GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN, 2022-2026

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SECTION I: EXECUTIVE SUMMARY OF INTEGRATED PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED

Georgia's 2022-2026 Integrated 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 two political jurisdictions and their respective planning bodies:

1. The state of Georgia provides Health Resources & Services Administration (HRSA)–funded Ryan White Part B care and treatment services across the state and Centers for Disease Control and Prevention (CDC)–funded prevention efforts for 157 counties in 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 counties. The Part A planning group is the Metropolitan Atlanta HIV Health Services Planning Council (Planning Council).

The Georgia Integrated HIV Prevention and Care Plan identifies HIV prevention and care needs and 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 National HIV/AIDS Strategy (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.

The approach taken to preparing the 2022-2026 integrated plan submission was to update sections of the previous plan, as well as incorporate applicable areas from the existing Ending the HIV Epidemic (EHE) plan. The documents submitted to meet requirements are Ryan White Part B documents included from the previous integrated plan, Georgia's Part B grant application, CAREWare and clinical quality-management data, the HRSA annual report, and agency programmatic applications.

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

A. DESCRIBE HOW YOUR JURISDICTION APPROACHED THE PLANNING PROCESS

Collaborations, partnerships, and stakeholder involvement were critical to the development and success of the Integrated HIV Prevention and Care Plan. Given the size of the respective planning bodies for the various entities to be included within the integrated plan (G-PACC and the Part A Planning Council), each planning group was charged with identifying representatives to serve as the "writing team." 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 Georgia. Agreements were reached by both 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 its respective body 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 health district was asked to participate in an exercise to provide insight as to the advantages of plan integration, areas of interest, types of guidance and tools that would be helpful, characteristics of the communities served, and goals and 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 (CBOs), and AIDS service organizations, among others.

The Georgia DPH Office of HIV/AIDS and the Ryan White Part A Program began planning for integrated care and prevention activities in mid-2021, with discussions and work centered around creating one cohesive planning body. The statewide planning council, G-PACC, was created to include representatives from major stakeholders, including but not limited to Ryan White parts A, B, C, and D; state HIV prevention programs; consumers; the Georgia Department of Corrections (DOC); the Housing Opportunities for Persons With AIDS (HOPWA) program; people with hepatitis; people involved in HIV surveillance; and the like, 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 stakeholders of the Atlanta EMA are committed to providing an integrated continuum of core and essential support services based on an assessment of the needs of the EMA's HIV population, those in care, those out of care, and those at high risk for HIV infection. Contributors to this plan included representation from the Planning Council, Ryan White Part A agencies, the state of Georgia Part B recipients, consumers, people living with HIV, health departments, HOPWA grantees and agencies, youth organizations, academic institutions, and other key partners along the HIV care continuum. Statistical data, Epi Info 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.

In developing Georgia's updated integrated plan, the Metropolitan Atlanta (Part A) HIV Health Services Planning Council's Comprehensive Planning Committee began discussing the joint HRSA-CDC guidance and began initial discussions 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, how to maintain activities that serve our population well, and where improvements are needed and 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.

The Planning Council serves as the planning body for the Ryan White Part A Program. The council consists of a diverse group of individuals who represent both consumers, Ryan White–funded care agencies, prevention, HOPWA, and other HIV-supportive service providers. The members of the Planning Council are reflective of the epidemic within the 20-county EMA. Touting more than 100 members, the Planning Council serves as one of the largest consumer-led planning councils within the HRSA network. The Planning Council embodies the consumer-led philosophy within its bylaws and is led by three individuals who have openly disclosed their HIV status.

The committees and task forces leading the work of the integrated plan with the exception of only a few are led by chairs and vice chairs who are personally impacted through the lived experience of having an HIV diagnosis.

For subject matter experts, this methodology has proven to be successful in maintaining ongoing community engagement and feedback. Many members serve on other planning bodies, including G-PACC, agency community action boards, and the EHE planning work groups.

In anticipation of the need to develop the 2022-2026 integrated plan, we formulated the 2020 needs assessment to serve as a tool to inform the development of the integrated plan. It was important that the questioning was user-friendly and bespoke tailoring — instead of being cookie-cutter, it needed to be understandable to the individuals using the instrument. As a result, we devised an electronic survey that could be implemented on the virtual platform Survey Monkey, which would reach a greater audience. Prevention information was also captured for individuals who were not HIV-positive.

The Planning Council was able to contract with a national vendor who developed the assessment and worked with stakeholders to refine it once the process started. A needs assessment during the pandemic was extremely challenging, creating a need to generate stronger and more consistent citizen engagement.

The need prompted the council to be innovative and to utilize the Planning Council chair as the face of the needs assessment. The council strategically branded the assessment utilizing flyers, videos, and voiceovers, which gave the needs assessment a human feel.

The introductory video was developed in house and was used for both advertisement and as a training tool at the beginning of the assessment. The Planning Council chair not only became the face of the assessment but also the

ambassador. He utilized social media to promote the assessment and to recruit others to spread the word as well. A QR code was also developed to allow for easy access to the assessment link. The code was placed on fliers and distributed to agencies including those who serve as providers for the EHE initiative, which aims to provide more resources to communities disproportionately affected by HIV.

With a need for collaboration, much effort was given to maintaining the cross-pollination between planning groups. Leadership or designees from the various planning groups were asked to participate in Planning Council meetings and committee meetings to provide ongoing feedback in the development of goals and objectives.

This approach worked best within an EMA with a very diverse client base, which required responses to specialized needs for populations served. Additionally, the ongoing involvement of the Consumer Caucus as a work group of the Planning Council served to provide ongoing feedback. Community input was the norm within the Planning Council, as the consumer-led body met monthly and established itself as a formidable body of experts identifying the evolving needs of the HIV community.

The Consumer Caucus was engaged throughout the process and helped to develop the questions used in the assessment. During the process it was determined by the caucus that many of the questions from older assessments were developed during a time when there was a great deal of missing information around the transmission of HIV. In reviewing proposed epidemiological questions, many surveyed areas proved to be invasive in the language used and scientifically useless in today's care arena. Questions like, "Are you a top or a bottom?" were stated to be insensitive and "nosey" and were deemed useless in the goal of treatment and prevention.

The statewide planning council, G-PACC, provided members, guests, advocates, and participants who joined their quarterly meetings with an overview of the requirements for the integrated plan and need for their input in the process. Following the presentation of an epidemiologic profile by the director of the state's HIV surveillance office, participants broke into virtual breakout groups to have discussions for objectives and activities, with some participants serving as facilitators. Group reports highlighted items from their stakeholder discussions and were shared 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.

The Comprehensive Planning Committee held six meetings to discuss potential measurable objectives and strategies for each NHAS goal and applied ideas shared during the stakeholder virtual discussions to prioritize those activities with the greatest chance for positive health outcomes for the state of Georgia.

B. DESCRIBE HOW PLANNING INCLUDED REPRESENTATION FROM THE PRIORITY POPULATIONS

G-PACC understands the responsibility and importance of including people living with HIV throughout the development of the integrated planning process. The community planning process involves representatives of populations at greatest risk for HIV infections and people living with HIV. 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 58 council members who serve as voting and nonvoting 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, 54% of Georgia's statewide integrated planning body (G-PACC) are consumers who also serve as co-chairs to facilitate planning meetings, monthly committee activities, conference calls, and stakeholder engagements.

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. G-PACC, consortia, and the Metropolitan Atlanta HIV Health Services Planning Council also include consumers. Emphasis is placed on inviting consumers who were reflective of the Atlanta EMA epidemic.

C. ENTITIES INVOLVED IN PROCESS

The people involved in developing the Integrated HIV Prevention and Care Plan included consumers, Ryan White parts A, B, C, and D representatives, HIV/AIDS prevention representatives, community and religious leaders, CBOs, 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.

Georgia's statewide integrated planning council, G-PACC, comprises 58 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 49 voting and nine nonvoting members.

G-PACC membership categories include the following:

- Academia
- AIDS Drug Assistance Program (ADAP) pharmacy
- African American female
- Agency representatives
- Aging population
- Consumer
- Corrections
- Emerging populations
- Faith-based organizations
- Federally Qualified Health Center
- Health department
- Hepatitis patients
- Heterosexual male
- HIV prevention agencies
- HIV surveillance
- HOPWA
- Hospital
- Linkage services
- Social workers
- Medical providers
- Syringe services program
- Infectious disease medicine
- Infectious disease research
- Community health centers
- Mental health
- Men who have sex with men (MSM) – African American (AA)
- 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
- Sexually transmitted infection (STI) patients
- Veterans
- Youth
- Intravenous drug users
- Epidemiologist
- Department of Community Affairs

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 subpopulations that the health departments aim to reach for HIV prevention and care activities. One method of engaging disparate 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.

Community input was integrated into the planning process. Membership from both the Metropolitan Atlanta HIV Health Services Planning Council and its committees and workgroups worked along with G-PACC to formulate a series of

listening sessions to inform the writing of the integrated plan.

Both planning bodies utilized regularly scheduled meetings to capture additional information throughout the year. Support staff documented the concerns and feedback of the various committees and task forces as the work plan was carried out during meeting sessions.

This feedback was provided to the writing group, and a series of questions and topics were formulated to best respond to the needs within the EMA. The sessions were further informed through the priority setting and resource allocation process wherein the findings of the needs assessment and other data were used to determine priority areas of need and to allocate resources.

Additional community data was added to this process, including analysis of the Ryan White Part A office, consumer survey data, utilization reports from consumers of Ryan White Part A, reports from EHE staff, client-service data, and a formal feedback process available to consumers through the open forum opportunities conducted during virtual meetings and collaboration with state prevention programs.

All planning activities and meetings were open to the public, inclusive, and evidence-based. Great care was taken to ensure that deliberations considered the needs of historically underserved populations, persons who are unaware of their HIV status, and consumers who have been lost to care.

The listening sessions were a joint collaboration between the Metropolitan Atlanta HIV Health Services Planning Council, G-PACC, and the Reginald & Dionne Smith Foundation, which, since 2012, has been working with local, national, and international partners to provide vetted information to the very people who need it the most — the underserved communities.

The series of listening sessions virtually targeted Georgia residents and was promoted as the Georgia Virtual HIV Community Listening Session. The topics that emerged from other stakeholder meetings were people living with HIV, HIV and stigma, housing and HIV, and PrEP and the community. Meetings were all well attended and showed promise for an ongoing joint series as a collaborative goal within the new integrated plan.

CDC reports that where someone lives can have a deep impact on both their health and well-being in terms of their stability, affordability, and quality of housing and even the characteristics of their neighborhood. A lack of affordable housing options can limit a person's ability to maintain stable housing and access other services, including staying engaged in ongoing health care (CDC, 2020).

G-PACC has also been committed to diligently working with the HOPWA representative for the past five years to consistently educate HIV consumers, CBOs, and stakeholders on the housing barriers experienced within the metropolitan Atlanta area and the entire state of Georgia. HOPWA promotes affordable, accessible, available, and adequate housing for low-income people living with HIV/AIDS, promotes increased housing stability and maximum independence among low-income people living with HIV/AIDS, increases housing options by targeting HOPWA resources and connection to non-HOPWA housing resources, and ensures adequate supportive services that promote housing stability and ongoing access to care and support.

The Georgia Department of Community Affairs receives HOPWA funding to serve 125 counties in Georgia that are mainly rural. The city of Atlanta HOPWA program receives funding to cover the 26-county metro Atlanta area. The city of Augusta HOPWA program receives funding to cover five Augusta-Richmond counties and two counties in South Carolina. The following are HOPWA-funded housing and support services:

- Facility-based housing
- Emergency and short-term housing, including hotel and motel lodging

- Master leasing
- Tenant-based rental assistance
- Short-term rent, mortgage, and utility assistance
- Permanent housing placement
- Supportive services — case management and client advocacy, mental health, substance abuse treatment, meals and nutritional services, and transportation
- The GHFA Permanent Supportive Housing Program (formerly Shelter+Care) support
- Housing information and referral services
- Resource identification

Over the past five years the HOPWA representative has provided detailed presentations and data to every G-PACC quarterly meeting.

This partnership was developed during the formulation of the last HIV integrated plan when housing was identified as a structural and financial burden to HIV consumers. In efforts to keep everyone aware of the available resources for housing opportunities, changes in policy as they relate to rental increases, and recommendations on where to access assistance with HOPWA applications, G-PACC and the HOPWA representative have hosted a total 90 meetings and engagement sessions related to housing barriers in Georgia.

D. ROLE OF THE RWHAP PART A PLANNING COUNCIL/ PLANNING BODY

The Ryan White Part A legislation builds on a commitment to ensure that people most impacted by HIV have a voice in both the planning and funding of services. There are several community engagement and planning requirements attached to both Part A and HIV prevention funding.

The Metropolitan Atlanta HIV Health Services Planning Council has a range of different voices, including voices of individuals living with HIV. At least 33% of voting members are consumers of Ryan White Part A services who do not have a conflict of interest, meaning they are not affiliated in any way (as staff, consultant, or board member) with a Ryan White Part A–funded agency.

The Planning Council works closely with the Part A recipient but has a different role. The Part A recipient is the recipient of federal funding and is responsible for contracting with providers for services, but the Planning Council provides input into what needs rise to the top in the community and what kinds of services should be funded.

The Planning Council establishes permanent or ad hoc committees to carry out core functions (e.g., a Membership Committee, Service Standards Committee, or Needs Assessment Committee).

E. ROLE OF PLANNING BODIES AND OTHER ENTITIES

G-PACC serves as an advisory council and collaborates with the state office by making recommendations to improve the HIV continuum of care in Georgia by strengthening the (1) scientific basis, (2) community relevance, (3) key stakeholder involvement, (4) population- or risk-based focus of HIV prevention interventions and high-quality care in the state, and (5) communication and coordination of services across the continuum of HIV prevention, care, and treatment.

It was imperative for G-PACC to convene a community process to discuss proposed content within the integrated plan and stakeholder engagement. During each planning meeting, council members and people living with HIV were given the opportunity to provide input and suggestions to the plan. Three representatives from G-PACC were also placed on the integrated writing team to serve as a voice for the entire planning body, including people living with HIV. The opportunity to provide suggestions at every meeting was made available with open discussions regarding the integrated plan's structure, objectives, and goals.

G-PACC also utilized its Comprehensive Planning 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 parity, inclusion, and representation, 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 Integrated HIV Prevention and Care Plan. An emphasis was placed on recruiting service providers and persons living with or affected with HIV/AIDS. The Ryan White Part B Clinical Quality Management (CQM) Core Team represents stakeholders, subrecipients, consumers, or a combination of positions.

There are also 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. The Metropolitan Atlanta HIV Health Services Planning Council and the Atlanta Ryan White Part A Program (the only Part A program in Georgia) work together to facilitate discussions and initiatives with other planning groups within the EMA. As an example, during the development of the EHE plan, efforts were taken to engage both the Planning Council and the DPH Prevention Program in listening sessions, forums, and surveys to assist in the development of the plan. This cross-finding engagement has proven to be both effective and supports the ongoing engagement of consumers.

F. DESCRIBE HOW THE JURISDICTION COLLABORATED WITH EHE PLANNING BODIES.

The EHE planning work group is inclusive of individuals who serve on various other planning bodies including the Planning Council. The Georgia EHE work group consists of five teams involved in prevention, data, treatment, housing, and policy.

As an ongoing effort to engage and connect planning bodies, the Fulton County Department of HIV Elimination (DHE) has employed a community engagement specialist to attend Planning Council/body meetings and committee, caucus, and task force gatherings. The community engagement specialist makes connections with community members, consumers, and stakeholders via various activities and provides feedback to all parties, creating a link between the various work groups. This information is used to inform the development of plans and to assist with various care and prevention initiatives.

As an added measure, the EHE Planning Body through DHE makes regular presentations to committees of the Planning Council as well as to the full body of the Planning Council.

i. Collaboration with RWHAP Partners

G-PACC membership includes representatives from major stakeholders, including but not limited to Ryan White parts A, B, C, and D. The Ryan White Part B CQM Core Team includes representation from all Ryan White parts. Part B CQM personnel attend local Ryan White Part A Program QM meetings to share updates and best practices and to identify opportunities for collaboration, e.g., quality training.

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. 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 Metropolitan Atlanta HIV Health Services Planning Council and G-PACC both have membership that includes representatives from major stakeholders, including but not limited to Ryan White parts A, B, C, and D; state HIV-prevention and Fulton/DeKalb HIV-prevention programs; consumers; DOC; HOPWA; people with hepatitis; HIV surveillance programs; etc. Additionally, the Planning Council's composition requires that there is mandatory representation on the planning councils in each of the specified categories. These positions support integration and ongoing information from the various parts.

The council's role in this process is to work together to provide strategies for action in the development of a coordinated system of care for people living with HIV in accordance with the integrated plan. The body reviews and revises the plan to ensure there are clear goals, objectives and approaches for action as well as mechanisms for assessing progress.

Additionally, the Ryan White Part B CQM Core Team includes representation from all Ryan White parts. Part B CQM personnel attend local Planning Council meetings to share updates and best practices and to identify opportunities for collaboration — for example, in quality training. Additionally, the recipient

requires that agencies representing various parts provide designees to the Assessment, Comprehensive Planning, and Quality Management committees. This is a contractual agreement that guarantees the engagement of all parts. This arrangement is in addition to the HRSA-mandated representation that serves on the planning councils.

ii. Engagement of People with HIV

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. G-PACC understands the responsibility and importance of including people living with HIV throughout the development of the integrated planning process. The community planning process involves representatives of populations at greatest risk for HIV infections and people living with HIV. The fundamental tenets of community planning in Georgia are parity, inclusion, and representation. The community planning process also encourages community participation.

Membership for the Ryan White Part B consortia is required to reflect the diversity of the local community and affected populations. Emphasis is placed on recruiting service providers and persons living with or affected by HIV/AIDS. Additionally, several members of the Ryan White Part B CQM Core Team represent stakeholders, subrecipients, consumers, or a combination of positions. Currently, the CQM Core Team includes consumers, state office staff, Part B–funded health district representation, and the recipients or designees of other Georgia Ryan White parts. The CQM Core Team reviews performance measurement data and plays a key role in selecting performance measures and developing quality priorities.

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 HIV/AIDS Program recipients and providers to ensure that identified disparities in health care infrastructure are addressed.

It has been determined that collaborative efforts work best when planning activities for populations at risk. The Georgia DPH and the Metropolitan Atlanta HIV Health Services Planning Council collaborated to host several HIV community listening sessions in efforts to hear the concerns on the HIV epidemic, provide recommendations and strategies to fight the epidemic, and advance strategies to overcome structural barriers and bridge the gap on working together. The listening sessions were also designed to get feedback and provided opportunities for stakeholder discussions to identify needs and increase the areas of focus for EHE efforts beyond the 2022 HIV planning year. Each session was attended by diverse communities impacted by HIV in the state of Georgia and the city of Atlanta.

These HIV community listening sessions placed a special emphasis on the following key areas:

- People living with HIV/AIDS
- Stigma
- Housing crisis
- PrEP

Each listening session included HIV introductions and opportunities for participants to express their current realities pertaining to COVID-19, loss, structural racism, and difficult day-to-day experiences. The listening sessions were hosted virtually and open to all stakeholders across the state of Georgia. The feedback gathered from the listening sessions was utilized to assist in developing goals and objectives for the state of Georgia.

G-PACC is committed to hosting and facilitating ongoing community engagement sessions in efforts to:

- Communicate community issues related to the specific population
- Identify the gaps in HIV-related services
- Advise HIV-related service needs in urban and rural areas

During the past two years, all community engagement sessions have been facilitated using virtual platforms.

- Bring specific and unique expertise to the prevention and care planning process

During the past two years, all community engagement sessions have been facilitated using virtual platforms. HIV community engagement sessions have been centered around self-care, stigma, the trans population, housing, mental health, newly released former inmates, and Black and Latino MSM. Structural barriers and recommendations to address those barriers are mentioned during each HIV community engagement session to foster input from stakeholders and bridge the gap on working together.

