Part A Recipient and Subrecipients	Require that 100% of funded Part A providers implement at least one strategy annually in each of the three CLAS component categories (i.e., 1) Governance, Leadership, and Workforce; 2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability).	Part A-funded agencies	• Number/ percent of funded agencies that have implemented at least one strategy in each of the three CLAS categories • Number/type of stigma and discrimination awareness campaign activities implemented

2017-2021 SMART Objective 3: By 2021, 90% of clients among minority populations engaging in HIV care will achieve a viral load of less than 200 copies/mL.

Strategy 1: Direct Minority AIDS Initiative (MAI) funds to providers possessing HIV treatment expertise and experience in addressing treatment barriers experienced among socially marginalized and isolated populations.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2017; ongoing through December 2021:	Ryan White Part A MAI Subrecipient including Nurse Educators, Clinical Pharmacists, and Medical	Establish partnerships with MAI providers equipped with resources to treat patients with high rates of serious medical co-morbidities, significant oral disease, severe mental illness, neuropsychiatric conditions, chronic substance dependence and multiple psychological	AA MSM Hispanics Women, Infants, Children, and Youth	• Number of Subrecipient/ Providers funded

	Case Managers	challenges.		
Strategy 2: Increase efforts to improve HIV care access, retention and treatment adherence among underserved individuals.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Ryan White Part A MAI Subrecipient, funded Nurse Educators, Clinical Pharmacists, and Medical Case Managers	Expand Ryan White Clinic operating hours (i.e., evening hours and/or weekends) in at least three of five targeted zip codes in order to meet the needs of "hard-to-reach" populations. Allocate resources for walk-in (no appointment) clinics. Allocate resources to increase appointment scheduling flexibility in at least one specialized clinic targeted toward the needs of "hard-to-reach" populations.	AA MSM Hispanics Women, Infants, Children, and Youth	• Number of service locations • Number of clients served at each service location • Number of service locations with expanded operating hours • Number of clients accessing services during expanded operating hours • Number of walk-in clinics • Number of clients using walk-in clinic services • Number of specialized clinics offering appointment scheduling flexibility
By December 31, 2017; ongoing through December 2021:	Part B Recipient	Connect newly diagnosed and previously diagnosed clients to ADAP and other medication services.	AA MSM AA Women Hispanics Transgender	• Number of clients enrolled and receiving ADAP services

By December 31, 2017; ongoing through December 2021:	DPH	Expand Test-Link-Care Network to link and re-engage PLWH not in care and identify barriers to retention. Enhance active re-engagement by linkage staff using DPH Data to Care models.	AA MSM AA Women Hispanics Transgender	• Number of TLC networks • Number of clients linked and reengaged using Data to Care
Strategy 3: Provide enhanced treatment adherence support and education for populations at higher risk of not achieving viral suppression.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Ryan White Recipients and Subrecipients	Provide 100% of clients with HIV educational information on enrollment at HIV service delivery sites. Ensure educational materials are culturally and linguistically appropriate. Provide 100% of enrolled clients with annual education opportunities. Provide 100% of clients with treatment adherence counseling at initiation of ART. Identify clients who are not virally suppressed and provide treatment adherence support (i.e., counseling reminders) for 90% of these clients. Implement innovative youth-oriented initiatives to assist youth with treatment adherence and engagement in care (e.g., use of social marketing, youth transition to adult care activities). Provide comprehensive outpatient health services to include resistance testing, diagnostic procedures, general lab, radiology, treatment, adherence counseling and support.	AA MSM Hispanics Women, Infants, Children, and Youth	• Number/percent of clients receiving educational information at enrollment • Number/type of educational offerings for clients • Number/percent of clients provided with treatment adherence support at ART initiation • Number/percent of clients not virally suppressed prior to receiving treatment adherence support • Number/percent of clients virally suppressed after receiving enhanced