Continuous engagement sessions have also resulted in an increase in stakeholder engagement within the statewide planning group, G-PACC. G-PACC hosted an HIV community stakeholder engagement session on the rise of anti-trans violence in America with many individuals from the trans community, community advocates, and service organizations to address the need for more protection, resources, and advocacy for this underserved population. During this engagement session, statistics were provided to educate participants on the growing number of violent acts directed toward the trans community, ways to report violence toward trans individuals, and the lack of protection and advocacy they face daily.

1. Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives.

The Metropolitan Atlanta HIV Planning Council's community planning process and engagement of people living with HIV involved representatives of populations at risk for HIV infections as well as persons living with HIV. The fundamental tenets of the community planning process were parity, inclusion, and representation. This inclusive community planning process included representatives of various races, ethnicities, genders, ages, sexual orientations, other characteristics including educational backgrounds, and professional expertise.

The community planning process also encouraged community participation by stakeholders outside the HIV care network. Private doctors and agencies that provide services but are not Ryan White–funded were engaged to provide additional input. It has been discovered that there are many specialization groups that are not Ryan White recipients but have great impact and involvement with individuals who are HIV-positive and Ryan White–eligible. This is generally associated with groups that cater to specific demographics (e.g., transgender, youth, women, heterosexual, etc.).

Additionally, the Planning Council utilized its membership and statutory representation as a way of achieving the participation of people living with HIV. Currently, the Planning Council has 54 voting members and 62 at-large members. To date, a mandated 33% of Planning Council members are consumers who serve as chairs, vice chairs, or co-chairs to facilitate planning meetings, monthly committee activities, task forces, Consumer Caucus events, conference calls, and stakeholder engagements.

The people involved in developing the Integrated HIV Prevention and Care Plan included consumers, medical providers, Ryan White parts A, B, C, and D representatives, HIV/AIDS prevention representatives, community and religious leaders, CBOs, and ASOs, among others.

Several members of the Planning Council serve on the QM Committee and participate in the development of performance measurement data and developing priorities.

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. In addition, invitations were widely shared to encourage participants to attend virtual consumer-led listening sessions (integrated plan stakeholders' meetings.

People living with HIV have been involved throughout the 2022 Planning Council year and have served as an essential part of developing the integrated plan. Part A Planning Council members and its committees and workgroups include community representatives, consumers of services, CBOs, and service providers.

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 nonvoting, serve on a council committee. Consumers serve in positions of leadership including serving as co-chairs of all council committees.

Over the course of a year the membership committee and Planning Council staff monitored 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 were that the planning body was composed of a majority of African American persons, who overwhelmingly represented the epidemic within the EMA.

2. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the integrated plan.

Membership for the Ryan White Part B consortia emphasizes recruitment of persons living with or affected by HIV/AIDS. The Ryan White Part B CQM Core Team also includes consumers in the discussions related to performance measure goal setting, provision of feedback regarding barriers to accessing medication, and suggestions to increase adherence to ADAP. Feedback from people living with HIV was integral in plan development, especially when assessing behavioral decisions made related to care and the quality of health care delivery. The inclusion of people living with HIV 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.

People living with HIV 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 stakeholders' meeting.

For members of the Planning Council and its various work groups including the Consumer Caucus, there will be ongoing reporting on the status of the plan as well as requests for updates and modifications.

There will be ongoing reporting and monitoring of the rolling needs assessment to ensure that the plan is reflective of received data. Ryan White Part A staff will make quarterly data reports to the council, as well as quarterly management reports to the caucus.

iii. Priorities: List key priorities that arose out of the planning and community engagement process.

The gaps identified by people living with HIV 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. People living with HIV 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.

In preparation for the development of the 2022-2026 integrated plan, committee meetings were used as strategic planning sessions to discuss and formulate key priorities for the next integrated plan. Additionally, statewide listening sessions revealed increasing concerns around HIV stigma, housing, the trans populations, and the need for greater access to PrEP. Discussions revealed a need to maintain and improve the linkage between EHE practices and early intervention strategies. The key identified priorities were:

- **HIV testing**. Continue to provide HIV testing and partner services in Ryan White Outpatient/Ambulatory Health Services (OAHS) sites for partners, friends, or family members of Ryan White clients (funded via CDC prevention funding); enhance collaborations with local jails to ensure that HIV testing takes place and continue to expand routine testing in juvenile justice facilities.
- **System-level changes**. Implement HIV opt-out testing policy at medical clinics and jails, require all mental health and substance abuse service entity contractors to provide HIV testing and linkage to care, expand

partner services by health department staff at CBOs, and continue efforts to fully incorporate HIV testing into routine medical laboratory testing.

- **Surveillance data**. Use surveillance data to identify HIV-positive individuals who are not in care, link them to care, and support the HIV care continuum.
- **Social media interventions**. Continue to create advertisements on common social media sites (e.g., Jack'D, Facebook, Instagram, Grindr, and Adam4Adam) and mobile applications to link individuals to testing, medical care, PrEP services, support networks, and housing resources. This intervention is provided through funding from the Building Capacity for HIV Elimination in Ryan White HIV/AIDS Program Part A Jurisdictions project. Additional steps will be taken to engage other partner stakeholders.
- **Service expansion**. Continue to utilize telehealth to provide services such as OAHS, case management, mental health care, and substance use counseling. Expand the principle of rapid entry to link people living with HIV to care (and access to antiretroviral therapy [ART]) within 72 hours. All Ryan White Part A subrecipients will continue to have weekend and/or morning and evening hours to facilitate access for individuals who are not able to make daytime appointments. A clinician will be assigned to mobile testing units so that individuals testing positive for HIV can immediately have their first medical appointment, including ART initiation, and high-risk individuals with a nonreactive test result can initiate PrEP (medications paid for by non–Ryan White source).
- **Linkage to care**. The provision of telehealth enables agencies to engage new clients faster, providing initial telehealth services directly after testing to decrease the time frame from diagnosis to engagement to linkage into care. This service provision also helps clients who have fallen out of care begin reengagement via initial contact through a telehealth service. Staff is also available to support clients from the time of their new diagnosis through linkage to care and will continue to assist clients as needed to help them adjust to life with HIV.
- **Patient navigators**. Ryan White Part A–funded patient navigators serve clients in education, peer counseling, support, and assistance with navigating the health care system. As people living with HIV, patient navigators share strategies to help those newly diagnosed remain engaged in HIV care and navigate them through the challenges and barriers.

Medical case managers will be used to assist with identifying the needs and removing barriers of those newly diagnosed or enrolled into care to help link clients to the appropriate services, support client's continued engagement and retention in medical care, and help clients achieve the ultimate goal of viral suppression. Medical case managers will also provide medical adherence counseling and facilitate linguistic services for those who need translation support at appointments, medical transportation assistance to case management and clinic appointments, and mental and oral health services. Community health workers are being integrated to facilitate navigation.

- **Medical case managers**. Medical case managers will work with clients to develop an individualized service plan that helps identify and address both immediate and long-term issues, and will be tasked with educating and advising clients on how to identify potential barriers to care and connect them to appropriate staff. Clients will be educated on the importance of retention in care, adherence to HIV care appointments, medication scheduling, accessing prescriptions, and how to communicate with case managers or health center staff to address concerns should they arise. Nonmedical case managers (self-management coordinators) will help to facilitate linkage to and continued engagement in care by offering medically stable clients with low-intensity social service needs someone they can reach out to as needed. Referrals for health care and support staff (client benefits specialists) are also included as a component of the Early Identification of Individuals with HIV/AIDS strategy as they help clients access resources that they may not have otherwise known they were eligible to receive by assisting them to complete and submit applications for client assistance programs and referring them to Affordable Care Act counselors and navigators or other benefit programs. These efforts ensure additional safeguards for informing the newly diagnosed of their status.
- **State Electronic Notifiable Surveillance System (SENDSS)**. Efforts will be taken to continue to refine the SENDSS Linkage Module to connect the client's lab testing history, partner services interview, and linkage to care referrals and outcomes, inclusive of name of agency where they tested and named partners.
- **Early intervention services**. Since 1996, the Department of Behavioral Health and Developmental Disabilities (DBHDD) Early Intervention Services (EIS) program has tested over 200,000 individuals for HIV. On behalf

of DBHDD, Imagine Hope Inc. manages the EIS program. A network of EIS nurses and counselors are embedded in 39 DBHDD substance use treatment facilities, including medication-assisted treatment clinics, throughout the state. Through the HIV EIS program, HIV prevention services are offered on-site in the 39 participating substance use treatment facilities. HIV EIS workers offer free HIV-prevention education, counseling, and testing to people entering treatment. HIV-positive clients, whether previously or newly diagnosed — are referred to medical care and social services. HIV EIS staff develop and enhance relationships with other health care providers, working together to assist in the development of a network of medical and social service providers that serve the substance-use population.

- **System-level interventions**. Employ provisional enrollment for presumptive eligibility, which allows individuals with proof of HIV status to be enrolled while collecting other required documents (e.g., proof of income and proof of residency). Ideally, all documentation should be provided prior to enrollment into services. A lack of proper documentation should not impede enrollment into care. If a client is able to provide proof of HIV status but does not have income or residency documentation, that client may be enrolled into OAHS, mental health services, substance abuse services, nonmedical case management, or medical case management.
- **Enrollment flexibility**. During the COVID-19 pandemic, Ryan White Part A exercised greater flexibility with its enrollment and recertification protocols to place greater focus on bringing people into care virtually. Some of the process changes included (1) accepting photos of eligibility documentation, (2) purchasing DocuSign for clients to sign consents and rights and responsibilities forms, and to provide self-attestation, (3) distributing cellphones and prepaid phone cards to clients, and (4) purchasing webcams and laptops for subrecipient staff. The Atlanta EMA is also creating a centralized eligibility portal and plans to distribute mobile internet-enabled tablets to provide internet access to clients for telecare services. Additionally, Ryan White Part A ensures that all Ryan White subrecipients are aware of EMA policies and procedures that allow individuals with only a preliminary positive test result to enter care and Ryan White Part A funds may be used for confirmatory HIV testing, ensuring clinicians are following current protocols of ART initiation regardless of CD4 count or viral load.

- **Increasing HIV testing**. HIV testing will continue to increase in geographical areas with high burden of disease among the following priority populations: Black males 25-34, Black females 25-34, and trans-identified persons aged 19-34. Efforts will be taken to employ members of target populations to provide testing and partner services. They will be responsible for contact tracing and contact testing of newly diagnosed individuals while giving priority to those with acute infections. Other potential strategies for increasing HIV testing include HIV testing and counseling for couples and partnering with CBOs, faith-based agencies, group homes, beauty salons, barber shops, gas stations, bars, night clubs, extended-stay motels, and higher education institutions in disproportionately affected ZIP code areas to provide testing, counseling, and education. During the COVID-19 pandemic, efforts have increased to mail free home HIV test kits via the High Impact Prevention Program.

- **Normalization of HIV/reducing stigma**. The U.S. Preventive Services Task Force recommends HIV screening for all persons aged 15 to 65, but only about half of all Americans have ever been tested. Fear of stigma and discrimination is still a factor discouraging testing. The listening sessions revealed a great concern among young people concerning how HIV prevention and care were implemented. The EMA will support initiatives to normalize HIV testing and detect HIV more quickly. Other efforts include the use of social network testing, which reduces stigma by enlisting peers to promote access to testing services, and targeting testing messages to high-risk communities.

- **Housing assistance**. Housing status is a stronger predictor of HIV health outcomes than individual characteristics such as gender, race, age, drug and alcohol use, mental health issues and receipt of social services. Persons experiencing homelessness are at heightened risk of acquiring HIV, with rates of new transmissions as high as 16 times the rate in the general population. Even after accounting for other factors such as substance use, mental health, and access to services, the condition of homelessness is independently associated with increased rates of behaviors that can transmit HIV. Fear of exclusion from housing or shelter plays a negative role in getting people in HIV testing. Partnerships between the U.S. Department of Housing and Urban Development (HUD) housing programs and other service organizations present important opportunities for HIV education and testing to support HIV prevention, timely HIV

The U.S. Preventive Services Task Force recommends HIV screening for all persons aged **15** to **65**, but only about half of all Americans have ever been tested.

diagnosis, and linkage to ongoing medical care for both HIV-positive and HIV-negative persons.

- **Outreach/culturally sensitive outreach**. Outreach funds can be used to identify and refer individuals to new and existing early intervention services. Early intervention services stress the importance of bringing persons into care earlier in HIV disease progression. Outreach services are aimed at identifying persons with HIV who may be unaware of their status, or who may know but are not in care. Early intervention services, such as providing HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services and linkages to care with appropriate providers of health and support services, will continue to be a part of the services provided under Ryan White Part A.
- **HIV Prevention Program-funded CBOs** will continue to focus their HIV messaging, outreach, and HIV testing and counseling activities to target groups in ways that are culturally and linguistically appropriate and that address culturally established patterns for avoidance of HIV status awareness. Activities include effective behavioral interventions and other health education strategies (e.g., health fairs, awareness days, social marketing). In fiscal year 2020, Ryan White Part A launched a social marketing campaign to target young Black MSM populations.
- **System-level interventions**. Interventions will address barriers that prevent people from testing and accessing care. CDC recommends HIV testing for all patients over the age of 13, with the option to opt out.

Following this policy, efforts will continue to fully embed HIV testing into routine medical laboratory testing to reduce stigma and increase the number of individuals that consent to testing. This policy will be adopted in Federally Qualified Health Centers, emergency departments, and medical clinics, such as college student health clinics, adult health clinics, STI/TB clinics, refugee clinics, family planning clinics, perinatal and maternal clinics, pediatric clinics, and high school clinics.

iv. Updates to Other Strategic Plans Used to Meet Requirements: If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe:

1. How the jurisdiction uses annual needs assessment data to adjust priorities

Needs assessments conducted by the 16 funded Ryan White agencies show that, in order of importance, the six most-needed services for people living with HIV are primary care, oral health, medical case management (MCM), nonmedical case management, mental health, and medication assistance. 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 people living with HIV 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.

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 local client satisfaction surveys. Through review of needs assessments and budget proposals, the Georgia DPH Office of HIV/AIDS ensures that allocations address the identified local funding needs for core medical and support services. Funded agencies submit yearly budgets that are reviewed and approved by the Office of HIV/AIDS to ensure funds are allocated to core medical services and support services.

The Metropolitan Atlanta HIV Health Services Planning Council provides comprehensive HIV medical and support services planning for people living with HIV in the 20-county Atlanta EMA by utilizing its needs assessment. Assessment results are utilized to identify gaps in services and areas needed for service improvement. This is especially important in evaluating priorities and allocating

resources. Through evaluation of the previous needs assessment process, it was determined by the Planning Council through its Needs Assessment Committee that assessment data would be more beneficial if received more frequently than every three years. The Planning Council agreed to develop an assessment tool that provides ongoing data, including real-time snapshots that can be queried in several ways.

The Planning Council is responsible for using data to prioritize HIV medical and support services and allocate resources according to existing needs. Understanding the needs of people living with HIV allows the Planning Council to effectively plan improvements in access, barrier reductions, and service linkage for people who know their status and are not receiving medical care. Funding allocations follow effective planning, and the needs assessment is designed to provide essential information for that decision-making.

Specific objectives include (1) identifying trends in the HIV epidemic, focusing on historically underserved populations and disproportionately affected populations; (2) identifying consumer service needs, unmet needs, utilization patterns, and barriers to care; (3) obtaining detailed information on people living with HIV with unmet needs, including demographics, barriers, and strategies to link them to care; and (4) identifying and evaluating the system of care, gauging service gaps and barriers in the care continuum.

To accomplish these objectives, the following activities were undertaken: (1) surveillance and sociodemographic data about the population of the region and status of the epidemic were obtained, and (2) a detailed survey of people living with HIV was conducted. The assessment is managed by Planning Council support staff and overseen by the Planning Council's Assessment Committee.

2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders

The HIV Prevention Program incorporates ongoing feedback of people with HIV and stakeholders by having engaged relationships with our funded HIV Prevention partners; this is accomplished by the inclusion of people living with HIV/AIDS in our required local community planning processes. Beyond the larger statewide and EHE planning processes, funded HIV Prevention providers, including Georgia's 18 health districts, are required to include community members, including people living with HIV/AIDS, in the planning and development

of all community mobilization activities. This is listed as one of the required minimum quality standards for HIV prevention and HIV testing that all contracted providers must meet. The level of participation of these stakeholders may range from participation in a one-time community task force to membership in a subcommittee of an existing local planning body or membership in a standing local planning body specifically developed for the purpose of ongoing support with HIV prevention community mobilization projects.

Moreover, membership for the local Ryan White Part B consortia emphasizes recruitment of persons living with or affected by HIV/AIDS. The Ryan White Part B CQM Core Team also includes consumers in the discussions related to performance measure goal setting, provision of feedback regarding barriers to accessing medication, and suggestions to increase adherence to ADAP.

For our funded HIV Prevention partners, this is accomplished by the inclusion of people living with HIV/AIDS in our required local community planning processes. Beyond the larger statewide and EHE planning processes, funded HIV Prevention providers, including Georgia's 18 health districts, are required to include community members, including people living with HIV/AIDS, in the planning and development of all community mobilization activities. This is listed as one of the required minimum quality standards for HIV prevention and HIV testing that all contracted providers must meet. The level of participation of these stakeholders may range from participation in a one-time community task force to membership in a subcommittee of an existing local planning body or membership in a standing local planning body specifically developed for the purpose of ongoing support with HIV prevention community mobilization projects.

As a Planning Council in the Atlanta EMA, the body decided to implement a rolling needs assessment that is ongoing throughout the year and does not limit updates to a point in time.

3. Any changes to the plan as a result of updates assessments and community input

One change that was prompted by the input of community members resulted in a significant change to the rules and regulations regarding oversight and monitoring of syringe services programs (SSPs).

In response to a town hall forum conducted by the HIV Prevention Program in 2022, a change to the title of our signature MSM symposium was made.

Participants in the town hall meeting felt that the original title, MSM Symposium, could be perceived as stigmatizing because of the direct reference to this population's sexual orientation. As a result, the program title was changed to Journey to Change.

As the result of the reporting and update challenges identified during the last plan, this plan will seek to establish a firmer integration between independent bodies. The lack of structural integration will be mitigated through agreements, intentional and scheduled meetings, the cross-pollination of planning members between agencies, and the collaborative planned and scheduled meetings of support staff from both the Metropolitan Atlanta HIV Health Services Planning Council and G-PACC.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

1. **Data sharing and use: Provide an overview of data available to the jurisdiction and how data was used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose.**

The DPH Office of HIV/AIDS provides and shares data to facilitate the development of needs assessments and produces the HIV care continuum for Part A, Part B, local health districts, community engagement, and planning body activities. Data sharing from our HIV surveillance program is processed by data request agreements that are approved by current HIV epidemiology and surveillance security and confidentiality protocol.

The DPH Office of HIV/AIDS adheres to all Georgia public health laws, mandates, and the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) data security and confidentiality guidelines.

According to Georgia's law on notifiable disease reporting, health care facilities providing HIV/AIDS care and testing should report any new patients to their facility (including referrals), any current/previous patient updates (change of address, name, pregnancy status, or gender), and any new clinical status (new AIDS status or AIDS-defining illnesses) within seven days.

HIV epidemiologic data reports are electronically shared using the Enhanced HIV/AIDS Reporting System (eHARS), EvaluationWeb, and SENDSS. Georgia's HIV Prevention Program will continue collaboration with HIV surveillance programs 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 diagnosis rate and ensuring linkage to care as well as other support services for newly diagnosed persons. In addition, data about 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 caused by ongoing care.

The Part B program's 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. The DPH HIV Surveillance Laboratory Database and eHARS were used for developing DPH's Unmet Need and HIV Care Continuum reports. Local consumer surveys to produce the needs assessments identifying barriers to and gaps in services. Performance measure data, including viral load suppression, prescription of ART, gap in medical visits, and medical visit frequency, is shared during two of the quarterly statewide Planning Council meetings.