		Provide innovative youth-oriented initiatives to assist with the transition into adult care.		treatment adherence support • Number/type of youth-oriented initiatives implemented • Number/percent of youth receiving transition to adult care at age 25
2017-2021 SMART Objective 4: By 2021, reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black/African American gay and bisexual men, and Black/African American women.				
Strategy 1: By 2021, reduce HIV-related disparities in communities at high risk.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Between 2017 and 2021:	FCDHW DCBOH DPH and Local Health Departments	Utilize PrEP clinics to reduce new HIV infections and provide high risk negatives (HRN) access to HIV prevention education and services.	AA YMSM MSM Transgender Women AA Women Hispanics	• Number enrolled in PrEP services • Number of HIV Tests performed • Number of persons retained in PrEP services • Number of HRNs that are newly diagnosed HIV positive • Number of PrEP counseling/ health education

				sessions provided • Number of condoms distributed to HRNs via PrEP clinic
Between 2017 and 2021:	FCDHW mobile unit staff DCBOH mobile unit staff	Utilize mobile units to conduct HIV testing, outreach, and recruitment in high incidence and prevalence neighborhoods throughout Fulton and DeKalb Counties.	AA YMSM MSM Transgender Women AA Women Hispanics	• Number of HIV tests performed • HIV positivity rate • Number linked to medical care • Number of outreach events conducted
Strategy 2: Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
Between 2017 and 2021:	FCDHW DCBOH DPH	Routinize the screening of sexually transmitted infections/diseases, viral hepatitis, and tuberculosis in the health departments within communities disproportionately impacted by HIV.	AA MSM Transgender Women AA Women Hispanics	• Number of STI, VH, and TB tests performed among persons with HIV • Number of STI tests performed in conjunction with HIV tests
Between 2017 and 2021:	FCDHW DCBOH DPH Part D	Build partnerships with youth leaders, adult allies, and youth-serving organizations for policies and champion programs that recognize young people's rights to scientifically and medically accurate sexual health information.	Youth and young adults 13-24	• Number of Capacity Building requests from schools • Number of

	CBOs			trainings provided to schools • Number of partnerships developed • Number of Atlanta Public Schools, Fulton County Schools, Decatur City Schools, DeKalb County Schools implementing comprehensive sex education
Strategy 3: Reduce stigma and eliminate discrimination associated with HIV status.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By the end of 2017:	DCBOH FCDHW CBOs DPH and Supported Health Districts	Provide CDC supported evidence- based interventions.	General Population PLWH	• Number of participants in interventions • Number of implemented interventions
By the end of 2017:	DCBOH FCDHW DPH	Provide CBO/ASO technical assistance for interventions.	CBOs/ASOs	• Number of agencies provided technical assistance
By the end of 2017:	FCDHW DPH	Implement anti-stigma campaign inclusive of print and digital media and marketing.	AA MSM Transgender Women AA Women Youth and Young Adults	• Number of media impressions Key Performance Indicators: reach, demographics

			Hispanics	and location
By the end of 2017:	FCDHW CBOs DPH	Promote the involvement of businesses in HIV and AIDS awareness, prevention, education, and mobilization through the Business Responds to AIDS (BRTA) program.	General Population	• Number of businesses enrolled • Pre- and post-surveys of attitudes, beliefs and knowledge
2015-2020 NHAS Goal 4: Achieve a more coordinated response to the HIV epidemic in Georgia.				
2017-2021 SMART Objective 1: By 2021, increase coordination of HIV programs across the state of Georgia.				
Strategy 1: Institute integrated planning processes for the delivery of HIV prevention and treatment services in Georgia.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	DPH Parts A and B Recipients G-PACC Part A Planning Council FCDHW DCBOH	Hold annual meetings with (CDC & HRSA) funded parts, agencies, administration, HOPWA, Veterans Administration (VA), SAMHSA, PLWH, other providers, and AIDS Service Organizations (ASOs)/Community-Based Organizations (CBOs) to share information, including best practices, and obtain input to support integrated planning. Establish G-PACC work groups to monitor and share progress towards NHAS goals and Integrated Plan objectives. Plan and implement annual Atlanta Area Outreach Initiative (AAOI) event which incorporates HIV and STD testing, linkage to care, and education on treatment as prevention.	Stakeholders	• Number of meetings held • Types of information shared • Record of input received • Number/type of strategies implemented to support integrated planning • Work plan and integrated plan updates