Part A primary sources of data and data systems include:

- e2Fulton to collect client-level data, generate the Ryan White HIV/AIDS Program Services Report, run HIV/AIDS Bureau (HAB) performance measure data, measure service utilization by priority category, and prepare the Ryan White unit cost analysis
- Electronic customer-satisfaction survey distributed to clients through e2Fulton after service visits
- The DPH HIV Surveillance Laboratory Database and eHARS for developing Unmet Need and HIV Care Continuum reports
- EvaluationWeb to capture HIV testing data and provide reports on the success of testing strategies for target populations
- Electronic consumer surveys to produce the needs assessments identifying barriers to and gaps in services.

Data Type	How Reported	Description

HAB Core Performance Measures with Disparity Data
 	
Source: e2Fulton
	Quarterly to the Planning Council and annually to Priorities Committee	Data is presented for the overall population on viral load suppression (VLS), prescription of ART, gaps in medical visits, and medical visit frequency and stratified by:
		• Age
		• Race/ethnicity
		• Gender
		• Vulnerable populations identified by the task force:
		  ◦ Black men aged 24-35
		  ◦ Black women aged 24-35
		  ◦ Transgender men and women aged 24-35
		• Identified subpopulations

Service Utilization **Source**: e2Fulton	Quarterly to the Planning Council and annually to Priorities Committee	• Reports the number of clients served per service category through the current reporting quarter

HAB Core Measures and HAB Measures by Service Category
 	
Source: e2Fulton
	Quarterly to the QM Committee and annually to Priorities Committee	• Reports HAB core measures for the overall population for the current quarter of the current fiscal and previous two fiscal years
		• Reports core measures for selected service categories
		  ◦ OAHS – VLS and retention in care
		  ◦ Oral health – retention
		  ◦ MCM – retention
		  ◦ Referral – retention

Atlanta EMA HIV/AIDS Demographic Table **Source**: eHARS, American Community Survey Five Year Estimates	Annually to Priorities Committee	• Incident and prevalent cases for most recent three years and relative change • EMA demographics

Data Type	How Reported	Description
Unmet Need Framework Estimates **Source**: HIV surveillance data	Annually to Priorities Committee	• Unmet need, late diagnosis, in care — not virally suppressed for EMA, priority populations, and subpopulations

RWHAP Part A Application
 	
Source: Various
	Annually to Priorities Committee	• Needs assessment
		  • Epidemiologic overview
		  • HIV care continuum
		  • Unmet need
		  • Co-occurring conditions
		  • Complexities of providing care
		• Early identification of individuals with HIV/AIDS
		  • Populations of focus
		• Resource inventory/coordination of services and funding streams
		• Work plan
		• Diagnosis-based HIV care continuum services table and narrative
		• Minority AIDS Initiative (MAI) service category plan narrative
		• Resolution of challenges
		• Clinical quality management program

Care Continuum Data **Source**: e2Fulton	Annually to Priorities Committee	Data is reported on the HIV care continuum for overall and stratified for subpopulations • Linkage to care • Engaged in care • Retained in care • Prescribed ART • VLS • VLS among retained
Detectable Viral Loads **Source**: e2Fulton	Annually to Priorities Committee	Demographic and geographic data is presented on those who have viral loads of at least 200 copies at last test: • Geographic data (by county, heat map, etc.) • Demographics (race/ethnicity, gender, age)

Source: Georgia HIV Surveillance data reported through June 2019

Data Type	How Reported	Description
Time Trends **Source**: e2Fulton	Annually to Priorities Committee	Trends for VLS, prescription of ART, gap in medical visit, and medical visit frequency are presented by quarter
Demographic data **Source**: e2Fulton	Annually to Priorities Committee	Demographic data on the populations served is presented by: • Race • Ethnicity • Gender • Race/ethnicity and gender • Age group • HIV risk factor • HIV status
Service Utilization — Visit per client **Source**: e2Fulton	Annually to Priorities Committee	Calculates the number of units per client (number of service units/number of clients)
Unit Cost Analysis **Sources**: Expenditures Report and Part A/MAI Service Category Data (from APR Report)	Annually to Priorities Committee	Reports on the following for Part A and MAI only: • Expenditures • Cost per client (expenditures/number of clients) • Cost per service (expenditures/number of service units)
Unmet Need	Annually to Priorities Committee	The need for HIV-related health services by individuals living with HIV who are aware of their status but are not receiving regular primary HIV health care
Needs Assessment	Annually to Priorities Committee	Results from the needs assessment survey identifying needs of people living with HIV (could be in or out of care)

Data Type	How Reported	Description
Client Satisfaction Survey **Source**: e2Fulton	Presented quarterly to Planning Council	Client satisfaction data including: • Quantitative data from survey • Qualitative data from comment identifying strengths and areas of improvement
Agency-Level Data on Performance Measures **Source**: e2Fulton	Presented quarterly to individual agencies	Agency-specific data on performance measures will be shared with agencies to identify areas of low performance and improvement. Agencies with better than average performance will be asked to share best practices.

2. **Epidemiologic snapshot: Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction that uses the most current available data (trends for most recent five years).**

Georgia HIV Epidemiologic Profile

The most recently published Georgia HIV Epidemiologic Profile covers 2015-2019 and can be downloaded here: https://dph.georgia.gov/document/document/integrated-hiv-epidemiologic-profile-georgia-2021/download. It can also be found at Georgia HIV Surveillance Data | Georgia Department of Public Health (under Epidemiologic Profile archives).

This short document describes data for 2020, a year with a marked decrease in diagnoses because of the COVID-19 pandemic. It also provides a cluster detection update.

Diagnoses

The most important trend observed in 2020 was a sizeable decrease in HIV diagnoses, from 2,456 in 2019 to 2,041 in 2020 (17% decrease). This pattern was observed across the country and directly related to the COVID-19 pandemic, which resulted in reductions in testing services, particularly at health departments whose staff were actively engaged in COVID-19 response, as well as reductions in people accessing care because of concerns related to transmission of COVID-19 in health care settings and implementation of telehealth, which likely reduced bloodwork performed.

Decreases in diagnoses were slightly larger for some demographic subgroups, in particular persons 13-24 who accounted for 26% of diagnosed persons in 2019, compared with only 23% in 2020.

The clinical setting with the largest decrease in diagnoses was health department clinics: the percentage of diagnoses made at health department clinics decreased from 12% in 2019 to 9% in 2020; the only other setting with a marked decrease in diagnoses was blood banks, which accounted for 3% of diagnoses in 2019 compared with 1.5% in 2020 (a small proportion of overall diagnoses, but a large decrease as few blood drives were held in 2020).

Work is underway to determine to what extent diagnoses in 2021 are making up for the missed diagnoses in 2020 and which groups are experiencing the largest ongoing gaps in diagnoses.

People With HIV

The number of people with HIV increased from 58,594 in 2019 to 59,949 in 2020. There were no meaningful changes in the distribution of people with HIV by demographic characteristics.

HIV Care Continuum

Overall, the data in the HIV care continuum changed little between 2019 and 2020. The most notable changes were a small decrease in the proportion of persons receiving any HIV care (using proxy measure of at least one CD4/VL test): 69% in 2020 compared with 71% in 2019, and a larger decrease in the proportion that had two or more lab visits ("retained in care"): 48% in 2020 compared with 55% in 2019. The percentage virally suppressed remained stable at 59%, and the percentage suppressed among those in care increased from 88% in 2019 to 90% in 2020.

The reduction in persons retained in care is likely due in some part to increased use of telehealth services and temporarily foregoing lab tests for stable patients. An examination of patients returning to care in 2021 and 2022 after an apparent gap in care shows a substantial portion virally suppressed at return to care, evidently still taking ART.

The decrease in percentage receiving any care was greater for persons 20-29 than for other age groups (73% in 2019 compared with 70% in 2020), and the decrease in percentage retained in care was greater for women than for men (46% retained in 2020 compared with 55% in 2019).

Deaths

There was an increase in deaths among people with HIV in 2020 due to COVID-19 deaths. There were 840 deaths among people with HIV in 2020 compared with 760 in 2019.

STIs

The most notable change in STI diagnoses in 2020 was a decrease in chlamydia diagnoses (579/100,000 in 2020 compared with 640/100,000 population in 2019). Gonorrhea and P&S syphilis remained fairly stable (GC 200/100,000 in 2019 and 2017 in 2020, P&S syphilis 16.6/100,000 in 2019 and 16.4 in 2020). A large portion of chlamydia diagnoses occur during routine screening of young women, which was less likely to occur in 2020 as many routine visits were postponed because of COVID-19.

HIV Cluster Detection and Response Update

Until recently, the majority of priority clusters (defined as having four or more diagnoses in the last 12 months) comprised Black MSM under 30 years of age. In 2021 several clusters appeared that involved Hispanic men in metro Atlanta, one of which has become the largest cluster in Georgia, with 45 members. Detection of these clusters coincided with an increase in diagnoses among Hispanic men.

Priority clusters as of July 2022, sorted by number of diagnoses in the last 12 months

Cluster ID	Cluster count	Diagoses in past 12 months	Percent H/L	IDU or MSM/ IDU count	Predominant membership	Comment
680.1	45	11	37.8	5	Hispanic/Latino and white MSM, metro	
130.5	7	6	.	.	Young Black MSM, metro	
1233.1	14	6	.	.	Young Black MSM, metro	
1733.1	9	6	.	.	Young Black women, half metro	

*Transmission category for transgender persons was sexual contact for 93%, sexual contact and injection drug use for 4%, and injection drug use for 2%.

Cluster ID	Cluster count	Diagoses in past 12 months	Percent H/L	IDU or MSM/ IDU count	Predominant membership	Comment
1091.2	15	5	93.3	.	Young Hispanic/ Latino MSM, metro	
1171.2	6	5	33.3	.	Hispanic/Latino and Black MSM, metro	
1198.1	5	5	.	.	Black MSM, metro	
1381.1	7	5	.	.	Young white MSM, nonmetro	
1534.2	8	4	.	.	Young Black MSM, metro	
1838.1	4	2	100.0	1	Hispanic/ Latino men and women, metro	Priority because of Hispanic/Latino membership
23.28	5	0	80.0	.	Older Hispanic/ Latino MSM, metro	Priority because of Hispanic/Latino membership
680.2	7	0	71.4	.	Young Hispanic/ Latino MSM, metro	Priority because of Hispanic/Latino membership

An investigation that involved interviews of providers serving Hispanic men (both primary care and HIV care providers) and of Hispanic gay and bisexual men in metro Atlanta was launched in spring 2022 to better understand factors driving the increase in diagnoses among Hispanic men. Barriers identified included need for culturally and linguistically appropriate services, need for establishing partnerships with CBOs and providers serving Latino/Hispanic populations, need for dissemination of culturally concordant information on HIV prevention and

treatment in Spanish and physical and online venues, and expansion of LGBTQ-friendly comprehensive services.

3. HIV prevention, care, and treatment resource inventory (see Appendix A)

To compile this HIV prevention, care, and treatment resource inventory, the DPH Office of HIV/AIDS, the Ryan White Part A Program, and the Ryan White Part B Program as part of the HIV Integrated Plan workgroup worked directly with partners in Georgia and the city of Atlanta to collect accurate information across all Georgia programs.

The organizational structure of the DPH Office of HIV/AIDS allows for collaboration and coordinated efforts among different funding sources in its Prevention, EHE, and Care programs. These efforts decrease the duplication of efforts by streamlining the way funding is utilized 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 EHE programs. One example of this coordination includes the designation of CDC prevention funding to support the expansion of linkage activities in several health districts. These funds support full-time district linkage coordinators who 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.

Another example includes the interaction of various funding to the Georgia 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 prerelease and case management planning in order to link HIV-positive inmates to services upon release.

At the local level, Part B clients receive services from other Ryan White–funded and nonfunded programs that enhance and augment the comprehensive range of services required by individuals and families. For example, Part B clients receive housing assistance through the HOPWA program; women, infants, children, and youth receive assistance through Part D funds (Savannah, Waycross, and metro Atlanta); and primary care and counseling and 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.

Georgia has three Part D–funded programs located in the EMA (the Grady 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 with 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 Infectious Disease Program 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.

iv. Describe the jurisdiction's strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services.

As of August 2020, Georgia HB 217 allows for the legal establishment of syringe service programs. Any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other

high-risk behaviors" can start an SSP. SSPs in Georgia are required to provide the following services: syringe disposal; distribution of sterile syringes and new injection supplies at no cost and in sufficient quantities to prevent sharing or reusing; education materials; treatment options, including medication for opioid use disorder and referrals; Naloxone distribution and training, or referrals to these services; consultations/referrals to mental health or substance use disorder treatment; and security plans addressing site, personnel, and equipment security distributed to police or sheriff's departments with jurisdiction over SSP locations. As the governmental agency responsible for the registration and regulation of organizations operating SSPs, the DPH Office of HIV/AIDS will have opportunities to influence providers who are directly involved in the provision of substance use and treatment services and recovery interventions.

During the current fiscal year, only one Part B–funded health district (Columbus) allocated funding toward substance use prevention and treatment services to provide substance abuse assessment and counseling of HIV-positive patients in their Ryan White primary care clinic. The clinic does so by employing a behavioral health counselor to assess individuals dealing with addictions and substance abuse; family, parenting, and marital problems; suicide; stress management; problems with self-esteem; and issues associated with aging and mental and emotional health. Services are provided in individual and group sessions to help clients overcome dependencies, recover from illness, and adjust to life.

For fiscal year 2022, Part A allocated funds for outpatient substance abuse services for treatment and counseling, as well as legal and child care services (including telehealth and nontraditional hours), through seven agencies. All providers must include strategies to engage and retain clients in care as part of the client's individualized service plan. In addition, three of the substance abuse providers are also direct providers of OAHS. In fiscal year 2021, EHE began funding the Atlanta Harm Reduction Coalition, which serves persons who inject drugs, for OAHS services targeting individuals who have not entered care or who have fallen out of care. MAI funds provide funding for care teams — including substance abuse service providers — as part of a rapid-response team to provide additional support for individuals at risk of leaving care and for the provision of ART to individuals being released from jail into a court-mandated recovery program.

v. Services and activities provided by these organizations in the jurisdiction and if applicable, which priority population the agency serves.

Prevention services range from substance abuse prevention and education to treatments services, including recovery services, harm-reduction strategies, overdose reversal, and peer support. Services provided by funded Part B agencies and are included in the table.

Core Medical Services
Ambulatory/Outpatient Medical Care
Dental Care/Oral Health
Health Insurance Premium and Cost Sharing Assistance
Mental Health Services
Medical Nutritional Therapy
Medical Case Management (including Treatment Adherence)
Substance Abuse Services Outpatient

Support Services
Case Management (nonmedical)
Emergency Financial Assistance
Food Bank/Home Delivered Meals
Health Education/Risk Reduction
Housing Services
Linguistics Services
Medical Transportation Services
Outreach Services
Psychosocial Support Services

vi. Describe how services will maximize the quality of health and support services available to people at risk for or with HIV.

One of our primary focus populations for HIV prevention (including HIV testing), substance users will be able to more easily and safely obtain supplies needed for safe injection in a supportive environment. The SSP services will also allow opportunities for consumers to receive education about addiction, recovery, and safer drug use. These SSP programs will be required to provide linkage to recovery services, HIV, STI, and hepatitis C virus testing, as well as referral to other supportive programs.

Georgia's Ryan White Part B Program uses funds for the provision of core medical and support services based on documented need by funded agencies and their local consortia. The activities funded 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. Part B Office of HIV/AIDS personnel continue to work with health districts, consortia, and providers to ensure that services are provided to

address the needs of emerging populations. Public health districts, Part B–funded agencies, ADAP enrollment sites, and private providers are encouraged to provide services that are culturally competent and sensitive, including linguistic services when appropriate, to reduce communication barriers. Public health districts collaborate with CBOs to provide services for emerging populations, including dissemination of culturally specific information and linkages to care, prevention services, and supportive services. Collaboration encourages a smooth transition into HIV/AIDS care and treatment services, and reaches individuals who would not otherwise access public health agencies.

b. Strengths and gaps: Please describe strengths and gaps in the HIV prevention, care, and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts.

Staffing: Since first quarter 2020, the DPH HIV Prevention Program has been significantly impacted by the deployment of staff in response to the prioritization of other infectious diseases. Rapid and unexpected changes in work environments and focus of assignments have resulted in unprecedented staff turnover and position vacancies. There continues to be a shortage of bilingual and culturally specific workers. This is a special concern for areas where cluster data is indicating growing cases of HIV infection in Hispanic populations.

Workforce literacy: 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 suggests 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 U.S. territories that completed a 62-question web-based survey. Georgia's summary was very concerning. On average, Georgians answered only 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.

SSP: Georgia legislators passed HB 217 in 2019, giving DPH the responsibility for the registration and regulation of SSPs throughout the state. DPH has completed a three-phase project-management plan to develop rules and regulations, secure data collection and monitoring systems, and standard operating procedures for this registration and regulatory process. There are currently a few SSP programs within the metropolitan area that were in operation prior to the registration. Georgia DPH has finalized their data monitoring and data collections systems. However, there are not yet any agencies operating under the newly established legislation.

PrEP: Recent studies indicate that PrEP continues to be underutilized by populations at increased risk for HIV infection. The slow uptake of PrEP can be attributed to multiple structural and cultural barriers: geography, low rates of health insurance coverage, low health literacy, stigma, low healthcare system capacity, and low HIV risk perception.

Leveraging funding across programs (such as prevention and various Ryan White parts) allows funded agencies to provide more robust services that can be tailored to the needs of the area and are more wraparound in nature. Various funded agencies already provide what can be referred to as a status-neutral approach or a one-stop shop model. Clients are able to access prevention and care services within the same health clinic in a more seamless manner.

Needs assessments conducted by the 16 funded Ryan White agencies show that, in order of importance, the six most-needed services for people living with HIV are primary care, oral health, medical case management, nonmedical case management, mental health, and medication assistance. 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 people living with HIV 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. The major gaps identified by the 16 Ryan White Part B–funded 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. People living with HIV 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.

c. Approaches and partnerships: Please describe the approaches the jurisdiction used to complete the HIV prevention, care, and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.

The Georgia HIV Resource Hub (formerly GACAPUS) is the primary repository for collecting and compiling HIV prevention, care, and treatment resources. This is further supported by the resource database compiled by our HIV/STI hotline (Georgia AIDS & STI InfoLine). In 2022, the Office of HIV/AIDS conducted multiple community inquiries and listening sessions that have been helpful in assessing the completeness of these resources and expanding to include new and potential partners. Listening sessions included strategies for leveraging existing resources in four focus areas: people living with HIV, HIV stigma, housing and HIV, and PrEP.

Data provided by Ryan White Part B–funded agencies enabled 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 local client satisfaction surveys. Through review of needs assessments and budget proposals, DPH Office of HIV/AIDS ensured that resources and allocations address the identified local funding

needs for core medical and support services. Funded agencies submit yearly budgets that are reviewed and approved by the Office of HIV/AIDS to ensure funds are allocated to core medical services and support services as listed in the inventory.

4. Needs Assessment

a. Identify and describe all needs assessment activities or other activities, data, and information used to inform goals and objectives in this submission. Include a summary of needs assessment data including:

i. Services people need to access HIV testing, as well as the following status-neutral services needed after testing

Questionnaires were distributed to funded Ryan White agencies with community advisory boards (CABs) and CBOs to establish a comprehensive plan that addresses the needs, barriers, and outcomes across the entire spectrum of HIV-related services (prevention and care in order of importance, the six most-needed services for people living with HIV are primary care, oral health, MCM, nonmedical case management, mental health, and medication assistance). These six needs are identified regardless of where HIV-positive individuals reside (urban, suburban, or rural) as priorities by the consortia. Other identified needs include overall lack of services in the communities where people living with HIV reside. Rural and urban populations identified transportation and housing as a consistent need.

We asked Ryan White agencies with local consortia planning bodies to recommend areas they felt the statewide planning group (G-PACC) should include in its planning and analysis. It was determined that more outreach activities surrounding housing and its resources are needed, as well as home visits for the aging HIV-positive population, the importance of meals and nutrition for people living with HIV/AIDS, food insecurity and malnutrition risk data, more information on the social determinants of health, transportation, food assistance programs, and oral nutrition resources for people living with HIV/AIDS.

Ryan White agencies and CBOs were asked to provide recommendations for the type of guidance they would like to see at the state level that would assist with their local planning activities. Agencies reported the need for more social media, public relations, and development training; more awareness on services offered; professional development for health care providers to become competent on issues for the transgender community; more cultural humility training on all

diverse groups; expand e2Fulton training for all personnel handling HIV care; expansion for shared data collection to reduce burden of the person infected; engagement of community and faith-based organizations to work in collaboration and provide feedback to the EHE plan at the state level, setting a goal to increase access to mental and substance use health care providers and prioritize mental health for patients living with HIV/AIDS or at great risk to come in contact with HIV/AIDS; fully endorsing U = U undetectable = untransmittable and work with public health and marketing companies in the private sector for a cohesive campaign to raise awareness through traditional and social media outlets across the state; setting a goal to increase access to mental and substance use health care providers and prioritize mental health for patients living with HIV/AIDS or at great risk to come in contact with HIV/AIDS; funds being allocated for HIV/AIDS awareness days; purchase of HIV test kits and condoms for Tier 3 districts; creation of electronic submission of HIV forms to increase productivity; increasing hands-on training opportunities; increasing access to mobile clinics to expand care/testing in rural areas; and coordinated collaboration of health districts' program leads.

Agencies were also asked to recommend a few goals or objectives they would like to be included in the comprehensive planning document at the state level, and those recommendations were as follows:

Housing, funding for mobile HIV prevention and care units, increase funding to provide group or cohort nutrition education classes or workshops, continue and expand Georgia's Health Insurance Continuation Program (HICP) to provide health insurance access for all eligible individuals living with HIV/AIDS based on socioeconomic status, increase access to affordable housing, expand access to Medicaid for all individuals diagnosed with advanced HIV or an AIDS-defining illness, increase viral suppression rates to 95% for all counties in Georgia, create a state-level public health consult line for primary care and general practitioners for PrEP and post-exposure prophylaxis (PEP), continue addressing priority populations, sensitivity trainings, harm-reduction strategy, education and guidance regarding serodiscordant couples.

Ryan White agencies and CBOs also identified areas within their respective local community planning activities that state-level planners should be conscious of when writing the plan. They mentioned the awareness of increased homelessness with behavioral issues; the cost of housing; transitional housing; the lack of efficiency and affordability of MARTA or public transit systems for transportation to health care centers; the increasing cost of living and insufficient

wages of employment; lack of access to healthy food; the need to build relationships with partners outside of the Ryan White providers to build a comprehensive care plan; the need for diverse representation — ensuring that all communities have a presence during the planning process; telehealth, which greatly impacts HIV medical care by addressing stigma and barriers such as transportation; and broadband internet connectivity, which greatly impacts the educational health of individuals facing health disparities such as hypertension and diabetes in addition to HIV/AIDS; and cultural awareness, competency, and humility.

We also asked how their district engages people with HIV during their needs assessment process and priority setting, and how their feedback is incorporated. They conveyed that they engage with active and invested CABs, the Ryan White Community Caucus and Ryan White consortia, survey tools, and active consumers, who participate on the agency's board.

Participants said they wanted the following things prioritized: 1) feedback is incorporated in improving agency programs and services, 2) consumers have a voice in the agency's strategic plan, 3) expand and more ways to reach more clients for feedback, 4) larger CABs, 5) more information in waiting rooms and exam rooms, 6) flyers advertising CAB for recruitment, 7) having information regarding HIV placed in the lobbies, 8) having a designated educational area, and 9) improve television screens in the lobby. Another health district reports that their organization provides annual satisfaction surveys to help with assessing food and nutrition programs. The health districts also host a client advisory board (CAB) meeting once per quarter to hear ideas and solutions and to provide updates to clients who are living with HIV/AIDS. Their quality assurance team also takes feedback back to our culinary and distribution teams to incorporate into their recipes and delivery processes. Others also indicated that their district utilizes client surveys, support groups, testimonials, and focus groups to engage with clients, and based off the feedback, they develop a strategy to incorporate or change program policies.

Feedback from describing gaps in the HIV prevention, care, and treatment inventory for their district determined that the lack of public transportation and not being able to meet clients where they live or are comfortable is a gap. It was also reported that HIV prevention and care mobile units could be effective. There was a need for more housing resources and mental health services expressed.

Clayton County, Athens, Dallas, South Fulton, and Gainesville are in need of more general buildings and not specific service sites for one specific thing. Additionally, the lack of Medicaid expansion is a continued concern in Georgia. The following

areas are more concerns raised by health districts: decreased funding for nutrition education; the state should continue to use surveillance cluster tracking to prioritize additional areas that may require more urgent attention for a comprehensive response to emerging HIV/AIDS outbreaks; local and statewide hospital systems should prioritize and close the gap in urgent care and emergency departments to provide training in collaboration with public health for clinicians and social workers to treat and link individuals to care for PrEP, PEP, HIV/AIDS, and other sexual health conditions; and the state should use surveillance-level data to prioritize other sexual health concerns (syphilis, gonorrhea, chlamydia, monkeypox (Mpox)) and provide access to PrEP and PEP, limited access to an HIV provider, access to HIV rapid tests, and delay to implement rapid start module.

Ryan White agencies were provided a short overview of strengths, challenges, and identified needs with respect to HIV care, including structural and systemic issues impacting populations disproportionately affected by HIV.

The strengths are: medication and access to medications and drop-in services; extended weekday and weekend hours for convenience of clients; television ads normalizing HIV; free GED classes; good communication between departments providing prevention and care services; willingness to serve communities that may be underrepresented; the collaboration with (linkage, care, and prevention) has reduced the number of patients lost to care and increased clients' engagement; diversity in services offered at our clinic (dental, care, housing, transportation, etc.); and providing HIV care within the health department has increased our clients' access and adherence to care.

Due to the strengths listed above, 86% of individuals engaged in Ryan White care achieve viral suppression. DPH continues to learn from the COVID-19 pandemic and Mpox outbreak with a sense of urgency and should continue to apply this to HIV/AIDS and associated sexual health concerns.

Challenges addressed by the health districts were: addressing stigma and culture issues; the lack of housing and extensive public transportation; the need to expand GED classes and job vocational training; the need for more workshops for HIV-positive people to participate in; and getting the youth population in the community involved.

The DPH HIV Prevention program identifies the need for visibility in communities and in media — this can be ad campaigns and social media posts that are

leveraged or developed by the Office of HIV/AIDS and in collaboration with DPH Office of Communication, as well as individual campaigns and media posts at the local level from our funded providers (community partners and health districts).

In addition, greater physical visibility of local community providers is needed. Since the beginning of the COVID-19 pandemic, the physical presence of HIV service providers in communities has dwindled in favor of safer and more convenient virtual options. This has posed a major barrier in organizations' ability to show up for communities that need services in a meaningful and substantial way.

Likewise, the accessibility of physical spaces for individuals to receive prevention and treatment services has also been impacted. Clinic hours have been cut significantly, and HIV testing and prevention services are no longer as visible and accessible as they once were. In order to provide convenient and accessible status-neutral services to meet the needs of focus populations, service hours and geographic accessibility must be expanded.

Misunderstandings, misconceptions, and lack of knowledge of recent changes to Georgia's laws regarding criminality of transmission, age of consent for testing and treatment, and immigration status that may impact an individual's level of comfort for accessing HIV testing, prevention, and treatment services. There is need for a media campaign targeting all underserved and sometimes invisible populations that will bring awareness and provide clarity on these legal issues.

The Atlanta EMA Ryan White Part A Program determined unmet needs by using HRSA's enhanced method. Georgia DPH surveillance data was utilized to provide both required and subpopulation estimates. Ryan White Part A CAREWare data was utilized for enhanced estimates, including enhanced subpopulation estimates.

- Overall, 18% of the EMA had a late diagnosis of HIV. Subpopulations with higher rates included females (20%), people of multiple races (22%), 35- to 44-year-olds (24%), 45- to 54-year-olds (31%), 55- to 64-year-olds (26%), 65 and older (39%), males with high-risk heterosexual contact (39%), females with high-risk heterosexual contact (23%), Cobb (19%) or Clayton (22%) County residents, Black males 25 to 34 years-old (19%) and Black females 25- to 34-years-old (20%). Overall, 17% of the EMA had unmet needs. Subpopulations with higher rates included transgender people

(20%), Blacks (18%), 25- to 34-year-olds (19%), males who inject drugs (23%), males with high-risk heterosexual contact (20%), males with other/no identified risk (20%), females with other/no identified risk (21%), Clayton County residents (19%), Black males 25 to 34 years old (19%), Black females 25 to 34 years old (23%), and transgender people 25 to 34 years old (25%).

- Overall, 8% of Ryan White Part A clients had unmet needs. Subpopulations with higher rates included transgender people (20%); whites (12%); people of multiple races (12%); those 45 to 54 years old (9%); those 55 to 64 years old (9%); 65 those and older (11%); males who inject drugs (53%); MSM who inject drugs (14%); males with high-risk heterosexual contact (25%); males with other/no identified risk (12%); females with other/no identified risk (13%); transgender people who inject drugs (75%); transgender people with both sexual contact and intravenous drug use risk factors (33%); transgender people with other/no identified risk (17%); Fulton (9%), Cobb (9%), or Clayton (9%) County residents; Black males 25 to 34 years old (10%); Black females 25 to 34 years old (15%); and transgender people 25 to 34 years old (26%).
- Overall, 15% of the EMA were in care but not virally suppressed. Subpopulations with higher rates included transgender people (22%), Blacks (18%), 13- to 24-year-olds (27%), 25- to 34-year-olds (23%), 35- to 44-year-olds (18%), males who inject drugs (18%), MSM who inject drugs (19%), females who inject drugs (18%), Fulton (17%) or Clayton (17%) County residents, Black males 25-34 years old (25%), Black females 25-34 years old (27%), and transgender people 25-34 years old (28%).
- Overall 17% of Ryan White Part A clients were in care but not virally suppressed. Subpopulations with higher rates included transgender people (18%), American Indian/Alaska Natives (31%), 13- to 24-year-olds (21%), 25- to 34-year-olds (24%), 35- to 44-year-olds (18%), MSM who inject drugs (19%), transgender people with sexual contact (19%), transgender people with both sexual contact and intravenous drug use risk factors (50%), Black males 25-34 years old (25%), Black females 25-34 years old (23%), and transgender people 25-34 years old (44%).

Across the metrics and populations explored using the Unmet Need Framework, increased need was consistently observed among intravenous drug users and 25- to 34-year-olds, with particularly high need among 25- to 34-year-old Black males, 25- to 34-year-old Black females, and 25- to 34-year-old transgender people, which reaffirms the rationale for their selection as subpopulations of focus.

The Consumer Needs Assessment Survey:

Approach: The Atlanta EMA utilizes an ongoing electronic survey that is web-based, audio-assisted, and is available in English and Spanish. The survey is a mobile-first design, with no applications or software to install. Emoticons are incorporated with the response options of each question. The survey comprises 122 questions with about 550 data points. Individuals completing the survey were provided a $25 gift card.

The survey questions were developed by the Planning Council's Assessment Committee in collaboration with the Consumer Caucus. The Consumer Caucus also beta-tested the survey.

The survey is accessed by a QR code that is widely distributed to Ryan White HIV/AIDS Program subrecipients, Planning Council members, housing agencies, prevention service providers, and other stakeholders, including churches and night clubs.

These data augment the information obtained through community engagement sessions and focus groups.

- After diagnosis: 325 were offered help to obtain care; 300 were given an appointment, 246 were given a list of clinics, and 223 were linked to care within three months. When asked why they did not receive care after diagnosis, 26% weren't ready to deal with having HIV, 23% didn't want anyone to know they had HIV, 21% were depressed, 21% didn't feel sick, 23% couldn't get time off work, 16% didn't know where to go, and 16% couldn't get transportation.
- Who first helped get you into HIV care? Eighteen percent said a doctor/health care provider, 14% said the person giving test results, 13% said a case manager/social worker, and 13% said nobody.
- What happened to make you get back in care? Thirty percent said a change in insurance status, 29% got sicker, 28% heard about new provider, 24% got stable housing, 23% were able to deal with other problems in life, 22% said someone helped them return to care, and 10% were contacted by patient navigator.
- Reasons for remaining in care: Fifty-two percent said support from health care provider, 50% felt better, 44% didn't want to give it to someone else,

34% said the support of other people living with HIV, 22% said the support from a case manager, 22% said agency reminders, 20% said mental health services, 14% said HIV support groups, and 13% reported staying sober.

Need Addressed	Survey Data	Action Taken
Rapid Linkage	Health-seeking behaviors: • 78% had a provider visit within six months and 63% within three months. • 21% had no provider visit in 12 months with 93% reporting being unable to get time off from work.	• **Centralized Linkage System** — An EHE-funded centralized linkage system is in development that will utilize community health workers (CHW) to support clients and provide outreach to increase rates of linkage, retention, and re-engagement. • **Extended weekday and weekend hours** — subrecipients are required to provide services in the early morning (before 8 a.m.) or evening (until at least 8 p.m.) at least two days per week and to provide services at least one half-day every other weekend. Additionally, EHE funds have been allocated to facilitate extended hours, telecare, and electronic tablets to facilitate engagement. • **Easier Eligibility Process** — The EMA implemented a module in e2Fulton for sharing eligibility documents and to allow easy uploading of supporting documents.

Need Addressed	Survey Data	Action Taken
Linkage, Retention, Viral Suppression	Medical regimens: • Between 72% (CD4) and 74% (viral load) had labs in the past six months. • 23% did not know lab results. • 75% reported undetectable viral load. • 88% reported taking ARVs. • 28% reported missing medications more than once monthly.	• The EMA is implementing a client portal as one module of the e2Fulton system. This will allow clients to track progress, view lab results, receive messages of support, communicate with providers, and receive reminders to take medications and appointment reminders. • Funding provided for Health Insurance and Premium and Cost Sharing Assistance.
Linkage, Retention	Financial support: • Of the 44% reporting difficulties caring for their health, the most frequent responses were not enough money for food or rent, no safe or private room, and afraid for others to know I have HIV.	• Additional funds allocated for emergency financial assistance. • New nutritional campaign to prescribe and provide nutritional baskets of fruits and vegetables.
Linkage, Retention	Housing need: • Over the past two years 25% needed help finding a place to live, 25% needed permanent housing, 20% needed housing for people living with HIV, 22% needed money to pay utilities, and 14% needed short-term housing.	• Funds allocated to provide rapid rehousing and temporary shelter until such time that HOPWA services are accessed.

Need Addressed	Survey Data	Action Taken
Linkage, Retention, Viral Suppression	Access: • Transportation — 67% use personal vehicle or public transportation to medical appointments: 42% use personal vehicle, 24% use public transportation, and 1% walk. • Among respondents insured through the federal marketplace, 58% had help from a professional reviewing option and/or signing up; 36% have experienced problems getting their medications, which resulted in treatment interruptions for 86% • 16% didn't know where to go. • Treatment adherence — 85% were offered services, and 48% received services, for a gap of 52%.	• Rapid transit passes, on-demand car service, gas cards • Fund insurance navigators to facilitate enrollment • Stopgap medications • Health Insurance Premium and Cost Sharing Assistance • Partnered with the Kaiser Family Foundation and Thrive SS to launch innovative, targeted social media campaigns to reduce stigma, increase testing and raise awareness of Ryan White care and treatment availability and treatment adherence
Linkage, Retention, Viral Suppression	Case management: • 39% use a case manager to coordinate care, 44% had no case manager to coordinate care, and 16% didn't know.	• Medical case management with greater emphasis on adherence counseling • Nonmedical case management • Peer navigators • CHWs • Referral specialists

Need Addressed	Survey Data	Action Taken
Linkage, Retention, Viral Suppression		• Capacity Building Assistance Learning Collaborative — to build the capacity of subrecipients to replicate effective models of care. • CQII create+equity Collaborative — The aim is to apply quality improvement interventions to measurably increase viral suppression rates for people with HIV experiencing the impact of social determinants of health related to housing instabilities, substance use, mental health, and age across Ryan White HIV/AIDS Program–funded providers

ii. Services people at-risk for HIV need to stay HIV-negative (e.g., PrEP, syringe services programs) — Needs

In 2022 G-PACC facilitated several engagement sessions throughout the HIV planning year and identified the need for more health care centers that provide comprehensive health care and sexual health services such, as access to PrEP, HIV testing, and SSPs and programs are not limited to STI and hepatitis counseling and testing; peer-based risk reduction counseling; mental health counseling; case management, opioid overdose prevention training; and aftercare for overdose.

iii. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV-positive diagnosis — Needs

Expansion of linkage to care (which represents two of the four pillars or the EHE initiative: treat and prevent). Ensure rapid initiation of ART (pillars: treat, prevent). Partner services (pillars: prevent, respond). Peer navigators (pillar: respond). Expansion of service visibility and hours of operation (pillars: respond, treat).

iv. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression — Needs

Services that people with HIV need to stay retained in HIV care and treatment to achieve viral suppression include peer navigators, out-of-care linkage specialists, health insurance counseling, navigation services for individuals who have limited or no insurance coverage, expanded housing, mental health, and substance abuse services.

Early initiation of ART and retention in HIV care are central to achieving viral load suppression and reducing mortality and progression to AIDS. Linkage to care is the first step in this process. 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. To achieve this, strategies to minimize barriers to medication adherence must be developed (pillars: treat, prevent, respond).

Another way to keep HIV-positive individuals retained in care is to use data to identify HIV-positive persons who have not achieved viral suppression. Generating data reports from client-level data will assist in identifying and engaging with those who have been out of care and who are not virally suppressed, and identifying needed support services and adherence needs (pillars: treat, prevent).

v. Barriers to accessing existing HIV testing, including state laws and regulations, HIV prevention services, and HIV care and treatment service — Accessibility

Barriers to accessing HIV services are prevention, testing, care, treatment.

Georgia's statewide approach has been to tailor services to the needs of specific at-risk and underserved populations. In support of a status-neutral approach,

Georgia is committed to providing services addressing social determinants of health regardless of HIV status.

Georgia continues to support and encourage activities specific to the MSM population by promoting home HIV testing and ongoing Journey to Change symposiums targeting MSM in Georgia to educate this specific population on updates regarding HIV prevention, care, testing, and treatment. DPH strives to provide evidence towards MSM discoveries to improve health through relevant and proven outcomes. DPH fosters opportunities to share understanding among interested partners in STD/HIV prevention about a MSM sexual health standard of care.

Additionally, Georgia has increased its collaboration to strengthen linkage to care activities for newly released former inmates. This activity ensures that newly released inmates are directly linked to HIV care and provided ART. This activity is designed to support people with HIV with a focus on meeting their needs while decreasing new HIV infections within this specialized population.

b. Priorities: List the key priorities arising from the needs assessment process.

The goals and strategies presented in this plan were drafted and prioritized though Georgia's planning and needs assessment processes. Further insight into needs was provided by ongoing community engagement sessions and collaborative 2022 listening sessions with G-PACC and the Ryan White Part A Atlanta Metropolitan Planning Council.

In August and September 2022, the statewide planning group engaged in a process to prioritize specific strategies to support the achievement of this HIV integrated plan's goals.

The DPH HIV Prevention program has identified the key priorities:

- Availability and visibility of on-site and targeted HIV testing, especially for focused populations
- Enhanced strategies to increase uptake of PrEP throughout the state
- Enhanced strategies to increase syringe services and harm-reduction services

- Enhanced understanding of the role of condom distribution in the age of biomedical prevention
- A strategic social media campaign promoting HIV prevention services
- Peer navigators and linkage coordinators to ensure linkage to care and prevention services
- Culturally and linguistically competent providers and service delivery for all clients
- Health literacy and comprehensive sexual health education for providers and clients

c. Actions taken: List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.

d. Approach: Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in Appendix 3.

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.