Strategy 2: Coordinate monitoring, tracking (trending data analysis), and progress reporting toward achievement of NHAS goals in Georgia**.**				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	DPH Ryan White Recipients FCDHW	Establish process to regularly monitor and share data. Develop and implement monitoring, tracking and progress report work plan that identifies activities, timelines, responsible parties, and data indicators. Conduct ongoing HIV prevention and treatment monitoring and tracking, including tracking progress toward NHAS goals and Integrated Plan objectives annually. Review monitoring and tracking findings annually and identify areas needing improvements. Implement continuous quality improvements (CQIs), as needed, based on ongoing monitoring and tracking. Based on monitoring and tracking, complete and submit all required progress reports by established deadlines.	Stakeholders	• Prevention and treatment number/percent served • Work plan updates • Integrated plan updates • Number/type of Continuous Quality Improvement (CQI) projects implemented • Number/type of progress reports
Strategy 3: Share information within planning bodies, jurisdictions and consumers.				
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 31, 2017; ongoing through December 2021:	Parts A and B Recipients DPH FCDHW G-PACC JPPG Part A Planning	Establish a mechanism and team to create annual progress reports and achievements towards NHAS goals. Collect and disseminate monitoring, tracking, and progress report information annually to all planning bodies. Obtain input from planning bodies on successes and areas for improvement.	Stakeholders	• Program and goal/objective data collected and trends identified • Number/type of reports developed

	Council	Prepare and submit progress reports by established deadlines. Disseminate progress reports to prevention and treatment partners and stakeholders.		

2017-2021 SMART Objective 2: By 2021, develop improved mechanisms to monitor and report on progress toward achieving national goals.

Strategy 1: Strengthen the timely availability and use of data.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2017; ongoing through December 2021:	DPH Ryan White Recipients Part A Planning Council FCDHW DCBOH	Share and match prevention and treatment data. Share HIV Surveillance data for development of district-specific care continuum. Share HIV testing data for improved program planning to better reach target populations.	Data Stakeholders and Jurisdictions Supported Health Districts/ Jurisdictions	• Frequency of sharing • Data availability

Strategy 2: Use data to improve program planning and implementation.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2018; ongoing through December 2021:	DPH Ryan White Recipients Part A Planning Council FCDHW DCBOH	Modify program implementation based on data to define target populations, high risk zip codes, to inform evidence-based interventions and expand reach of social marketing campaigns, etc.	Stakeholders	• Number of activities implemented based on data evaluation

Strategy 3: Enhance program accountability.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2017; ongoing through December 2021:	Ryan White Recipients Part A Planning Council	Monitor use of public funds for allowable purposes. Ongoing monitoring and evaluation of program deliverables and developed	Recipients and Subrecipients	• Number of timely reports submitted by Recipients to fund sources

	FCDHW DCBOH DPH	workplans. Contract monitoring by jurisdictional staff providing oversight. Ongoing monitoring and evaluation of Integrated Plan.		• Number of agencies compliant with contractual requirements.

Appendix C: Letter of Concurrence

September 23, 2016

Bilen Getachew, MHA
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U.S. Public Health Service
Southern Branch, Division of Metropolitan
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Rockville, Maryland 20857

Dear Mrs. Getachew, Ms. McCants, Ms. Hooper and Dr. Momodu:

The Georgia Prevention and Care Council concurs, with the following submission by the Georgia Department of Public Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

Our statewide integrated planning group (The Georgia Prevention and Care Council), has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

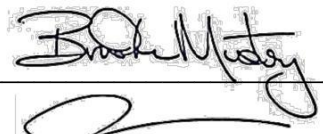
We strongly believe that these documents address the state of Georgia's prevention and care needs of priority populations and are being supported through the funding commitments of the health department. The 2017 Integrated Plan reflects the planning efforts of the statewide HIV Integrated community planning group and that an inclusive review process was used to ensure concurrence. All members of the statewide integrated planning group received adequate time to provide recommendations.

Our process included:

- The development of an integrated writing team that was comprised of integrated planning group co-chair members, the state health department staff, jurisdictional planning group representatives, consumers, and representation from Ryan White Part A and B management.
- A presentation during every statewide integrated planning meeting that reflected the progression of the integrated plan to ensure that members of the statewide integrated planning group were aware of goals and objectives proposed within the integrated plan.
- The opportunity for integrated planning members to submit their feedback to committee co-chairs with a response to their inquiry and/or recommendations.
- Providing the integrated planning body (Georgia Prevention and Care Council) the opportunity to vote to accept the plan.

We feel confident that this integrated plan will advance the coordination of Georgia's HIV prevention and care efforts and further position us to end the HIV epidemic in our state.

Agreed and accepted,

Signature:  Brooke Mootry, Health Department Co-Chair

Signature:  Jeff Vollman, HIV Care Co-Chair

Signature:  Adolphus Major, HIV Prevention Co-Chair

The City of Atlanta (Fulton/DeKalb Counties) Jurisdictional HIV Prevention Planning Group (JPPG) concurs with reservations with the submission of the *Georgia HIV Integrated HIV Prevention and Care Plan.*

Reservations include:

Goals and Objectives: Ensure that all program activity that requires action includes goals and objectives to hold all planning bodies accountable for program implementation. Confirm that program objectives have a beginning and end date within 2017-2021.

CAPUS: Georgia Care and Prevention for the United States Resource Hub should be removed from the integrated plan as it was a demonstration project.

PrEP: This document does not contain the recent HRSA guidelines allowing funding to support PrEP education with Ryan White dollars.

This **letter of concurrence with reservations** is hereby submitted to the Centers for Disease Control and Prevention on behalf of Fulton County Department of Health and Wellness and JPPG.

Amistad Adolph St. Arromand

Leisha McKinley-Beach	Amistad Adolph St. Arromand
Government Co-Chair	Community Co-Chair

The **METROPOLITAN ATLANTA HIV HEALTH SERVICES PLANNING COUNCIL (RYAN WHITE PART A**) **CONCURS WITH RESERVATIONS** with the following submission of the Integrated HIV Prevention and Care Plan as jointly prepared by the three local entities with major roles in the delivery system of quality care in terms of clinical care treatment as well as prevention in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The ***Metropolitan Atlanta HIV Health Services Planning Council (MAHHSPC)*** has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The **Metropolitan Atlanta HIV Health Services Planning Council concurs with reservations** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

Through a very robust committee structure that was led by the MAAHSPC Comprehensive Planning Committee under the guidance of the committee Chair Katherine Lovell, the committee held a total of sixteen meetings beginning on September 16, 2015 and running through August 10, 2016. In addition, a review period was implemented for the members of MAHHSPC to review the Integrated Plan from the inception of the writing team to the creation of the final document. Finally, the Comprehensive Planning Committee Chair presented detailed presentations to the entire body of MAHHSPC on four occasions at the full Planning Council meetings in January, May, July and August of 2016.

In order to manage the task of writing the document, a writing team was developed with equal representation from the Metropolitan Atlanta HIV Health Services Planning Council (Ryan White Part A), the Jurisdictional Planning and Prevention (Group) and the Georgia Department of Public Health (Ryan White Part B) and their planning body, the Georgia Prevention and Care Council (G-PACC).

As a matter of record, there were several reservations raised to include but not limited to:

1) Within the initial vote of the Executive Committee there was a **8 to 1 decision** to submit a letter of non-concurrence due to primary concerns that the third partner in this process, the Georgia Department of Public Health (Ryan White Part B) has not comprehensively detailed its statewide plan to cover the 139 counties outside of Metropolitan Atlanta as the Fulton County Department of Health and Wellness covers two counties under the High Impact Prevention Program while the Metropolitan Atlanta HIV Health Services Planning Council (Ryan white Part A) covers twenty (20) counties.