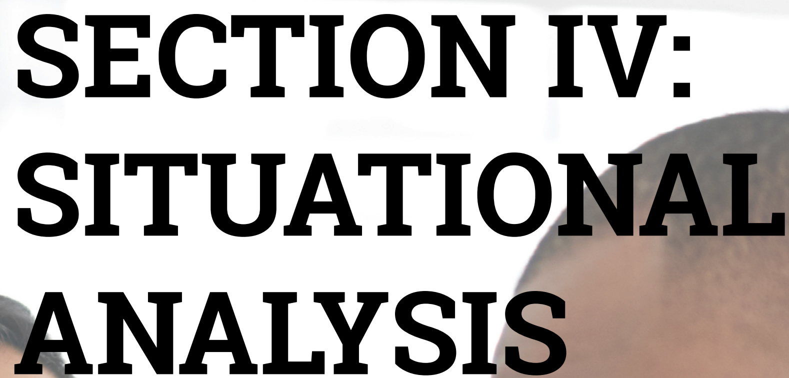
The Georgia Ryan White Part B ADAP/HICP program has implemented two quality-improvement projects to help address retention and access issues, which the program anticipates will lead to an increase in program utilization. The projects include two reports called the Medication Utilization Report and the Recertification Report. The Medication Utilization Report is provided to the ADAP/HICP enrollment sites each month with a list of clients from each agency who did not pick up prescribed medications within 30 days. Follow-up is conducted with each site to find out if they have reached out to the client, identified barriers and addressed them, and if the client was finally able to pick up their prescriptions. The Recertification Report is provided to the ADAP/HICP enrollment sites each month with the list of clients who are due for recertification. Follow-up is conducted with each site to find out what steps the agency is taking to ensure they are identifying issues and barriers ahead of time and are working with the clients to make sure recertifications are submitted on time.

The Part B program also updated the recertification policy to remove the six-month recertification requirement per PCN 21-02, as of December 10, 2021. Currently all recertifications occur on an annual basis. To verify that the program has up-to-date client information, clients are expected to submit all appropriate documentation during their 12-month recertification. The program surveyed all enrollment sites for feedback on additional areas of improvement related to client recertification processes. Feedback was reviewed against HRSA policies, and changes in required documentation were identified to lessen case manager burden when completing applications and recertifications on behalf of clients.

To improve the availability and accessibility of HIV testing, the Office of HIV/AIDS has implemented a statewide HIV self-testing awareness and distribution program. This program features two options for receiving HIV self-tests. All consumers receiving HIV self-tests must complete an online survey, entering basic demographic information and answering a few questions regarding their decision to utilize HIV self-testing. The survey allows the consumer to select the option to have (1) up to two HIV self-tests discreetly delivered to their home address or (2) to visit a local pickup site and receive up to two HIV self-tests. Consumers are encouraged to complete a post-test survey to access status-neutral follow-up linkage and access to services.

To address the decrease in access to condoms related to social distancing and self-quarantining over the last two years, providers around the state have developed mail-order condom distribution programs. Through social media and their agency websites, providers make available a generous variety of condoms and other safer-sex supplies through the mail. These programs have been popular in rural parts of the state as well as in the metropolitan area. The success of these programs has been in the convenience and anonymity of condom delivery. Consumers are reporting their satisfaction with the quantity and variety of products available through these programs.

Georgia legislators passed HB 217 in 2019 giving DPH the responsibility for the registration and regulation of SSPs throughout the state. DPH's three-phase project-management plan develops rules and regulations, secure data collection and monitoring systems, and standard operating procedures for registration and regulatory process. There are currently a few SSP programs within the metropolitan area that were in operation prior to the registration. We are currently completing the last tasks for finalizing the data monitoring and data collection systems.



SECTION IV: SITUATIONAL ANALYSIS

A. Based on the community engagement and planning process in Section II and the contributing data sets and assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the integrated plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas:

   i. Diagnose all people with HIV as early as possible
   ii. Treat people with HIV rapidly and effectively to reach sustained viral suppression.
   iii. Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs

While recognizing the monumental efforts over the past 35 years to address HIV through the implementation of new strategies, we have witnessed some progress. However, the number of HIV cases continues to rise and remain alarmingly high in certain areas in Georgia. HIV infection remains an important public health problem in the state of Georgia. As of the end of 2020, there were 60,073 persons living with HIV in Georgia; 2,018 persons were diagnosed in 2020.

This section focuses on the strengths, challenges, and needs for Georgia. Information was gathered from data collection and questionnaires that were given to the health districts across the state, as well community listening sessions facilitated by a partnership from G-PACC and the Atlanta HIV Health Services Planning Council.

Specific stakeholder and vulnerable populations are identified by planning groups. It also presents current and emerging challenges, both statewide and in the Atlanta EMA, as well as determines overarching themes in specific geographic areas, service gaps, workforce issues, structural challenges, and other developing issues that will impact achievement of the goals of the integrated plan.

i. Diagnose all people with HIV as early as possible

The following strengths identified by the Office of HIV/AIDS HIV Prevention are robust systems that aim to diagnose all people with HIV as early as possible:

1. An extensive public health network that consists of 18 health districts and 159 counties. This entire public health network that touches even the most rural and remote communities in the state represents potential partners in reaching individuals who may be infected and not know it.
2. Multiple academic organizations in Georgia that have expertise in the field of HIV prevention, particularly biomedical interventions.
3. Allowing easy access to resources, including capacity-building assistance and staffing assistance programs due to Georgia being the home of CDC.

The following weaknesses were identified by the Office of HIV/AIDS:

1. The dwindling public health workforce and constant turnover of clinical health care workers. This is most evident in the number of individuals who register for and receive certification in the DPH HIV Counseling and Testing Training Curriculum. It is also evident based on studies that the scientific and clinical knowledge about HIV among the public health workforce in the Southeast is unsatisfactory.
2. Institutional stigma and lack of prioritization of HIV media and marketing needs do not allow for adequate and timely marketing and social media campaigns that that can reach people at greatest risk with messages that are meaningful, compelling, and appealing.
3. In the metropolitan area, all health department clinics are not on board with HIV testing. This represents a huge missed opportunity. Of all Fulton County's community clinics, there is only one, the district office, where HIV testing is available. Further, this one clinic in Downtown Atlanta is located in an area that is not accessible to many people. The environment is not welcoming, and parking is a challenge.
4. Georgia continues to miss opportunities for reaching another vulnerable population, Hispanics. Current cluster data shows very clearly this need.
5. The lack of qualified culturally and linguistically specific staff within the public health system has been identified as a contributing factor to the rapid spread that cluster data is indicating in this population.

Opportunities:

1. We have a strong training program and an automated learning management system that can be expanded and upgraded to manage

the increasing need for training new staff and strengthening the knowledge base of existing staff.

2. Fulton County has multiple community clinics located throughout the county that can be leveraged for expansion of HIV testing that will be convenient and safe for members of the community.
3. We have seen models of community centers that are designed specifically to meet the needs of gay and bisexual men. This is particularly needed in the Atlanta metropolitan area. Fulton County Health and Wellness currently has staff that are innovative and capable of setting up, staffing, and operating this type of community center.

Threats:

1. The biggest threat, as we have seen over the last two and a half years, is the potential massive loss of staff related to the COVID-19 pandemic.

Ryan White Part A continues to promote testing as the single most effective way to determine early diagnosis. The need to diagnose all people living with HIV as early as possible will require an ongoing increase in HIV testing. Efforts should be made to increase testing in geographical areas with a high burden of disease among priority populations Black MSM, MSM, transgender people, Black females, and Hispanics. Efforts should be taken to employ members of target populations to provide testing and partner services. They will be responsible for contact tracing and contact testing of newly diagnosed HIV-infected individuals while giving priority to those with acute infections. Other potential strategies for increasing HIV testing include HIV testing and counseling for couples and partnering with CBOs, faith-based agencies, group homes, beauty salons, barber shops, gas stations, bars, night clubs, extended-stay motels, and higher education institutions in disproportionately affected ZIP code areas to provide testing, counseling, and education.

DPH HIV Prevention–funded CBOs should continue to focus their HIV messaging, outreach, and HIV testing and counseling activities to target groups in ways that are culturally and linguistically appropriate and that address culturally established patterns for avoidance of HIV status awareness as well as the promotion of stigma. Activities should include effective behavioral interventions and other health education strategies (e.g., health fairs, awareness days, social marketing).

System-level interventions will address barriers that keep people from testing and access to care. CDC recommends HIV testing for all patients over the age of 13,

with the option to opt out. Following this guidance, efforts will continue to fully embed HIV testing into routine medical laboratory testing to reduce stigma and increase the number of individuals that consent to testing. This practice moves us closer to normalizing HIV and HIV testing. This policy should be adopted by Federally Qualified Health Centers, emergency departments, and medical clinics such as college student health clinics, adult health clinics, STI/TB clinics, refugee clinics, family planning clinics, perinatal/maternal clinics, pediatric clinics, and high school clinics.

ii. Treat people with HIV rapidly and effectively to reach sustained viral suppression

iii. Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs

The following are strengths identified by the Office of HIV/AIDS HIV Prevention:

1. There are multiple academic organizations in Georgia that have expertise it the field of HIV prevention, particularly biomedical interventions.
2. Georgia is the home of CDC, allowing easy access to resources, including capacity-building assistance and staffing assistance programs.
3. There is new leadership in Georgia's Office of HIV/AIDS, which provides an opportunity for fresh ideas and innovative strategies to evolve and move the programs to a new level.

Weaknesses:

1. Georgia's primary need for these services is in the metropolitan Atlanta area. Public health is segmented, with multiple public health jurisdictions that operate under different boards, each with varying degrees of capacity and commitment to the eradication of HIV
2. PrEP uptake in Georgia continues to be lagging, particularly among populations most at risk in the jurisdiction. Stigma continues to be a threat to the uptake of biomedical HIV-prevention interventions, particularly in females.
3. There continue to be misconceptions on the impact of PrEP for individuals who utilize other medications, particularly hormone therapy. This has been a particular problem for transgendered individuals who are at high risk for HIV infection.

Opportunities:

1. As Mpox continues to impact our highest-HIV-risk populations, new opportunities are being presented that allow access to MSM. The media coverage and community mobilization activities that have been directed to this community for the purpose of promoting Mpox vaccination has given us new opportunities to collaborate for the purpose of HIV testing.
2. As COVID-19–related restrictions have been relaxed, MSM and other focus populations are becoming more active and social within their communities. By the same token, our HIV testing partners are beginning to venture back out into venues where these populations tend to gather and congregate. We are already seeing an increase in targeted testing and outreach.
3. CDC has recently issued new guidance that allows a percentage of HIV prevention funds to be utilized for the purpose of ancillary services and supplies to support the implementation of PrEP.
4. The PrEP pilot project funded through state dollars as a result of legislative action has opened an unprecedented opportunity for the DPH HIV Prevention Program. For the first time since the start of the HIV epidemic, we have access to state funding for the support of HIV prevention in Georgia.
5. Implementation and application of PrEP continues to evolve rapidly. As innovation in technology and research improves PrEP medications and makes access easier with fewer doses and fewer visits for exams and lab tests, our work in promoting and enrolling consumers in biomedical HIV prevention interventions should evolve and become easier as well.

Threats:

1. Problems with access to insurance and options for covering PrEP/ nonoccupational post-exposure prophylaxis (nPEP) services continue to be contributing factors in recruitment and uptake of PrEP and nPEP.

Based on agency and consumer engagement, as well as data showing utilization of services, the Ryan White Part B Program can categorize the situational analysis for rapid and effective treatment of people with HIV to reach viral suppression as follows:

PrEP uptake in Georgia continues to be lagging, particularly among populations most at risk.

Entry and Access to Services:

Strengths

1. The organizational structure of DPH Office of HIV/AIDS allows for collaboration and coordinated efforts between the DPH HIV Prevention and HIV Care programs. These efforts decrease the likelihood of duplication of efforts by streamlining the way funding is utilized to ensure the continuity of prevention, care, and treatment services. Examples of this interaction include linkage services to Ryan White clinics provided to newly diagnosed individuals through the Prevention Program. The Ryan White Part B Program incorporated language into the policies and procedures that emphasizes that clinics do not need a confirmatory test to begin the linkage process with an aim at shortening any wait times for clients to begin receiving care.
2. Change of recertification policy to remove the six-month recertification requirement per PCN 21-02, as of December 10, 2021. Currently all recertifications occur on an annual basis, during which all supporting documentation is required to be submitted.
3. Increased provision of telehealth services statewide amid the COVID-19 pandemic (including mental health services where available). This move allowed for retention in care, even if clients were unable to visit a clinic, particularly during the early days of the pandemic.

Facilitators to Care

Strengths

1. Utilization of ride-hailing services like Uber Health to facilitate transportation barriers. Uber Health is a Health Insurance Portability and Accountability Act–compliant service where clinics are able to set up a business associate agreement with Uber. As part of this agreement, Uber will commit to safeguarding protected health information. The service will allow clinics to arrange, schedule, and track rides on behalf of clients through a dashboard. The dashboard tracks the complete trip history of each ride, including information such as rider, driver, pickup and drop-off location, and cost of each ride. Clients do not need to have their own account.
2. At the local level, Part B clients receive services from other Ryan White–funded and nonfunded programs that enhance and augment the comprehensive range of services required by individuals and families. For example, Part B clients receive housing assistance through the HOPWA program; women, infants, children, and youth receive assistance through Part D funds (Savannah, Waycross, and metro Atlanta); and primary care, counseling, and 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.
3. Availability and use of a language line that providers can utilize as a translation service to assist clients who do not speak English as a primary language.

Challenges

1. The principal challenge to facilitators of care is capacity, particularly in rural areas of the state. For example, use of the language line alone does not do a great job replacing cultural competency and making clients of other ethnicities feel like the clinic is their medical home. Ride-hailing programs like Uber Health are not easily available in rural areas of the state, so more rural areas still need to contract taxi services or other methods of private transportation, which can be more costly and can pose confidentiality issues if proper agreements are not in place. Housing continues to be a challenge across the state, especially as inflation brings costs of living up.

Needs

1. In addition to additional funding for service provision, another need is increased cultural competency training. Also, expanding the hiring pool to include potential hires who speak more than one language to diversify clinic staff.

Health Coverage

Strengths

1. Continued increase in the number of clients applying for insurance. According to the Centers for Medicare and Medicaid Services, 701,135 Georgians enrolled in health insurance plans during the 2021 enrollment period. This number represents the fourth-highest enrollment after Florida, Texas, and California. The provision of health insurance lessens the burden of cost of providing only HIV medications while allowing clients to access additional coverage for health care that is not specific to HIV.
2. Continuous provision of technical assistance from the state to local clinics educating on benefits of insurance, how to apply for subsidies and tax credits, and how to assist clients selecting a beneficial health plan.

Challenges

1. The state of Georgia has decided not to expand the Medicaid program at this time; therefore, Medicaid eligibility will remain the same as it has during previous years. Without expansion, the Georgia Ryan White Part B Program does not anticipate a change in the number of clients served by Medicaid. The state does expect enrollment in private health plans to increase during upcoming enrollment periods partly due to increased focus on the health care landscape and knowledge of the benefits of having insurance.
2. Not all health insurance marketplace plans cover medications and services needed by HIV/AIDS clients, and available plans can differ by region. Some health plans have high out-of-pocket expenses and can be difficult for clients to afford. In addition, more rural areas of the state have limited access to available health care plans, so coverage options are not necessarily equal across the state.
3. With decreased federal funding for insurance navigator roles, there is limited health insurance assistance that is knowledgeable in HIV care.

Local case management staff often ends up taking the brunt of the researching, educating, and planning for clients seeking health insurance assistance, which increases the burden of work. As a result, clients can miss opportunities to take advantage of tax credits and subsidies to decrease plan costs and get them better wraparound coverage.

Needs

1. More availability of funding for insurance navigators trained in the needs of clients with HIV, as well as increased availability of plans across the state.
2. Strong push to make sure clients who are eligible for tax credits and subsidies are applying for them before seeking assistance from Ryan White, which would liberate funds for other services.

The Ryan White Part A Program supports Rapid Entry clinics, which were established to explore the effectiveness of linking people living with HIV to care (and access to ART) within 72 hours. This strategy proved to be effective in reaching sustained viral load suppression. As a result, the goal of rapid entry has to become a fully integrated system within normal health care operations. All Ryan White subrecipients should promote rapid entry as a treatment strategy and compound the effectiveness by integrating greater modes of accessibility like weekend and evening hours as well as teleconsulting for individuals who may need coaching assistance in establishing linkage to care.

Efforts should continue to establish mobile testing units so that individuals testing positive for HIV can immediately have their first medical appointment, including ART initiation, and high-risk individuals with a nonreactive test result can initiate PrEP (medications paid for by non-Ryan White source). Linkage to care: Staff will be available to support clients from the time of their new diagnosis through linkage to care and will continue to assist clients as needed to help them adjust to life with HIV. Ryan White Part A–funded patient navigators serve clients in education, peer counseling, support, and assistance with navigating the health care system.

As people living with HIV, patient navigators have proven to be extremely effective in helping the newly diagnosed remain engaged in HIV care, while navigating them through the challenges and potential barriers. Medical case managers should continue to be used to assist with identifying the needs of those newly diagnosed and helping them get enrolled into care, to help link clients to the

appropriate services, and to support clients' continued engagement and retention in medical care, while ultimately helping clients achieve the goal of viral suppression.

Medical case management should also expand its capacity to provide medical adherence counseling and facilitate linguistic services for those who need translation support at appointments, medical transportation assistance to case management and clinic appointments, and mental and oral health services. Medical case managers play a vital role in the development of individualized sustainable service plans, which have been proven to identify and address both immediate and long-term issues and barriers.

Challenges

1. Distance between clinic locations can be a challenge for clients. While the program funds Ryan White clinics throughout the state, they are typically limited to one clinic per health district, and there are limited satellite locations/hours. Additional locations are often hindered by funding needs (additional cost for after-hours salaries, utilities, security, etc.)
2. The distribution of providers across the state continues to impact access to care, creating a service gap among people living with HIV, particularly for residents of rural areas and especially for those who require specialty care. 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.
3. Increased staff turnover due to burnout and noncompetitive salaries.

Needs

1. As mentioned above, the need for additional funding at the clinic level to expand services and attract providers with competitive salaries.

Additionally, Ryan White programs continue to increase awareness of PrEP and nPEP services through supporting community engagement sessions and educational campaigns among health service providers. These efforts serve to enhance community knowledge in the growing landscape and availability of PrEP and nPEP.

Access is also needed for HIV seronegative individuals to PrEP. 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 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 is important to develop the necessary partnerships with clinics that see people living with HIV and CBOs that serve historically underserved populations to ensure that they have condoms available for distribution and PrEP educational material (including injectables).

iv. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Real-time response systems are key to ending the HIV epidemic in the United States. New laboratory and epidemiological approaches help identify communities affected by rapid HIV transmission resulting from gaps in prevention and care services. It is imperative that data and other resources be used to swiftly and get clients the services they need to slow or even prevent HIV outbreaks.

Information was gathered from data collection, questionnaires that were given to the health districts across the state, and community listening sessions facilitated by a partnership from our statewide planning council and the Atlanta HIV Health Services Planning Council. It was determined that several overarching themes emerged from these: housing, stigma, PrEP, cultural competence, SSPs, communication barriers, competitive salaries for district-level employees and clinical staff, retention in staffing, working conditions, burnout from employees, and Medicaid expansion.

Health Equity

Health equity is an overarching theme that fosters the framework for the integrated plan. It is important to recognize that social factors and biases shape the health of everyone. When efforts are made to address health equity, improvements such as in the social determinants of health can occur. Social determinants of health are nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life and if health care is available and accessible. These forces and systems also include economic policies, systems, social norms, social policies, and political systems (WHO, 2022).

Social Determinants of Health

The social determinants of health refers to issues that impact people's daily lives in areas such as transportation, housing, stigma, racism/discrimination, education and literacy, employment, violence, availability of healthy food, air quality, water quality, and physical activity. In all areas of income, health and illness follow a common decline: the lower the socioeconomic position, the worse the health.

When creating services that are welcoming and accessible, it is important to recognize intersectionality and how the health of an individual is also shaped by multidimensional and overlapping factors that could marginalize people. These factors include gender, sexual orientation, race, class, income, education, age, ability, immigration status, ethnicity, indigeneity, and geographical regions.

Status-Neutral Approach

Status-neutral approaches promote health equity. This health equity by putting client needs above HIV status to improve care and eliminate stigma through HIV education, testing, and treatment emphasizes treating everyone regardless of their HIV status with similar access to services. This approach integrates prevention and treatment services so that both become part of comprehensive primary care and address the needs of the whole person while mitigating HIV-related stigma. All clients receiving HIV testing or other services (e.g., STI screenings) are treated the same. Depending on the results of HIV testing, people are referred to either HIV prevention or HIV treatment. Those who are HIV-negative are referred to PrEP and condoms. Those who are HIV-positive are referred to treatment.

DPH Response to HIV: Strengths

DPH is diligent in its efforts to eliminate new HIV infections; maintaining meaningful engagement with people living with HIV/AIDS; improving the health of people with STIs; efforts committed to eliminating new infections; improving the health and well-being of people with HIV, STIs, and viral hepatitis; and improving LGBTQ+ health and the health of people who use drugs.
The following bullets located below are the strengths that Georgia brings to the EHE effort.

- Statewide, local, and jurisdictional HIV planning processes
- Significant client and stakeholder involvement
- Collaboration with local city HIV planning councils
- Commitment to health equity

- Use of data to track and report progress on Program Funding Opportunity Announcement PS18-1802 and EHE goals

EMA Situational Analysis

Housing

People experiencing homelessness are more likely to acquire HIV, and their rates of new transmissions are 16 times higher than those of the general population. Housing instability also disproportionately affects minority communities, has been consistently associated with poorer health outcomes for people living with HIV, and is a stronger predictor of HIV health outcomes than characteristics such as gender, race, age, substance abuse, or mental health issues. Fear of exclusion from housing or shelter plays a negative role in getting people in HIV testing, and housing instability is also a barrier to accessing HIV medical care, medication adherence, and viral suppression.

Recommendations:

- Enhance partnerships between HOPWA, the HUD Office of Housing, and other service organizations to increase program coordination and service delivery.
- Provide short-term rental assistance and emergency financial (utility deposits and payment) assistance to clients identified as being temporarily or unstably housed.

Stigma

Fear of stigma and discrimination is still a major deterrent for HIV testing and treatment. Ryan White Part A continues to utilize social marketing, social media, education, awareness-raising, and routine HIV testing to reduce stigma surrounding HIV. Social determinants of health related to economic stability including poverty and unemployment, health care access and quality, and social and community conditions including cultural factors and intersectional stigmas related to HIV, sexual and gender identity, and poverty contribute to the burden of HIV in the South and Deep South regions.

Recommendations:

- System intervention. Continue efforts to fully embed HIV testing into routine medical laboratory testing to reduce stigma and increase the

number of individuals that consent to testing.

- Marketing and social media campaigns. Reduce stigma, increase testing, and raise awareness of Ryan White care and treatment availability.
- Support initiatives to normalize HIV testing and the colocation of primary care services.

Social Determinants of Health/Health Disparities

Social determinants of health and disparities continue to drive the HIV epidemic in the state of Georgia. Unique challenges of emerging populations include barriers that obstruct awareness of HIV status. This includes the lack of access to general HIV information, missing out on the benefits of early treatment, lack of targeted prevention messages, poverty, stigma, lack of access to regular health care, racism, discrimination, homophobia, and reluctance to talk about sex and drug use.

Recommendations:

To enhance client engagement, employ dedicated staff that reaches out to clients to determine if there are social determinants of health that need to be addressed.

Uninsured and Underinsured/Medicaid Expansion

Although the Affordable Care Act has made significant progress in Georgia for people having pre-existing conditions, Ryan White Part A has provided support to a wide number of uninsured people living with HIV. Ryan White Part A support includes medical care, case management, mental health services, and HIV drugs at no cost. It also helps patients purchase health insurance, which is often less expensive than providing drugs.

Recommendations:

Monitor the federal and state health care landscape to identify policy changes that can impact the delivery of HIV primary care services.

a. Priority populations: Based on the community engagement and planning process in Section II and the contributing data sets and assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.

The goals, objectives, and strategies presented in this plan were drafted and prioritized though Georgia's ongoing planning, community engagement, monitoring, surveillance, and needs assessment processes. Further insight into the needs of people living with HIV/AIDS was provided by 2022 community listening sessions, facilitated by G-PACC and the Metropolitan Atlanta HIV Health Services Planning Council, and surveillance reports by DPH HIV Surveillance and Fulton County epidemiologists.

In August 2022, G-PACC's Stakeholder Engagement Committee engaged in a process to prioritize specific strategies to support the achievement of this plan's goals. Many of the ongoing activities carried out across the state are in alignment with EHE and this plan. In addition, Section V includes strategies, prioritized by planning groups, DPH HIV Prevention Program, Ryan White programs, and the HIV integrated plan workgroup.

In efforts to identify needs, needs assessments and data reports are ongoing as part of initiatives of the HIV Prevention Program, Ryan White programs, and both planning groups. Planning groups and their respective committees comprise leaders, advocates, clinical providers, consumers, government agencies, social services representatives, CBOs, nontraditional partners, and researchers. In addition, there are population and topic-based representatives that provide expertise by identifying needs for non–English-speaking clients, Latino gay/bisexual men, Black MSM, women, young adults, older adults over the age of 50, Asian Pacific Islanders, and the trans population. People with HIV participate in listening sessions to get feedback and foster the opportunity for continued stakeholder discussions to identify needs and increase awareness in all areas of focus.

During HIV workgroup meetings, discussions that centered around the trans population were profound, as they have also been identified as a prioritized population in the state of Georgia. However, there is limited data available on HIV-related clinical indicators amongst transgender women. A Lack of robust data collection and research on transgender individuals resulted in limited data on clinical indicators amongst transgender women. Many systematic factors contribute to the spread of HIV amongst transgender people. Many face stigma, discrimination, social rejection, and exclusion, which results in lower engagement in HIV prevention, treatment, and support. That ultimately prevents them from accessing health care, education, employment, and housing, which contributes to poor outcomes. To decrease HIV transmission in Georgia and prioritize HIV services for the trans population, efforts to strengthen HIV prevention and care for transgender people is needed. Transgendered data for Georgia is located in Appendix B.

SECTION V: 2022-2026 GOALS AND OBJECTIVES

Goals and Objectives Description: List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent, and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. There should be at least three goals and objectives for each of these four areas.

A. Updates to other strategic plans used to meet requirements: If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.

The goals presented in this HIV integrated plan (see Appendix C) reflect the guidance from CDC/HRSA and align with the four pillars of the EHE initiative. It is important to note that some goals and strategies also align with other pillars. These four areas of focus are:

- **Diagnose** all people with HIV as early as possible.
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions, including PrEP and SSPs.
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

SECTION VI: 2022-2026 INTEGRATED PLAN IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP

2022-2026 Integrated Planning Implementation Approach: Describe the infrastructure, procedures, systems, or tools that will be used to support the five key phases of integrated planning to ensure goals and objectives are met.

A. IMPLEMENTATION: DESCRIBE THE PROCESS FOR COORDINATING PARTNERS, INCLUDING NEW PARTNERS, PEOPLE WITH HIV, PEOPLE AT HIGH RISK FOR EXPOSURE TO HIV, AND PROVIDERS AND ADMINISTRATORS FROM DIFFERENT FUNDING STREAMS, TO MEET THE JURISDICTION'S INTEGRATED PLAN GOALS AND OBJECTIVES. INCLUDE INFORMATION ABOUT HOW THE PLAN WILL INFLUENCE THE WAY THE JURISDICTION LEVERAGES AND COORDINATES FUNDING STREAMS, INCLUDING BUT NOT LIMITED TO HAB AND CDC FUNDING.

Integrated plan activities and outcomes will be shared with Ryan White– and HIV Prevention–funded agencies through program webpages and email correspondence. Agencies will be encouraged to disseminat Integrated plan activities and outcomes will be shared with Ryan White– and HIV Prevention–funded agencies through program webpages 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 people living with HIV 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 and 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.

The organizational structure of DPH Office of HIV/AIDS allows for collaboration and coordinated efforts among funding sources in the Prevention 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.

G-PACC membership includes representatives from major stakeholders, including but not limited to Ryan White parts A, B, C, and D; state HIV prevention; consumers; DOC; HOPWA; people with hepatitis; HIV surveillance programs; 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 people living with HIV 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 intersection of various funding to the Georgia DOC. 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 prerelease and

case management planning in order to link HIV-positive inmates to services upon release.

The Ryan White Part B CQM Core Team includes representation from all Ryan White parts, as well as consumers. Part B CQM personnel attend local Ryan White Part A Program CQM meetings to share updates and 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 nonfunded programs that enhance and augment the comprehensive range of services required by individuals and families. For example, Part B clients receive housing assistance through the HOPWA program; women, infants, children, and youth receive assistance through Part D funds (Savannah, Waycross, and metro Atlanta); and primary care and counseling and 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.

As another example, the Fulton County Department for HIV Elimination (DHE) houses multiple grants to support services for people living with HIV in the EMA, including Ryan White Part A, Part A Minority AIDS Initiative, and EHE grants. As a part of the EHE grant, community engagement sessions were held to gather consumer feedback and recommendations on how funds could be used to design innovations in our system of care and change the way that we respond to service needs. DHE utilizes these funding sources to address consumer needs and coordinate care within the EMA. DHE also works with the Planning Council to solicit consumer feedback. DHE staff and Planning Council members are part of the city of Atlanta's HOPWA Advisory Committee to work to improve housing options and to coordinate HOPWA services with care and treatment services.

Integrated plan activities and outcomes will be shared with Ryan White– and HIV Prevention Program–funded agencies through program webpages, email correspondence, and meeting minutes. Agencies will be encouraged to disseminate the plan and its updates 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 people living with HIV 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 and 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 meetings.

B. Monitoring: Describe the process to be used for monitoring progress on the integrated plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only integrated plans, state-only integrated plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination.

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 is prioritized when changes to the system are needed. Goals and objectives will be monitored by the Part B program staff, in collaboration with DPH HIV Prevention Program staff and colleagues across other Ryan White programs. Partner agencies will evaluate measures indicated in the document, and periodic updates will be provided to colleagues throughout the state, particularly with key partners who helped 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. 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 CQM 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-ensuring data, and providing training and technical assistance.
- **District Liaison Team.** Responsible for monitoring compliance with programmatic, state, and federal regulations and providing technical support and assistance to funded agencies.

DPH's HIV Prevention Program will focus on those related goals and objectives around prevention efforts to ensure activities are implemented effectively and monitored continually to determine areas that need revisions or enhancements. Best practices for prevention activities will facilitate planning around strategies that directly address factors that affect knowledge and attitudes about HIV/AIDS, HIV screenings, risk factors for other STIs, linkage to and reengagement 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 DPH program data sources will incorporate HIV surveillance, HIV counseling and testing data via CDC-sponsored EvaluationWeb, STI 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 technical assistance 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 their role providing review and feedback of the integrated plan, the

G-PACC subcommittees will have the responsibility of ensuring that the level of services delivered across the continuum represents equity when examined across the jurisdictions and regions.

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 and appropriate activities
4. 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.

The EMA employs continuous quality management to monitor Ryan White Part A and EHE progress. The current continuous quality management process will be revised to incorporate quarterly monitoring of the integrated plan and achievement of its goals and objectives. Part A staff who will be involved in integrated plan monitoring and evaluation include the following:

- **Quality Management Team** — includes the quality management specialists and quality management program manager. They are responsible for development, implementation, and evaluation of the quality

management plan and work plan; reviewing agency quality management plans; assessing results of the EMA-wide chart reviews; working with subrecipients on corrective action plans; developing and revising quality management guidelines and policies as indicated; providing technical assistance and trainings; coordinating the work of the QM Committee with the recipient's HRSA requirements; monitoring progress of the data evaluation and reporting activities; coordinating systems-level continuous quality improvement projects in collaboration with the Planning Council Quality Management Committee; and participating in statewide continuous quality improvement efforts in partnership with Part B.

- **Evaluation administrator** — responsible for analyzing and reporting quarterly data reports including e2Fulton utilization, performance measures, unmet need, and Ryan White cost data and producing data for the Priority-Setting, Quality Management and Assessment Planning Council committees. This position is also responsible for providing ongoing data analysis and support to consultants and chart review analysis, reports, and presentations.
- **Database administrator and database manager** — responsible for managing the e2Fulton database, monitoring agency compliance with RDR submissions, providing technical assistance and training, preparing data reports, submitting e2Fulton Data Report to HRSA, and coordination with the county's Information Technology Department and with contracted data analysts and data consultants.
- **DHE health program manager** — responsible for monitoring and evaluating the progress on the integrated plan within the EMA.

In addition, the Comprehensive Planning Committee of the Planning Council will continue to work with DHE and G-PACC in monitoring progress and in informing the Priorities Committee of progress so initiatives from the plans may be prioritized for funding.

The process to be used for monitoring progress on the integrated plan goals and objectives will consist of monitoring, input, and adjustment, which are critical in continuing to ensure that available HIV/AIDS resources in Georgia are maximized and the use of these resources is prioritized when changes to the system are needed. Goals and objectives will be monitored by the planning councils, in collaboration with DPH HIV Prevention Program 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.

Additionally, the Ryan White Part A and B programs will generate reports from the CAREWare and e2Fulton (previously CAREWare) databases 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 their system. Performance measure reports will become more timely, accurate, and useful for quality improvement activities.

C. Evaluation: Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.

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, DPH's HIV Prevention program, and HIV surveillance to plan, prioritize, target, and monitor available resources in response to needs of people living with HIV and in order to improve engagement at each stage in the HIV care continuum.

In addition to using service utilization data, the program will evaluate progress by assessing clinical performance measures based on CAREWare data on a quarterly basis. Clinical performance measures are as follows:

Georgia Part B Program HAB Performance Measures From CAREWare
HAB Performance Measures
Core01 HIV viral load suppression
Core02 Prescription of antiretroviral therapy

Georgia Part B Program HAB Performance Measures From CAREWare
HAB Performance Measures
Core03 HIV medical visit frequency
Core04 Gap in HIV medical visits
Core05 CD4 < 200 with PCP Prophylaxis
Core06 Annual Retention in Care
HAB05 Percentage of Pregnant Women Prescribed ART
HAB07 Cervical Cancer Screening
HAB08 Hepatitis B Vaccination
HAB09 Hepatitis C Screening
HAB10 HIV Risk Counseling
HAB11 Lipid Screening
HAB12 Oral Exam
HAB13 Syphilis Screening
HAB14 TB Screening
HAB15 Chlamydia Screening
HAB16 Gonorrhea Screening
HAB17 Hepatitis B Screening
HAB19 Influenza Vaccination
HAB21 Mental Health Screening
HAB22 Pneumococcal Vaccination
HAB23 Substance Abuse Screening
HAB26 Hepatitis A Screening
HAB27 Hepatitis A Vaccination

These measures show overall state and individual subrecipient rates and include stratification of specific core measures by age, race/ethnicity, and gender. Program data is also shared with subrecipients for use in their clinical quality-management programs.

The Planning Council's Quality Management, Assessment, and Comprehensive Planning committees will work together with DHE quality management staff to compile and use surveillance and program data (e.g., service utilization, HAB measures, e2Fulton, 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 as well as to identify areas that require improvement. The measures are consistent with those tracked by Part B listed in the above table.

The EMA uses an ongoing electronic client satisfaction survey to obtain information on what is working well and what might need improvement. The EMA also has an ongoing electronic needs assessment survey, which is used to evaluate gaps in services and barriers to care, informing the service continuum.

D. Improvement: Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.

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 CQM Core Team to identify opportunities for quality improvement.

By monitoring the data quarterly and reporting to the Planning Council and the QM Committee monthly, the health program manager and DHE staff will determine progress toward strategy and will develop a plan of action for all activities that are identified as needing improvement by the Planning Council or DHE. They 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-Do-Study-Act cycle will be used, as needed, to guide quality improvements.

E. Reporting and Dissemination: Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation, and improvements made to the plan.

Integrated plan activities and outcomes will be shared with Ryan White– and HIV Prevention–funded agencies through program webpages and email correspondence. Agencies will be encouraged to disseminate the plan to consumers and local stakeholders, including local Ryan White Part B consortia and the Planning Council — including regular reporting to the Consumer Caucus. 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 people living with HIV in accordance with the integrated plan. The body will provide feedback to the plan to ensure that 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 and edit the plan as needed during the five-year period. DHE's community engagement specialist will use focus groups and CABs to provide updates and to solicit community input. Progress reports will be posted on DHE's website.

F. Updates to Other Strategic Plans Used to Meet Requirements: If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe:

i. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities.

A member of each jurisdictional planning body will continue to serve 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.

Integrated plan activities and outcomes will be shared with Ryan White– and HIV Prevention–funded agencies through program webpages and email correspondence. Agencies will be encouraged to disseminate the plan to

consumers and local stakeholders, including local Ryan White Part B consortia.

As a nonintegrated planning body implementing an integrated plan, the challenge of synchronizing and documenting success was extremely challenging. The planning group learned from the last plan the importance of regular documentation and reporting of accomplishments and challenges. This will require collaboration on the part of all entities.

As a first step in the process, the planning bodies will meet at a staff level to discuss the development of the work plan for each planning group and how the various entities will be involved in the reporting.

Reporting will be performed by each planning body, run concurrently with the meeting schedules of the various agencies, and consist of both meeting minutes and reports. This information will be shared with each member agency of the integrated plan as a way to easily compile data and reporting in a nonobstructive manner.

Planning bodies at the beginning of each planning year will establish a memorandum of agreement that will provide an overview of scheduling and reporting timelines. The agreement will be signed by the chair of each planning body.

ii. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes.

iii. Revisions made based on work completed.

The plan will be shared with the statewide integrated planning body, G-PACC, and the Planning Council. G-PACC's role is to provide strategies for action in the development of a coordinated system of care for people living with HIV in accordance with the integrated plan. The body will provide feedback to the plan to ensure that 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 and edit the plan as needed.

As the Metropolitan Atlanta HIV Health Services Planning Council, in the EMA, the greatest challenge experienced during the last integrated plan was the difficulties associated with monitoring a multiagency plan. The joint document integrated

prevention and care for three independent organizations, and it was sometimes extremely difficult to track the progress of individual planning body accomplishments.

In preparation for the development of the 2022-2026 integrated plan, both the Metropolitan Atlanta HIV Health Services Planning Council and G-PACC have discussed the need to meet quarterly as well as to continue cross-pollination of the two planning bodies. Presently, the Comprehensive Planning Committee chair also serves on G-PACC.

There are also plans to further develop community engagement by continuing group listening sessions during the next five years.

During quarterly meetings Planning Council staff and leadership will discuss any need for revisions and updates within the planning document.

At the end of each Planning Council year, a joint update will be compiled outlining the accomplishments made by each planning body. This information will include updates made by Ryan White Part A staff, quality management, and any other stakeholders having relevant tasks within the integrated plan.