2) It was after much debate as to the need to move this Integrated Plan forward as the guidance was issued by HRSA but there were no punitive measures in place if an Integrated Plan is not submitted, and this was verified at the Ryan White All Titles Meeting in Washington, DC.

In the sake of transparency, there was a second motion made to **CONCUR with RESERVATIONS**; and to additionally request Technical Assistance from HRSA for our region, and to further seek local assistance should technical assistance not be available from HRSA.

This motion carried with a 5-4 vote.

3) The next reservation is related to the need for a documented process to monitor and track the goals and objectives created by each entity involved, as well as evaluation tools to report effectiveness and efficiencies of programming effort and to achieve a standard of mutual accountability, collaboration, and partnership among the entities involved in creating the plan.

It is worthy to note here that our Chair learned that the consulting firm, JSI, has been awarded a cooperative agreement with CDC to work through these very types of issues and JSI will be launching and operating the "Integrated HIV and AIDS Prevention Plan Technical Assistance Centers"!!!

4) While it is clear that the writers of this plan gave considerable thought and planning to the composition of the stake holders and others on the writing and review team, there is a lack of evidence, firm language, goals and objectives, or activities that asserts and support the statement that during the process there was "Meaningful Involvement of Persons Living with HIV and AIDS". The composition of the primary writing team does not fully and appropriately reflect the at-risk populations that the Integrated Plan is designed to support.

5) There were serious concerns raised about the use of terms like "HIV-Infected" and this was deemed inappropriate language usage given that the standard reference is made as "Persons Living with HIV-AIDS"!!!

While this was recognized as an issue that many would debate but it was acknowledged that the underlying sentiment was that if the public health professionals designing this plan did not fully incorporate language that is culturally and linguistically appropriate, there could be even greater and impactful issues that arise as program are implemented and disseminated into the broader community where the virus really lives.

6) In terms of creating an environment wherein the members of the MAHHSPC would be able to review the progress of the compilation of the Integrated Plan, each entity involved with the Integrated Plan process utilized their standard planning bodies to assert that there was meaningful engagement of Persons Living with HIV-AIDS but this effort merely meets a minimum guideline and great impact that could have been realized with a wider array of stakeholders that reflect the epidemic. But this was a lost opportunity due to a lack of greater outreach beyond the standard planning bodies.

7) As the CHAIR of the Metropolitan Atlanta HIV Health Services Planning Council serving a body of more than one-hundred (100) individuals, I feel compelled to note that there a number of "PROCESS" issues primarily due to a lack of structure in terms of the decision making process.

Of greatest concern is the fact that there was a FINAL draft presented for a final vote by the three bodies and the Jurisdictional Prevention Planning Group (JPPG) voted as of August 12, 2016; the Georgia Prevention and Care Council (G-PACC) voted as of August 16, 2016; and finally the Metropolitan Atlanta HIV Health Services Planning Council (MAHHSPC) voted on August 18, 2016.

Following all three votes, it was later decided by the writing team that additional edits to the narrative and the goals and objectives were needed. As the chair of the MAHHSPC, I strongly asserted that any substantive changes would compromise the INTEGRITY of the voting process as the edited document would technically not the document that was approved. As the chair of MAHHSPC, I recommended that: 1) we submit the plan that was voted upon and then make the necessary edits that arose on September 2, 2016 after the original voting period that ended on August 18, 2016 and submit the supplemental plan as a revised document which is in line with our desire to make this document a living vehicle.

This letter of **CONCURRENCE with RESERVATIONS is hereby submitted to CDC and HRSA on behalf of the Metropolitan Atlanta HIV Health Services Planning Council (Ryan White Part A) and hereto attested to by:**

Ken Lazarus, Chair
Metropolitan Atlanta HIV Health Services Planning Council