APPENDIX A

Funding Source & Funded Organizations	2022 Budget: Dollar Amount	%	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management & Treatment Adherence	Substance Abuse Services – Outpatient	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 Services
Part A	**$ 24,459,193.39**																								
AID Atlanta	$ 1,423,760.86			x				x				x		x											
AIDS Healthcare Foundation (AHF)	$ 2,309,498.80		x			x		x				x				x								x	
Aniz, Inc.	$ 257,247.00											x			x			x						x	
Atlanta Legal Aid Society, Inc.	$ 95,458.03																								
Cherokee County Board of Health	$ 332,476.44		x											x											
Clarke County Board of Health	$ 219,240.10		x			x										x								x	
Clayton County Board of Health	$ 415,387.11		x			x										x								x	
DeKalb County Board of Health	$ 949,582.52		x			x		x				x	x			x							x	x	
Emory University Hospital at Midtown	$ 1,023,735.32		x			x						x				x		x	x				x	x	
Fulton County Board of Health	$ 1,771,391.88		x			x						x			x				x					x	
Grady Infectious Disease Program (IDP)	$ 7,166,922.41		x			x						x	x	x	x	x	x						x	x	
Here's to Life	$ 212,246.00														x	x			x					x	
NAESM	$ 305,984.36											x			x				x					x	
Positive Impact Health Centers	$ 5,006,910.34		x			x		x				x	x	x	x	x			x				x	x	
Project Open Hand	$ 1,174,557.00												x						x						
Saint Joseph's Mercy Care Services, Inc.	$ 648,234.96		x			x													x						
Someone Cares, Inc.	$ 270,510.40											x			x										
Southside Medical Center	$ 876,049.87		x			x						x		x										x	
MAI (Part A)	**$ 2,766,911.85**																								
Fulton County Board of Health	$ 168,342.00		x																						
Grady Infectious Disease Program (IDP)	$ 1,797,696.92		x									x				x									
Someone Cares, Inc.	$ 800,872.93		x																						
Ending the HIV Epidemic (EHE)	**$ 2,568,283.00**																								
AID Atlanta	$ 142,912.00													x		x					x			x	
AIDS Healthcare Foundation (AHF)	$ 120,692.00		x																		x				
Atlanta Harm Reduction Coalition	$ 165,725.00		x																x					x	
DeKalb County Board of Health	$ 87,511.00											x	x										x	x	
Grady Infectious Disease Program (IDP)	$ 535,994.00		x			x						x		x							x				x
Heather Ivy Society	$ 84,845.00																				x			x	
HOPE Atlanta	$ 217,470.00																	x			x				
NAESM	$ 56,145.00																				x				
NAESM Men's Health Center	$ 111,835.00		x																						
Open Hand	$ 55,800.00																		x						
Positive Impact Health Centers	$ 452,301.00		x									x		x	x	x					x		x	x	x
Southside Medical Center	$ 140,000.00		x																		x				
Thrive SS	$ 194,740.00																							x	x
To Our Shores	$ 202,313.00		x											x										x	
Ending the HIV Epidemic (EHE) Counties	**$ 5,652,171.00**																								
Cobb	$ 1,277,757.00		x			x						x	x	x	x	x		x			x		x	x	x
Fulton	$ 2,125,085.00		x			x						x	x	x	x	x		x			x		x	x	x
DeKalb	$ 1,113,843.00		x			x						x	x	x	x	x		x			x		x	x	x
Gwinnett	$ 1,135,486.00		x			x						x	x	x	x	x		x			x		x	x	x
TOTAL FUNDING	**$ 153,344,336.24**																								

Funding Source & Funded Organizations	2022 Budget		Professional Services	Psychosocial Support Services	Referral for Health Care/Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services - Residential	HIV Prevention and Testing	Condom Distribution	Prevention for Positives	Prevention for Negatives	Surveillance	HIV Care Continuum Impact	EHE - Diagnose	EHE - Treat	EHE - Prevent	EHE - Respond
	Dollar Amount	%																
Part A	$ 24,459,193.29																	
AID Atlanta	$ 1,423,760.86					x												
AIDS Healthcare Foundation (AHF)	$ 2,309,498.80					x												
Aniz, Inc.	$ 257,247.00				x	x												
Atlanta Legal Aid Society, Inc.	$ 95,458.03		x	x														
Cherokee County Board of Health	$ 332,476.44																	
Clarke County Board of Health	$ 219,240.10																	
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Fulton County Board of Health	$ 1,771,391.88					x												
Grady Infectious Disease Program (IDP)	$ 7,166,922.41				x	x												
Here's to Life	$ 212,246.00				x													
NAESM	$ 305,984.36																	
Positive Impact Health Centers	$ 5,006,910.34				x	x												
Project Open Hand	$ 1,174,557.00																	
Saint Joseph's Mercy Care Services, Inc.	$ 648,234.96					x												
Someone Cares, Inc.	$ 270,510.40																	
Southside Medical Center	$ 876,049.87																	
MAI (Part A)	$ 2,766,911.85																	
Fulton County Board of Health	$ 168,342.00																	
Grady Infectious Disease Program (IDP)	$ 1,797,696.92					x												
Someone Cares, Inc.	$ 800,872.93																	
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AID Atlanta	$ 142,912.00					x											x	
AIDS Healthcare Foundation (AHF)	$ 120,692.00																x	
Atlanta Harm Reduction Coalition	$ 165,725.00																x	
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Open Hand	$ 55,800.00																x	
Positive Impact Health Centers	$ 452,301.00																x	
Southside Medical Center	$ 140,000.00																x	
Thrive SS	$ 194,740.00																x	
To Our Shores	$ 202,313.00																x	
Ending the HIV Epidemic (EHE) Counties	$ 5,652,171.00																	
Cobb	$ 1,277,757.00								x	x	x	x			x	x	x	x
Fulton	$ 2,125,085.00								x	x	x	x			x	x	x	x
DeKalb	$ 1,113,843.00								x	x	x	x			x	x	x	x
Gwinnett	$ 1,135,486.00								x	x	x	x			x	x	x	x
TOTAL FUNDING	$ 153,344,336.24																	

APPENDIX B

Table 1. DHE Priority Data Transgender CY20 and CY21

	CY2020 (1/1/20 - 12/31/20)			CY2021 (1/1/21 - 12/31/21)		
	New Dx 2020	Living with HIV as of 12/31/2020	Among people living with HIV, how many were virally supressed?	New Dx 2021	Living with HIV as of 12/31/2021	Among people living with HIV, how many were virally supressed?
White Transgender M2F	Not currently available in e2Fulton	46	36 of 42 (85.7%)	Not currently available in e2Fulton	50	40 of 50 (80%)
White Transgender F2M		< 5	100%		< 5	100%
White Transgender Other		< 5	100%		< 5	100%
Black Transgender M2F		309	204 of 280 (72.9%)		328	232 of 301 (77.1%)
Black Transgender F2M		12	6 of 11 (54.5%)		19	11 of 18 (61.1%)
Black Transgender Other		23	18 of 20 (90%)		21	16 of 20 (80%)
Hispanic Transgender M2F		34	26 of 32 (81.3%)		38	31 of 37 (83.8%)
Hispanic Transgender F2M		< 5	50%		< 5	100%
Hispanic Transgender Other		< 5	100%		< 5	100%
All Races/Ethnicities						
Transgender M2F		356	239 of 322 (74.2%)		382	272 of 351 (77.5%)
Transgender F2M		14	8 of 13 (61.5%)		22	14 of 21 (66.7%)
Transgender Other		24	19 of 21 (90.5%)		22	17 of 21 (81%)

Hispanic = any race

Run 10/6/22

Viral Load Suppression

Numerator: Number of patients, in the denominator, with a HIV Viral Load less than 200 copies at last HIV Viral Load test during measurement year.

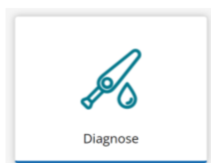
Denominator: Number of patients, regardless of age, with HIV with at least 1 medical visit during the measurement year.

Exclusions: None.

Table 2. Priority Data Table

	New Dx 2020	Living with as of 12/31/2020	Amoung people living with HIV, how many were virally supressed
White MSM	202	7652	5060
White Male High Risk for HIV Infection (HRH)	14	287	188
White Male IDU	14	251	119
White Female HRH	56	1120	558
White Female IDU	15	365	186
Black MSM	984	24329	13593
Black Male HRH	130	2987	1624
Black Male IDU	17	1291	608
Black Female HRH	291	9532	5470
Black Female IDU	13	1080	555
Hispanic MSM	140	2990	1660
Hispanic Male HRH	15	351	173
Hispanic Male IDU	<5	124	54
Hispanic Female HR	18	712	403
Hispanic Female IDU	<5	89	52
Trans M2F	57	653	346
Trans F2M	<5	30	17

APPENDIX C

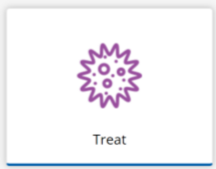


Diagnose all people with HIV as early as possible

NHAS Goal 1: Reducing new HIV Infections.

SMART Objective	**Objective 1:** By December 2026, 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**	**Population Of Focus**	**Data Indicators**
By December 2022 and ongoing:	• Georgia Department of Public Health (DPH) • Funded Community-Based Organizations (CBOs) • Local Health Depts.	Increase HIV testing in geographical areas with a 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 2022 and ongoing:	• Dekalb County Board of Health • Fulton County Department of Health and Wellness • 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
By December 2022 and ongoing	• DPH	Increased promotion and distribution of HIV self-testing kits.	• AA MSM • MSM • Transgender • AA Women • Hispanics	• Number of posttest surveys • Number of test kits distributed
By December 2022 and ongoing	• DPH	Research and investigate the feasibility of broad statewide distribution of Specimen Self Collection kits	• AA MSM • MSM • Transgender (MTF) • AA Women • Hispanics	• Positivity Rate • Number of individuals linked to care • Number of individuals who have tested negative

By December 2022 and ongoing	● DPH	Expand and promote the number of Syringe services programs (SSP) throughout the state. Provide Monitoring and Technical assistance for all SSP in the state	● AA MSM ● MSM ● Transgender (MTF) ● AA Women ● Hispanics	● Number of syringes distributed ● Number of syringes disposed ● Number of overdose reverse kits distributed ● Number of referrals for addiction recovery and other support services.
By December 2022 and ongoing	• DPH • G-PACC	Expand testing sites in correctional facilities in areas of high burden.	• Correctional facilities	● Number of new testing sites in jails



Treat people with HIV rapidly and effectively to reach sustained viral suppression

NHAS Goal 2: Increase access to care and improve health outcomes.

SMART Objective	**Objective 1:** By December 2026, 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).			
	Objective 2: By 2026, increase the percentage of people living with HIV/AIDS (PLWH) from 85% to at least 90% who are virally suppressed.			
	Objective 3: By 2026, increase the percentage of people living with HIV/AIDS (PLWH) from 85% to at least 90% who are virally suppressed.			
	Objective 4: By December 2026, increase the percentage of persons diagnosed with HIV that are virally suppressed to at least 80%.			
	Objective 5: By 2026, 90% of clients among Marginalized Populations engaging in HIV care will achieve a viral load of less than 200 copies/mL.			
Strategy 1.	Establish seamless systems to link people to care immediately after diagnosis.			
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2022 and annually	• Ryan White* and EHE Recipients & Subrecipients	Evaluate administrative processes and remove barriers to facilitate entry into Ryan White Programs (e.g., removing ID	• Part A Subpopulations of focus: • All MSM 19-34 y/o • AA Heterosexuals	● Linkage protocols standardized and implemented ● Number of patients seen by a medical

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		requirements for RW services, adding client global consent (or opt-out procedures) for providers to share client information). Standardize linkage protocols across programs to ensure clients have one provider appointment within 30 days of diagnosis	• AA Females 24-35 y/o • Transgender Females 19-34 y/o • Hispanics	provider within 30 days of diagnosis
Strategy 2.	Link clients to care and medications within 72 hours for newly diagnosed persons and PLWH previously out of care			
By December 2022 and ongoing	• Part A & EHE Recipient & Subrecipients	Maintain and evaluate rapid entry systems of care system between Part A and EHE providers. Link 90% of newly diagnosed persons to care within 72 hours and the co-location of services to ensure the client is served until a slot opens at a RW clinic of the patient's choice for ongoing care and treatment. Enroll clients with preliminary HIV diagnosis in care within 72 hours to lessen the time between diagnosis and entry in care.	• Part A Subpopulations of focus: • All MSM 19-34 y/o • AA Males 24-35 y/o • AA Females 24-35 y/o • Transgender Females 19-34 y/o • Hispanics	•Number of HIV tests performed overall and for each target population •Number of people who tested positive overall and for each target population. •Number of people linked to care within 72 hours
Strategy 3.	Prescribe antiretroviral medications for at least 90% of clients enrolled in medical care.			
By December 2022; and ongoing	• Parts A and B • Subrecipients • Funded	Offer 100% of patients ART.	• AA MSM • AA Women • Transgender • Hispanics	•Number/percent of clients prescribed ART

	• Health Care Teams, • Medical Case Managers, and • Discharge Linkage Teams	Provide intensive treatment adherence counseling for 100% of clients prescribed ART. Provide rapid initiation of ART for 100% of clients and continue provision until ADAP or Patient Assistance Program coverage begins.	• Part A Subpopulations of focus: • All MSM 19-34 y/o • AA Males 24-35 y/o • AA Females 24-35 y/o • Transgender Females 19-34 y/o • Hispanics	●Number/percent of clients who are virally suppressed
Strategy 4.	Deliver intensive treatment adherence counseling			

By December 2022; and ongoing	• Part A & EHE 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 the highest risk of non-treatment adherence, (e.g.,
			• AA MSM
			• AA Heterosexuals
			• Transgender
			• Hispanics
			• Part A Subpopulations of focus:
			  • All MSM 19-34 y/o
			  • AA Males 24-35 y/o
			  • AA Females 24-35 y/o
			  • Transgender Females 19-34 y/o
			  • Hispanics
				●Clinical chart reviews of documentation
				●Number/percent of clients receiving counseling
				●Number of clients identified 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

		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.		
Strategy 5.	Implement systematic approaches to address gaps in antiretroviral use.			
By December 2022, and ongoing	Parts A & EHE Recipients and Subrecipients	Provide rapid initiation of ART for 100% of clients and continue provision until ADAP or Patient Assistance Program coverage begins	• Hispanics • Part A Subpopulations of focus: • All MSM 19-34 y/o • AA Males 24-35 y/o • AA Females 24-35 y/o • Transgender Females 19-34 y/o • Hispanics	●Number/percent of clients prescribed ART 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.
Strategy 6.	Improve retention in care for people living with HIV experiencing health disparities.			
By December 2022 and ongoing:	• Part A & EHE Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high-risk populations) have access to medical and support services.	• PLWH • Part A Subpopulations: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Retention rate

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By December 2022 and ongoing:	• Part A & EHE Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high-risk populations) have access to antiretroviral therapy (ART).	• PLWH
			• Part A Subpopulations:
			  • All MSM 19-34 y/o
			  • AA Males 24-35 y/o
			  • AA Females 24-35 y/o
			  • Transgender Females 19-34 y/o
			  • Hispanics
				•Number of people on ART

By December 2022 and ongoing:	• Ryan White Part A Recipient	Reduce health disparities and access to care through rapid initiation of ART via MAI resources.	• Ryan White Subpopulations of focus: • All MSM 19-34 y/o • AA Males 24-35 y/o • AA Females 24-35 y/o • Transgender Females 19-34 y/o • Hispanics	•Disparities in viral load suppression rates (Health Disparities calculator)
By December 31, 2022; ongoing through December 2026:	• DPH	Expand Test-Link-Care Network to link and re-engage PLWH, not in care, and identify barriers to retention.	• AA MSM • AA Women • Hispanics • Transgender	•Number of TLC networks •Number of clients linked and re-engaged using Data to Care
By December 31, 2022; ongoing through December 2026	• DPH	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 re-engaged using Data to Care
Strategy 7.	Support retention in care to achieve viral suppression and reduce transmission risk.			

By December 2022 and ongoing:	• Parts A and B, and EHE 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 2022 and ongoing:	• Parts A and B, and EHE Recipients and Subrecipients	Ensure that all persons with HIV (with a focus on high-risk populations) have access to ART.	• PLWH	•Number of people on ART
Strategy 8.	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.			
By December 2023; ongoing through December 2026:	• Ryan White Part A MAI Subrecipient including Nurse Educators, Clinical Pharmacists, and Medical Case Managers	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 challenges. Expand MAI-funded services to include OAHS Drop-In Clinics and wrap-around services. (Mail-order pharmacy, mental health, and substance abuse services)	• Part A MAI Prioritized Populations: • AA MSM 25-34 y/o • AA Females 25-34 y/o • Trans-Identified Persons ages 19-34 y/o	•Number of Subrecipient/ Providers funded
Strategy 9	Provide enhanced treatment adherence support and education for populations at higher risk of not achieving viral suppression.			

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By December 31, 2022; ongoing through December 2026:	• Ryan White & EHE Recipients and Subrecipients
	
	• Ryan White & EHE 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 the 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).
			• AA MSM
			• Hispanics
			• Women, Infants, Children, and Youth
			• Part A Subpopulations of focus:
			  ◦ All MSM 19-34 y/o
			  ◦ AA Males 24-35 y/o
			  ◦ AA Females 24-35 y/o
			  ◦ Transgender Females 19-34 y/o
			  ◦ Hispanics
				●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 before receiving treatment adherence support
				●Number/percent of clients virally suppressed after receiving enhanced treatment adherence support
				●Number/type of youth-oriented initiatives implemented
				●Number/percent of youth receiving transition to adult care at age 25

		Provide comprehensive outpatient health services to include resistance testing, diagnostic procedures, general lab, radiology, treatment, adherence counseling, and support. Provide innovative youth-oriented initiatives to assist with the transition into adult care.		

Ryan White is inclusive of Parts A, B, C, and D

Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

NHAS Goal 3: Reduce HIV-related disparities and health inequities.

SMART Objective	**Objective 1:** By December 2026, reduce the number of new diagnoses by at least 25%.			
	Objective 2: By 2026, reduce disparities related to race, sexual orientation, gender, gender identity, and age to improve retention in care of targeted populations by 50%.			
	Objective 3: By 2026, 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, Transgender women, and Black/African American women.			
Strategy 1	Reduce barriers to prevention services for rural MSM.			
Timeframe	**Responsible Parties**	**Activity**	**Target Population**	**Data Indicators**
By December 2022 and ongoing:	• DPH • G-PACC	Assess rural MSM prevention needs and barriers to accessing services.	• MSM	●Number of participants completing an assessment ●Number of listening sessions/focus groups ●Report on barriers

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Strategy 2	Expand access to effective prevention services and intensify efforts, including pre-exposure prophylaxis (PrEP).			
By December 2022 and biannually	• DPH • G-PACC	Utilize the Office of HIV/AIDS 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 ●Number of media exposures ●Number of persons on PrEP ●Number of persons on nPEP
By December 2022 and biannually	• DPH • G-PACC	Broaden community awareness of PrEP and nPEP prevention of HIV infection among high-risk populations.	• Clinical Providers	●Updated HIV resource manual ●Number of media exposures ●Number of persons on PrEP ●Number of persons on nPEP
Strategy 3	Ensure that opt-out HIV screening is provided as a standard of care.			
By December 2026:	• DPH	Increase HIV testing in Federally Qualified Health Centers (FQHCs).	• FQHCs	●Number of FQHCs providing opt-out HIV testing
Strategy 4	Establish mobile units to facilitate access to care.			
Maintain mobile clinics through December 2026	• Part A and EHE Recipient and Subrecipients	Utilize at least two mobile clinics to serve identified zip codes and improve access to care.	• Part A Subpopulations of focus: • All MSM 19-34 y/o • AA Males 24-35 y/o • AA Females 24-35 y/o • Transgender Females 19-34 y/o • Hispanics	●Number/percent of clients receiving mobile clinic services
Strategy 5	Support access to continuous comprehensive care along the continuum to reduce disparities.			
By December 31, 2022; ongoing	• Ryan White & EHE Recipients	Increase the number of Patient Navigators, Non-Medical Case Managers, community health	• AA MSM • AA Women • Transgender Women	●Number of Patient Navigators

through December 2026:	and Subrecipients	workers and maintain funding levels to provide Peer Counselors	• Hispanics	●Number of Peer Counselors ●Number/percent of clients in communities with the greatest health disparities that receive peer support services ●Number/percent of clients receiving specified support services ●Number/percent of clients enrolled in HIP/HICP
By December 31, 2022; ongoing through December 2026:	• Ryan White Part A & B and EHE Recipients and Subrecipients	Conduct ongoing awareness campaigns targeted at communities with the greatest health disparities. Prevent	• AA MSM • AA Women • Transgender Women • Hispanics	●Number of Patient Navigators ●Number of Peer Counselors ●Number/percent of clients in communities with the greatest health disparities that receive peer support services ●Number/percent of clients receiving specified support services
By December 31, 2022; ongoing through December 2026:	• Ryan White A & EHE Recipients and Subrecipients	Conduct outreach to Spanish-speaking communities.	• AA MSM • AA Women • Transgender Women • Hispanics	●Number/percent of clients receiving specified support services
By December 31, 2022; ongoing through	• Ryan White & EHE Recipients and Subrecipients	Provide support services to decrease barriers to care, including medical transportation and translation assistance.	• AA MSM • AA Women • Transgender Women • Hispanics	●Number/percent of clients in communities with the greatest health disparities

December 2026:				that receive peer support services ●Number/percent of clients receiving specified support services
By December 31, 2022; ongoing through December 2026:	Ryan White & EHE Recipients and Subrecipients Clinical Quality Improvement (CQII)	Establish quality improvement interventions to increase viral suppression rates of people experiencing the impact of social determinants of health-related to housing instabilities, substance use, mental health, etc. through the CQII create+equity Collaborative	AA MSM AA Women Transgender Women Hispanics	●Number/percent of clients referred same day for offsite mental health and/or substance use services ●Disparities in viral load suppression rates (Health Disparities calculator) ●Evaluation of interventions by TA providers
By December 31, 2022; ongoing through December 2026:	Part A & EHE Recipients and Subrecipients	Build the capacity of HIV providers through Evidenced Based Interventions (EBI) to improve health outcomes for AA MSM and Transgender clients, through the UCSF learning collaborative	AA MSM AA Women Transgender Women Hispanics	●Number/percent of clients referred same day for offsite mental health and/or substance use services ●Disparities in viral load suppression rates (Health Disparities calculator) ●Evaluation of interventions by TA providers
Strategy 6	By 2026, reduce HIV-related disparities in communities at high risk.			
Between 2022 and 2026:	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	●Number enrolled in PrEP services ●Number of HIV Tests performed

			AA Women Hispanics	●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
Strategy 7	Reduce stigma and eliminate discrimination associated with HIV status.			
By the end of 2026:	CBOs DPH and Supported Local Health Departments	Provide CDC-supported evidence-based interventions.	General Population PLWH	●Number of participants in interventions ●Number of implemented interventions
By the end of 2026:	DPH	Provide CBO/ASO technical assistance for interventions.	CBOs/ASOs	●Number of agencies provided technical assistance
By the end of 2026:	DPH Part A & EHE Recipients and Subrecipients Part A Planning Council	Implement anti-stigma campaigns inclusive of print and digital media and marketing. Reduce stigma through targeted Social Media Campaigns	AA MSM Transgender Women AA Women Youth and Young Adults Hispanics	●Number of media impressions Key Performance Indicators: reach, demographics, and location

Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them

Goal NHAS Goal 4: Achieve a more coordinated response to the HIV epidemic in Georgia.

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SMART Objective	**Objective 1**: By 2021, increase coordination of HIV programs across the state of Georgia			
	Objective 2: By 2026, develop improved mechanisms to monitor and report on progress toward achieving national goals.			
	Objective 3: By December 2026, increase the number of persons who receive accurate information about HIV risks, prevention, and transmission.			
	Objective 4: By 2026, increase the number of PLWH retained in care to 90%			
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, 2022; ongoing through December 2026:	DPH Parts A and B, EHE Recipients and Subrecipients G-PACC Part A Planning Council	Hold annual meetings with (CDC & HRSA) funded parts, agencies, administration, HOPWA, Veterans Administration (VA), SAMHSA, PLWH, other providers, and AIDS Service Organizations (ASOs)/ 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 the annual Atlanta Area Outreach Initiative (AAOI) event which incorporates HIV and STD testing, linkage to care, and education on treatment as prevention. Continue Integrated Plan listening sessions	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	Share information within planning bodies, jurisdictions, and consumers.			
By December 31, 2022; ongoing through December 2026:	Parts A and B, and EHE Recipients DPH	Establish a mechanism and team to create annual progress reports and achievements towards Integrated Plan goals and objectives. Respond	Stakeholders	●Program and goal/objective data collected, and trends identified

	G-PACC Part A Planning Council Comprehensive Plan Committee	Report HIV Prevention and Care Program Updates to stakeholders, community partners, and consumers. Collect and disseminate monitoring, tracking, and progress report information quarterly to all planning bodies. Obtain input from planning bodies on successes and areas for improvement. Prepare and submit progress reports by established deadlines. Disseminate progress reports to prevention and treatment partners and stakeholders.		●Number/type of reports developed
Strategy 3	Strengthen the timely availability and use of data			
By December 2022; ongoing through December 2026:	DPH Part A & B Recipients & contractors Part A Planning Council	Share and match prevention and treatment data. Share HIV Surveillance data for the development of a district-specific care continuum. Share HIV testing data for improved program planning to better reach target populations. Share Part A Service Utilization and Care Continuum data with stakeholders	Data Stakeholders and Jurisdictions Supported Health Districts/ Jurisdictions	●Frequency of sharing ●Data availability ●Data schedule and reporting
Strategy 4	Provide HIV perinatal services to reduce seroconversion.			
By December 2022 and ongoing:	DPH G-PACC	Promote mental health and substance abuse services to mothers after delivery.	HIV positive mothers	●Number of HIV-positive mothers offered services

	Part D			
By December 2022 and ongoing:	DPH G-PACC Part D	Strengthen and expand the linkage process for HIV-positive mothers who need postpartum care for babies.	HIV positive mothers	●Number of HIV-positive mothers linked to services
By December 2022 and ongoing:	DPH G-PACC 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 5	Present perinatal cases to a case review team to identify gaps and missed opportunities to develop recommendations for improvements.			
By December 2022 and ongoing	DPH Part D	Ensure HIV-positive mothers receive training to increase clinical care and adherence.	HIV positive mothers	●Number of HIV-positive mothers trained
By December 2022 and ongoing	Parts A, B, and D Recipients	Review no-shows and appointment processes in local Ryan White clinics and strengthen processes to include follow-up with clients to ensure linkage and communicating updated processes to DPH	HIV positive mothers	●Number of HIV-positive mothers linked to care
Strategy 6	Educate Georgians about HIV and how to prevent it.			
By December 2022 and ongoing:	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 2022 and ongoing:	DPH G-PACC	Expand marketing campaigns in health district neighborhoods burdened with increased levels of infection. (Social Media, Print Media, Traditional Media, Geofencing)	General population	●Number of marketing campaigns conducted
Strategy 7	Provide HIV resources in communities/zip codes with the highest concentration of health disparities			
By December 2022 and biannually	Part A & EHE Recipient, Subrecipients, and Contractors	Assess communities/zip codes with the highest concentration of health disparities.	Part A Subpopulations of focus: •All MSM 19-34 y/o	●Number of clients served in identified zip codes by mobile clinics

	Local Health Departments Part A Planning Council Assessment & Comprehensive Plan Committees	Assess disparities in communities/zip codes where HIV is most heavily concentrated to identify existing HIV service provider locations and services as well as any HIV resource gaps and barriers. Based on assessment, establish the health resources to be provided through the mobile clinic system. Develop partnerships with existing HIV service providers in targeted areas Increase access to care by offering extended clinic hours, telecare, Wi-Fi tablet for clients, co-located services, etc. Develop and implement a communications plan to educate the community and existing providers about the availability of mobile clinic HIV services and how to access these services. Sustain digital ads (Google, Grindr, and YouTube), provider listings, and web referrals by zip code via Greater Than AIDS and the Kaiser Family Foundation. Maintain at least two mobile clinics to serve identified zip codes with the highest concentrations of health disparities and improve access to care.	•AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Number/percent of clients served in mobile clinics that are retained in care (two or more medical visits performed at least three months apart) ●Number of online intake forms from web referrals ●Number of impressions (page views, clicks, and video metrics) against benchmarks set annually

		Integrate HIV services in existing clinical practices.		
Strategy 8	Prioritize and evaluate gaps in knowledge and services along the care continuum.			
Ongoing through December 2026; with annual reporting	Parts A & B and EHE Recipients, Subrecipients, & Contractors Part A Planning Council's Assessment, Comprehensive Plan, Consumer Caucus, Vulnerable Populations, and Quality Management Committees	Conduct ongoing Client Needs Assessments to identify gaps and barriers to services and inform priority setting and resource allocation planning teams annually of online survey results 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, Office of HIV/AIDS resource hub, Part A Website, Greater Than AIDS Metro Atlanta website, etc. Assess results from KFF digital ads and Client Satisfaction Survey each quarter to assist with service delivery monitoring and Continuous Quality Improvement. Continue Integrated Plan Listening Sessions and establish focus groups to discuss public policy, identify service gaps, and service improvements.	AA MSM AA Women Transgender women Hispanics Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Needs Assessment report identifying gaps and barriers ●Type/number of services clients receive ●Client satisfaction and consumer update findings ●Recipient and Subrecipient CQI Plans and PDSA cycles

		*Support Services include medical transportation, housing, emergency financial assistance, non-medical case management, food bank/home-delivered meals, health insurance premium and cost-sharing assistance, etc.		
Strategy 9	Provide funding for initiatives to improve linkages between HIV testing and HIV care.			
By December 2022; ongoing through December 2026:	DPH Linkage to Care Coordinators Part A Insurance Navigators, Patient Navigators, Case Managers (Non-Medical) Part A Planning Council DPH	Establish a partnership with Prevention to add medical providers to treat newly diagnosed after testing on mobile units. Collaborate with HIV testing teams to connect newly diagnosed and previously diagnosed positive persons to care. Maintain and enhance funding allocations for Insurance Navigators to enroll individuals in Health Insurance Marketplace. Continue funding for Psychosocial Support Services (Patient Navigation) in 15 primary care sites to assist Linkage to Care Coordinators with enrollment and retention in care of newly diagnosed persons.	AA MSM AA Women MSM Transgender women Hispanics Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Number of people tested ●Number/percent of people 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 10	Reduce barriers for clients accessing care.			
By December 2022; and on-going	Ryan White & EHE Recipients, Subrecipients, & Contractors Health Dept. Staff Supported	Utilize case management services to remove barriers. Expand ARTAS and other linkage resources. Offer mobile health solutions (telecare, Wi-Fi enabled telecare tablets,	AA MSM MSM Transgender AA Women Hispanics	●Number of clients who received support services ●Number and type of support services accessed ●Number of tablets distributed

	CBO Staff Supported Hosp. Staff DPH Supported Health Districts	mobile clinic options, Uber health, incentives) to clients.	Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Number of telecare visits ●Number of transportation visits
Strategy 11	Incorporate opportunities for client engagement into all aspects of service delivery.			
By December 2022, and on-going	Ryan White & EHE Recipients & Subrecipients Health Dept. Staff Supported CBO Staff Supported Hosp. Staff DPH Local Supported Health Departments	Link and/or reengage individuals who are "out of care". Expand access to care to include areas outside of the urban core within the Atlanta EMA. Expand access to care in rural areas.	AA MSM MSM Transgender AA Women Hispanics Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Number of trained navigators ●Number of clients reengaged
Strategy 12	Expand linkage processes in correctional facilities to ensure newly released persons are linked to a medical appointment within 30 days of release.			
By December 2022; ongoing	Ryan White Recipients and Subrecipients Funded Discharge Linkage Teams	Enhance collaborations in correctional facilities between groups testing in jails and prisons and pre-release planning.	AA MSM MSM Transgender AA Women	●Number linked to medical care within 30 days of release ●Number released with 30 days of medicine

	Funded CBOs DPH Local Supported Health Departments Department of Corrections	Ensure medical records are available and sent to the new provider of care. Provide effective transition via jail discharge linkage teams to ensure continuity of medical services for discharged persons.	Hispanics Part A Subpopulations of focus: AA Males 25-44 y/o AA Females 25-44 y/o Transgender Females 19-34 y/o	
Strategy 13	Implement systematic approaches to address gaps in antiretroviral use.			
By December 2022, and ongoing	Ryan White and EHE Recipients and Subrecipients Medical Case Managers Non-Medical Case Managers	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' offices. Presumptively approve ADAP enrollment for clients until final documentation is submitted.	Hispanics Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Number/percent of clients prescribed ART 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.
Strategy 14	Expand resources and clinic hours in underserved geographic areas to provide PLWH with more access to care options			
By December 2022; ongoing through	Ryan White & EHE Recipient and Subrecipients	Expand the system of mobile units, and satellite clinics, and expanded clinic	AA MSM AA Women	●Number of clients served by mobile units and satellite clinics

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December 2026:	DPH Local Supported Health Departments	hours (evening and Saturdays). Establish relationships with non-traditional partners including FQHCs.	Transgender Females Hispanics Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●Number of clients served during expanded clinic hours ●Number of non-traditional partnerships established
Strategy 15	Improve retention in care for people living with HIV experiencing health disparities to achieve viral suppression and transmission risk.			
By December 2022 and ongoing:	Ryan White & EHE 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 2022 and ongoing:	Ryan White & EHE 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 2022 and ongoing:	Ryan White & EHE Recipients and Subrecipients	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 16	Increase the number of available providers of clinical care and related services for people living with HIV.			
By December 2022 and ongoing:	Ryan White & EHE Recipients and Subrecipients	Increase the number of available providers of HIV care.	Ryan White clinics PLWH	●Number of providers

By December 2022 and ongoing:	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 2022 and ongoing:	Ryan White & EHE Recipients, Subrecipients & Contractors HRSA Public Health Foundation UCSF GA AETC	Coordinate with FQHCs to promote and refer new clinical initiatives Provide training for the current provider workforce. Utilize web-based resources (TargetHIV, DHE TRAIN*) to train providers. * TRAIN is a national learning network.	Ryan White clinics PLWH	●Number of providers trained
Strategy 17	Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-morbidities and challenges in meeting basic needs.			
By December 2022 and ongoing:	Ryan White and EHE Recipients and Subrecipients	Leverage available resources for primary care and support services. Incorporate COVID-19, Influenza and MPX vaccinations, HCV medication, HIV/STI testing, hormone therapy, mobile health options, etc. into the HIV service delivery system.	PLWH	●Number of medical providers ●Number of support services provided
Strategy 18	Reengage individuals identified as out of HIV care within seven days of identification by implementing Data to Care models.			
By December 2022 and ongoing:	DPH Linkage Staff & Health Department 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 19	Provide Health Insurance Premium Support			
By December 31, 2022, Ongoing:	Part A & B and EHE Recipients and Subrecipients Part A Planning Council Priorities Committee	Identify RW clients who are eligible for Health Insurance Exchange enrollment and vigorously pursue enrollment into a third-party payer. Prioritize and allocate funding for Health Insurance Premium Support & Cost Sharing Assistance Partner with enrollment agencies to help Ryan White Eligible clients who qualify to enroll in a third-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 20	Ensure availability of core and other support services to improve access to and retention in care.			

By December 31, 2022, Ongoing:	Ryan White Recipients and Subrecipients Part A Planning Council	Utilize Ryan White, EHE, 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
Strategy 22	Establish mobile units to facilitate care			
Ongoing through December 2026	Part A and EHE Recipient and Subrecipients	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.	Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •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 23	Support access to continuous comprehensive care along the continuum to reduce disparities.			
Ongoing through December 2026	Ryan White & EHE Recipients and Subrecipients	Provide linguistic services to 100 % of Spanish-speaking clients, including the use of patient education materials in Spanish.	PLWH and General Population	●Number of Patient Navigators ●Number of Peer Counselors

		Provide assistance for 100% of clients with vision and/or hearing impairments. Increase third-party coverage for eligible clients. Explore innovative treatment options such as Telemedicine for clients.		●Number/percent of clients in communities with the 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 24	Increase the provision of integrated services to reduce social determinants of health and reduce HIV-related health disparities.			
By December 31, 2022; ongoing through December 2026:	Part A & EHE Recipients 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 appointments as HIV primary care visits 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 ●Disparities in viral load suppression rates (Health Disparities calculator)

Section V: 2022-2026 Goals and Objectives

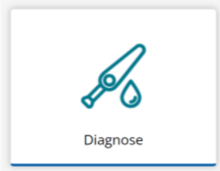
				●Evaluation of interventions by TA providers
Strategy 25	Reduce stigma and discrimination based on HIV status, gender identity and expression, sexual identity and expression, race/ethnicity, and socioeconomic status among PLWH.			
By December 2022; ongoing through December 2026:	Ryan White & EHE Recipients and Subrecipients Part A Planning Council DPH GA AETC UCSF Center for AIDS Prevention Studies Kaiser Family Foundation Thrive SS	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 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. Collaborate with Technical Assistance Providers to reduce health disparities.	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 training ●Number of provider staff trained with training documented in personnel records ●Pre/post-test training results ●Number of online intake forms from web referrals ●Number of impressions (page views, clicks, and video metrics) against benchmarks
By December 2022 and ongoing:	Part A & EHE 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)	Part A-funded agencies	●Number/ percent of funded agencies that have implemented at least one strategy

		Governance, Leadership, and Workforce; 2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability).		in each of the three CLAS categories ●Number/type of stigma and discrimination awareness campaign activities implemented
Strategy 26	Increase efforts to improve HIV care access, retention, and treatment adherence among underserved individuals.			
By December 31, 2022 and ongoing	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 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. Implement enhanced contact interventions for “hard-to-reach” populations.	AA MSM 19-34 y/o AA Females 19-34 y/o Transgendered Persons ages 19-34 y/o	●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
Strategy 27	Provide enhanced treatment adherence support and education for populations at higher risk of not achieving viral suppression.			
By December 31, 2022; ongoing through December 2026:	Ryan White & EHE Recipients and Subrecipients	Provide 100% of clients with HIV educational information on enrollment at HIV service delivery sites.	AA MSM Hispanics Women, Infants,	●Number/percent of clients receiving educational information at enrollment

		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 the 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. Provide innovative youth-oriented initiatives to assist with the transition into adult care.	Children, and Youth Part A Subpopulations of focus: •All MSM 19-34 y/o •AA Males 24-35 y/o •AA Females 24-35 y/o •Transgender Females 19-34 y/o •Hispanics	●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 before receiving treatment adherence support ●Number/percent of clients virally suppressed after receiving enhanced treatment adherence support ●Number/type of youth-oriented initiatives implemented ●Number/percent of youth receiving transition to adult care at age 25
Strategy 28	Adopt structural approaches to reduce HIV diagnoses and improve health outcomes in high-risk communities.			
Between 2022 and 2026:	Ryan White Recipients/ subrecipients	Routinize the screening of sexually transmitted infections/diseases, viral hepatitis, and tuberculosis	AA MSM Transgender Women	●Number of STI, VH, and TB tests performed among persons with HIV

	DPH USCF	in the health departments within communities disproportionately impacted by HIV.	AA Women Hispanics	●Number of STI tests performed in conjunction with HIV tests
Between 2022 and 2026:	DPH Part D CBOs	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 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 29	Coordinate monitoring, tracking (trending data analysis), and progress reporting toward the achievement of EHE Plan goals in Georgia.			
By December 31, 2022; quarterly and biannually	DPH Ryan White & EHE Recipients	Quarterly monitoring and sharing of 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	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 ●Service Utilization

Section V: 2022-2026 Goals and Objectives

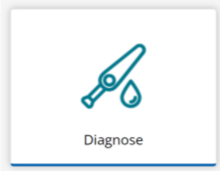


Diagnose all people with HIV as early as possible

NHAS Goal 1: Reducing new HIV Infections.

SMART Objective	**Objective 1:** By December 2026, 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**	**Population Of Focus**	**Data Indicators**
By December 2022 and ongoing:	• Georgia Department of Public Health (DPH) • Funded Community-Based Organizations (CBOs) • Local Health Depts.	Increase HIV testing in geographical areas with a 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 2022 and ongoing:	• Dekalb County Board of Health • Fulton County Department of Health and Wellness • 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
By December 2022 and ongoing	• DPH	Increased promotion and distribution of HIV self-testing kits.	• AA MSM • MSM • Transgender • AA Women • Hispanics	• Number of posttest surveys • Number of test kits distributed
By December 2022 and ongoing	• DPH	Research and investigate the feasibility of broad statewide distribution of Specimen Self Collection kits	• AA MSM • MSM • Transgender (MTF) • AA Women • Hispanics	• Positivity Rate • Number of individuals linked to care • Number of individuals who have tested negative

Section V: 2022-2026 Goals and Objectives



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